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The Poor and the Patient: Protestant Geneva in the Early Modern Period¹

Philip Rieder

Recent research has demonstrated the usefulness of considering both the history of lay and professional practices from the patient's point of view. Issues explored include the interactions between the ill and contemporary healers², between medical knowledge and lay expectations³, and between the ill person and his or her direct environment.⁴ The results of these studies recognise the existence of a lay medical culture, although the importance of lay, informal healthcare and self-help remains difficult to assess throughout the Early Modern period. Moreover, the extant data are generally related to the more literate and prosperous spheres of society and little is known of what happens in less affluent environments. The poor – understood here not as vagrants who were generally driven away, but as recognised impoverished inhabitants of the city⁵ – have left few or no manuscripts. The aim of this contribution is to make use of the exceptionally rich sources kept in Geneva's state and private collections in order to discuss available data on lay medical practices and reveal what general medical practices existed from the point of view of an ordinary or poor patient. It is important to stress from the out-set that medical practices are not reduced to acts performed by medical doctors alone, but understood to include self-help, informal counseling and any medical commodities or advice exchanged. The topic is as yet obscure and complicated by methodological issues pertaining to the difficulty of understanding the respective roles of different resources in a patient's efforts to retrieve or to preserve their health in the past. The following pages, by avoiding modern definitions and assumptions on efficiency and concentrating on practices, aim to assess how the patient used available medical commodities and services. Particular attention is paid to different strategies condi-

1 Research necessary for this article was subsidised by the Swiss National Research Fund (FNRS 114-068111).

2 Garcia-Ballester, 1989; Faure, 1992; Pomata, 1998.

3 Stolberg, 2003.

4 Smith, 2003; Rieder, 2003.

5 This is a common reality in early modern Europe. Vagrant poor frighten and are commonly repressed. Gutton, 1974, p. 103 et suiv.

tioned by the financial situation of the patient. Do those devoid of means enjoy only limited access to resources? Do the poorer members of society resort systematically to irregular practitioners? Addressing these questions is ambitious, given the nature of existing historical data. The first section of the paper contrives more modestly to map out both formal medical commodities and lay or informal services available in Early Modern Geneva.⁶ The second section concentrates on self-help and informal healthcare organised by and around the patient. In the last section of this paper, a series of insights into understanding how the less affluent used medical commodities are suggested.

Available Medical Services

Although the number and the nature of regular medical practitioners evolved during the rather long time span considered here, stretching from the Reformation to the French Revolution, a period of territorial and political stability for the Republic of Geneva, one permanent feature of Geneva's medical market is the global control exercised by the Republic's paramount political body, the Small Council (*Petit Conseil*). The role of the Council was particularly important in the direct aftermath of the Reformation when there was no established medical guild. During this period the town aldermen were overtly wary of the interests of established practitioners when it came to judging of the capacities of foreign healers seeking establishment within the city. In certain cases, aldermen overrode the advice of recognised and established practitioners in order to grant licences to particular healers, often prompted by patients' requests. Conditions of admission to practice remain flexible even after 1569, the year the first medical edicts (*Ordonnances médicales*) were implemented and the foundation of a guild (*Faculté*) encompassing physicians, surgeons and apothecaries.

Regular practitioners were comparatively numerous in Geneva during the entire period. High numbers could be related to the reformed denomination of the city as many practitioners, attracted to Geneva for confessional reasons, remained. Moreover, Protestants from France and nearby Swiss and German regions sent their children to be apprenticed to surgeons and apothecaries within the city. This probably boosted local trade and the overall number of healers. The last point is confirmed by particularly high numbers of practitioners present after each wave of protestant immigration, most explicitly following the Second Refuge in the late 17th century. In 1701, the medical density (counting both master surgeons and physicians) was approximately 1 practitioner for 500 inhabitants in Geneva. This was a period of crisis for providers of medical commodities and an effort was made to reduce num-

6 See Revel, 1996.

bers in the following years.⁷ Yet, as during the 16th and 17th centuries, the mean medical density remains above 1 practitioner/1000 inhabitants throughout the 18th century.⁸ Overall, concentrations of practitioners appear to be higher than those found in contemporary France.⁹

High concentrations of practitioners may have been responsible for the lack of work and low prices, these were at least the complaints voiced by regular healers. More generally, the organisation of the medical marketplace can be depicted as revolving around the “patients” requests and desires throughout the period. This is largely due to the fact that the control of medical practice remained in the hands of the Small Council. Moreover, as elsewhere, even healers considered to be ignorant were accepted if they could count on patients’ patronage.¹⁰ Healers expelled or formally banished from the city were sometimes readmitted, albeit on a temporary basis, in order to heal specific patients. In 1562, for instance, Jean des Vernaitz, a temporary resident suffering from a cataract, asked for permission for the surgeon Aymo Tissot, banished for repeated drunkardness, arrogance and lack of respect two years previously,¹¹ to be readmitted to the city in order to operate on his eyes. The decision taken was to allow Tissot to remain two months within the city walls.¹² Rulings in favour of the interests of the sick were common. The policies of the Guild tending to enforce its own monopoly were consistently frustrated by the City Council and lay requests. Even the edicts framing medical practices allowed provision for bone setters, operators of cataracts, of stones and other specialists to receive short term licences in order to practice as “the patient shall deem fit” on the condition that they operate in the presence of a regular practitioner.¹³

The edicts themselves were not strictly enforced. Notwithstanding the provision already mentioned which suggests that exceptions to the standard examinations or

7 In 1701, the guild officially petitions in order to reduce numbers of barber-surgeon and apothecary shops within the city. BPU, Ms fr 2171–2186. Archives de l'État de Genève (hereafter : AEG), Santé F1, pp. 154–155.

8 XVIth century numbers are approximations calculated from administrative documents. The town then held between 10 to 18'000 inhabitants, with something close to 5 physicians and 10 barbers or surgeons available between 1536–1569. 18th century data stems from the guild's records.

9 Jean-Pierre Goubert's overview concludes of the presence, in French towns of Geneva's size, of between 0.7 and 1.5 practitioners/1000 inhabitants in 1780. This is comparable to data found by François Lebrun for Anjou (1 physician/surgeon for 1400 inhabitants) and higher than densities calculated by Jean Meyer in his study of Brittany (1 physician/surgeon for every 4000–4500 inhabitant) although small active towns such as Nantes and Rennes boast a high rate of 1 practitioner for 1500–1700 inhabitants. Saint-Malo is even closer to the Geneva numbers with 1 practitioner for 1000–1200 inhabitants. Goubert, 1977; Lebrun, 1971, p. 218; Meyer, 1972, pp. 174–179.

10 Practical capacities are widely recognised: Ruggiero, 1981, p. 170.

11 AEG, Livre du Conseil des affaires criminels et consistoriaux, 15/10/ 1560.

12 AEG, Registre du Conseil (hereafter: R.C.), f. 32, 2/4/1562.

13 Gautier, 2001, pp. 610–618. For the 18th century, see: Louis-Courvoisier, 2001.

professional credentials were to be demanded by the patient and limited in time, less than 10 days after the formal acceptance of the edicts, Antoinette Deserre requested “permission to treat those suffering from ruptures of which she had previously cured more than one”. Antoinette Deserre is clearly a specialised lay healer and her pretensions are based on previous success. She shares this profile with many contemporary and subsequent lay healers. The fact that the Council grants her request, conferring thereby an indefinite licence to a lay healer without consulting the medical corporation, illustrates the accepted presence of lay healers even after the implementation of the new guild’s formal monopoly.¹⁴ Although it is not yet possible to establish comprehensive lists of lay practitioners, there are many traces suggesting the regular presence of lay healers within and in the neighbourhood of the city. Local lay healers, both men and women, are associated with occult powers both to harm and to heal; many are suspected of performing “miracle” cures and not conforming to orthodox Protestant worship patterns. As such, some are called before Geneva’s Consistory court¹⁵; others are tried in the Geneva witch trials or in criminal proceedings when their activities are suspected of having regrettable effects on their client’s health.¹⁶ Over time the status of established lay healers changes. They no longer receive definite official licences to practice in the 17th and 18th centuries when only itinerant specialists obtain provisional licences to practice, although native lay healers seem still to be widely tolerated – in fact, healing practices were commonly presented by suspected fortune-tellers as a justification to their activities.

Understanding how and why such healers were tolerated is a key issue in clarifying the reality of the Early modern medical marketplace. Possible explanations are numerous. Lay healers may not have charged, or charged only little, therefore encroached only superficially on the practices of more “professional” healers. On the other hand, their healing practices could be seen as related to domestic medicine, a sphere where established practitioners were rarely present. The most obvious reasons are that the overall control of the marketplace being in the hands of the Small Council, the stress was laid on organising medical practice around the patient’s needs, two elements which infer a tolerant attitude all-round. Even the more official activities of recognised practitioners are constantly jeopardised in the name of the same principal. At times, for instance, formal rules are relinquished in order to allow apothecaries and surgeons to prescribe medicines so that poorer patients may receive care without having to find the means to pay for a physician’s

14 AEG, R.C. 64, ff. 74v & 80, 18/5/1569 & 27/5/1569.

15 The Consistory court is composed of the city ministers and 12 elders (deemed both godfaring and respectable) chosen from the Council of citizens (Conseil des CC) by the Small Council and 2 must be members of the Small Council. *Edits Ecclésiastiques*, 1576, art. LXIX et LXX. See Kingdon, 1995.

16 Monter, 1971; Monter, 1976, pp. 167–190; Broye, 1990.

bill.¹⁷ It is probable, although difficult to prove, that as different categories of medical practitioners originated in specific social strata, their occupations were integrated into the social environments in which they were born. The 16th century is exceptional in this respect; medical occupations and social positions were then complicated by the fact that on one hand many migrant physicians lived in precarious conditions and on the other, certain irregular practitioners evolved in the higher spheres of Geneva society. This is the case, for instance, of Jaques Carre, a merchant and bourgeois of the city, who claimed in 1543 a right to heal because his father was a surgeon as was his father's father. He admits to healing “ruptures, dislocations and broken bones” and to preparing plasters of wax mixed with certain herbs, which he then uses in order to expel bad humours, but denies having ever given “brevet”¹⁸ or spells (“charmes”). In the 17th and 18th centuries social groups tend to be rigid, medical doctors and apothecaries were typically born in well-to-do families, surgeons stemmed from the middling sort and irregular healers came from popular environments. The social integration of practitioners is probably the first and the most useful outlet for their medical commodities, although observing common practice reveals that reputations and recognised capacities to heal tend to break down social barriers.

Self-Help, Patient Culture

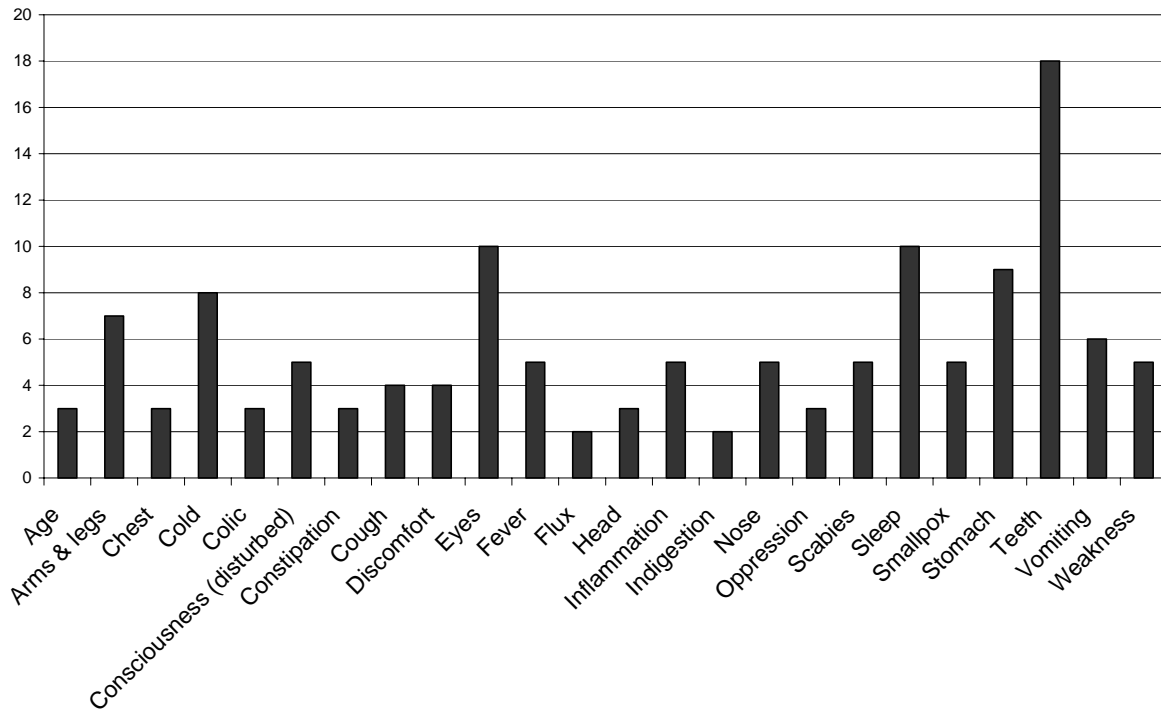
When it comes to describing who consults whom and why or, more simply, how one strives to remain healthy or retrieve lost health during the Early Modern era, it is important to start by stressing the idiosyncratic characteristics of patients' ills.¹⁹ In written testimonials, each particular health story tends to be presented as unique. Starting from the humoral, physical and occupational characteristics either inherited or imprinted in childhood, each individual construes a singular relationship to his or her health. In this context, one is oneself the most able to

Figure 1. Common complaints. Théophile Rémy Frêne (1741–1804).

17 This is particularly obvious when, after a revision of the edicts in 1658, Surgeons and apothecaries are “again” permitted to practice medicine after complaints by poor inhabitants of the cost of having to consult a physician in order to obtain a prescription. AEG, R.C., le 9 mars 1660, f. 25.

18 A bill on which figures or words are inscribed, used superstitiously in order to heal patients, see: Académie, 1694.

19 This explains difficulties encountered in understanding medical expressions today: Peter, 1971.



Source: Frêne 1993–1994.

Commentary: N= 124.

interpret the evolution of one's own health.²⁰ Jewson's much acclaimed model tracing the evolution of relations between patients, practitioners and medical knowledge is certainly correct in at least one respect: during the Early modern period the patient tends to control his or her own medical story and therefore the meaning of illness.²¹ How then can one understand the aches, pains and diseases of which patients suffered in the Early Modern period? Some information about the ailments that most plague everyday life can be found. Books of family recipes, for instance, offer some insights.²² The vast quantities of medicines destined to relieve stomach and digestive troubles may reflect difficulties met in procuring water of a good quality and in preserving food. Other ills are related to behaviour. Bad teeth incur many medical preparations and are reputedly an 18th century problem, due to changes in dietary habits (more sugar). Painful teeth figure among the most frequent ills which plague some patients for years: in the diary kept by Théophile Rémy Frêne (1727–1804), decayed teeth and subsequent pains cause the most numerous complaints. Eye problems are also common in 18th century, as described in the registers of Geneva's hospital.²³ The list of complaints the most commonly

20 Such interpretations are based on ancient hygiene, i.e. the 6 non-naturals: Pilloud/Louis-Courvoisier, 2003.

21 Jewson, 1976.

22 On secret remedies, see Ramsey, 1982a; Ramsey, 1982b; Ramsey, 1988.

23 Louis-Courvoisier, 2000, p. 45.

found in diaries confirm the symptom orientated medical culture of the patient as does the rare occurrences of named diseases – in Frêne’s case, only scabies and smallpox appear regularly as ontological entities.²⁴

Beyond examples such as those offered by diaries, there are few means of knowing how recipes were used and this is in part due to the fact that they are usually made up of common ingredients found in most kitchens. Traces in account books enable one to get a pretty clear idea of the availability of common ready-made medicines in households: Sirop de capillaire, Eau de carmes²⁵, Eau de la reine de Hongrie²⁶, Eau sans pareille, Eau cordiale, Panacée solutive, Beaume du Commandeur, Eau d’arquebusade²⁷, and other all purpose medicines appear regularly in 18th century documents. The presence and the ready usage of some of these items are confirmed in particular circumstances. In 1761, as Antoine de Normendie (1713–1761) lies in pain on his bed, possibly poisoned by a badly confectioned enema, a neighbour comes to assist his wife and brings with her a bottle of Eau de carmes²⁸. Overcome by weakness while visiting a friend, Théophile Rémy Frêne collapses and is offered by his host, in June 1779, true Venician theriac and tea in order to set him right.²⁹ The list could be pursued indefinitely, involving individuals from all strata of society.³⁰

Important use of ready-made medicines may be an 18th century phenomenon, but documents left by Early Modern patients confirm important lay autonomy and regular self-medication, with more or less frequent counselling by different categories of healers. Data on the way the affluent use medical services is available.³¹ The working classes tend to take their health problems into their own hands. In 1765, for instance, Benjamin Macaire, a 60 year old master watchmaker suffering from a swelling on his hip which is described as a tumour, consulted François-David Cabanis (1727–1798), a well established master surgeon. The plasters, pills and regimen prescribed did not resolve the tumour and some time later, a village surgeon named Lafon suggested to operate the swelling, arguing that it could be an abscess. Cabanis was against the idea, but Macaire decided to let Lafon operate.

24 Others do appear in his diary, namely apoplexy, dysentery and measles, but do not affect him directly.

25 Contains balm alcohol, rosemary, thym, cinamon alcohol, etc. Invented and sold at the “Carmes” monastery in Paris: Franklin, 1892, pp. 218–219; Béclard and al., 1821–1822.

26 “Alcoolat de romarin” according to Franklin. Franklin, 1891, pp. 221–222; BÉCLARD et al., 1821–1822.

27 Used for wounds. Contains aromatic herbs and alcohol. Franklin, 1891, p. 217; Béclard et al., 1821–1822.

28 AEG, P. C. 10905: Deposition de Dame Antoinette De Chapeaurouge du 24 aoust 1761.

29 Frêne, 1993–1994, p. 1311.

30 Rieder, 2002, pp. 696–699.

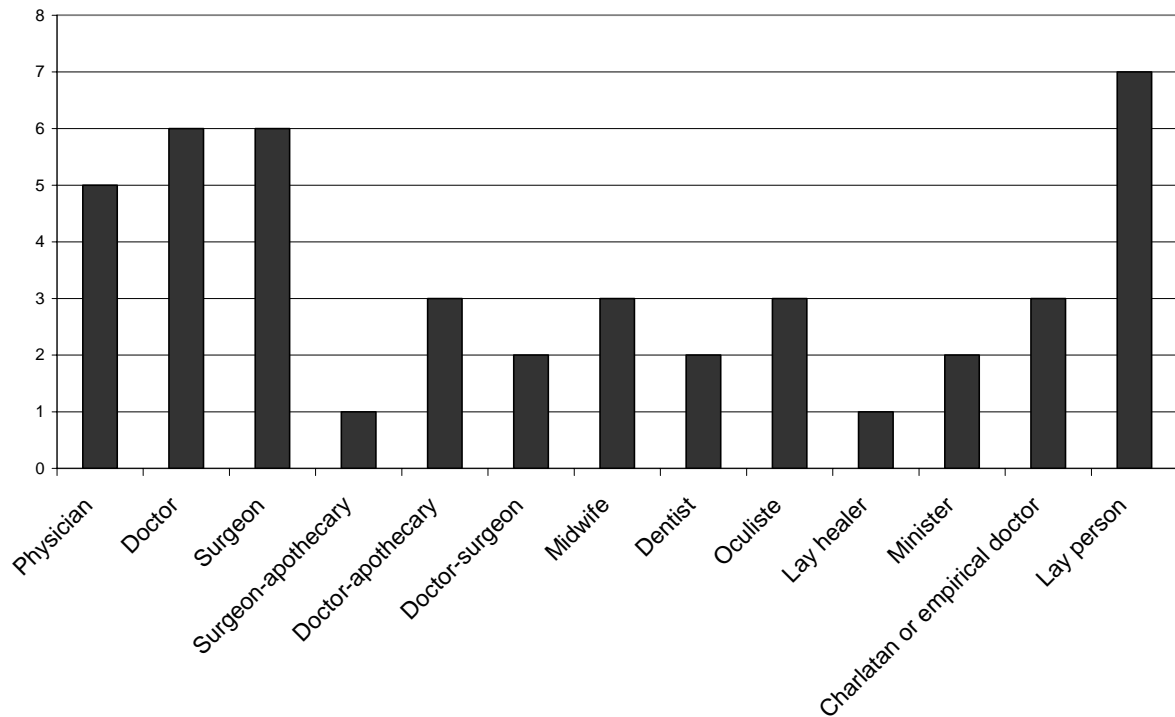
31 Rieder, 2005.

Eight days after the operation, the patient died, but neither the patient on his death bed nor his widow thereafter felt the need to incriminate the surgeon: did he not convince the patient of the necessity to operate?³²

Macaire had consulted two surgeons with very different profiles: a famous city surgeon and a reputedly ignorant village surgeon. This is all that is known of three years of the patient's life as it is confined to the investigation report that the watchmaker's sudden death occasioned. More information is available a few steps up the social ladder, in middle class families. These people were poor in the traditional sense that they had to work to survive, but they most certainly did not consider themselves to be poor. Jeanne-Marie Bellamy Prevost (1725–1785), is a good illustration of this social category. Wife to the minister Abraham Prevost, she enjoys the help of two servants in order to perform her household duties and care for her two children. During the eighteen months in the years 1772 and 1773 of her diary, she mentions only two consultations. The first is a rather unofficial request presented to a physician attending her mother in autumn of 1772 and the second occurs in the following spring when she feels the need of phlebotomy. And yet during the entire period her state of health is a source of great anxiety. She undertakes on her own ruling a variety of medical measures, namely medicines such as changes of scenery, goat's milk, exercise and a powerful purgative made from rhubarb, which she consumes often. In Bellamy Prevost's case, domestic or self-administered remedies form the main part of her health program: the physician is clearly called in to counsel or confirm her own strategies. She does mention rather vaguely lay or common opinions on certain medical problems, suggesting that she does confer with others on such matters. In this respect, other diarists are more explicit. A contemporary figure evolving in the same social class, the already mentioned minister Théophile Rémy Frêne, details in his diary conversations with a variety of healers, including surgeons, village "notables", neighbours, friends and physicians.

Frêne discusses medical questions with everyone and takes counsel from different types of healers (figure 2): he often resorts to lay advice or to help given by irregular healers, although he typically calls in a regular physician when he is seriously worried or considers himself or a member of his family to be "in danger". He also indulges in some self-doctoring. On one occasion, in a self-prescribed preventive treatment for dysentery – rhubarb taken as a purgative – his wife falls seriously ill and he fears for her life. Frêne immediately writes to a physician, Friedrich Salomon Scholl (1708–1771), established in Bienne, a town some 15km distant. **Figure 2.** Origins of medical advice and medicine given to Théophile Rémy Frêne for his own health problems (1740–1804).

32 AEG, P. C. 11723.



Source: Frêne 1993–1994.

Commentary: N=31. The table does not take into account the number of occurrences.

The physician cannot come immediately and the medicine he sends does not seem adequate to the husband who falls back on a recipe taken from Tissot's famous *Advice to people in general*³³ which he later judges to be at least partially responsible for his wife's recovery.³⁴

As suggested by the preceding examples, family medicine is probably the most common type of medicine. Individuals, male and female, often care for and nurse ill family members. In fact, in the context of Geneva's social discipline as it is enforced since the Reformation, nursing next of kin is a duty which incurs the formal disciplinary intervention of a minister or an elder if it is not respected. This applies to all social classes.³⁵ Recent research tends to suggest that family medicine and medical services exchanged in the neighbourhood constitute an important section of medical practices.³⁶ Such informal help is tolerated by the city and the guild: only practices arousing social protest or suspicion of superstitious or magical healing rituals get particular attention. Here most of the data appears to stem from

33 Tissot, 1993.

34 A more detailed account of these cases can be found in Rieder, 2002.

35 Among many examples: David Remond was rebuked for having left his ill wife alone on Sunday; Pierre Verna's son is admonished for not having visited his ill wife; Pierre Maupin is called for having abandoned his ill wife. AEG, R. Consist., vol. 2, f. 8, le 5 novembre 1545; vol. 58, f. 77, le 11 août 1659 et vol. 72, p. 107, le 3 novembre 1707.

36 Smith, 2003.

modest households, namely during the 18th century when the Consistory is wary of incriminating citizens evolving in the upper strata of society. Some irregular healers are well integrated within the neighbourhood and their offer of medical services may be standard practice. Scandals and conflicts sometimes reveal traces of such practices. On one occasion, for instance, in 1703, Lucretse Mermillon, unconvinced of the effects of a particular medication on her son's fever, demands repayment from her neighbour, Marguerite David, who had sold it to her for 18 sols – the price of a day's work for a farm hand³⁷. The argument about payment is the only reason Marguerite David's practice came to the court's notice³⁸. More often, incriminated lay healers protest that their sole goals are to be charitable and to do some good. Françoise Baud, married to Simoen Gilles master tanner, admits to having applied a plaster to a child's stomach "only charitably and without having been paid".³⁹ On one occasion, Mrs Chapuys, born Faure, offers a plaster to a young neighbour who might have been poisoned, the illegitimate son of Isabeau Du Boule, a cook ("rotisseuse"): the boy suffers from stomach pains. Chapuys reportedly also gathered some herbs ("Rote"), which she then applied onto the child's feet before, two hours later, throwing the same herbs into the Rhone and declaring the child to be bewitched.⁴⁰ The city executioner, an established irregular practitioner, is accused of confirming this accusation and could have been paid 18 sols for his opinion.⁴¹

Consulting irregular practitioners can lead the patient to be called before the Consistory court. The widow of Rolland, a baker, for instance, is questioned in November 1545 for having consulted a healer, sometimes called a witch, who is said to have given her some roots to heal her late husband. She admits having consulted Claude Verna⁴² and to having received roots, but nothing else, i.e. she does not admit to "superstitious" practices.⁴³ Claude Verna seems to live within the city and is regularly involved in cases where suspected "superstitious" acts were performed. Patients calling on healers who chanted formulas or prayers, use magic spells or religious symbols, or more precisely, are suspected of such behaviour, are numerous. It is tempting to suggest that such healers, constantly present throughout the Early Modern period, are less expensive and treat primarily the poorest members of the community. A sociological study would be necessary to establish any degree of

37 This may not be expensive for medicine, but a lot of money for a working family. A non-qualified manual worker earned about 20 sols per day in 1720 and one pound of bread then cost 4 sols. Piuz, 1985.

38 AEG, R. Consist., 71, 28/6/1703.

39 "Verbal de l'auditeur De la Rive, du 21 juillet 1728", P. C. 7564.

40 «Déclaration de Jean Marie Jaillet, femme Clejat, le 4 août 1728», P. C. 7564.

41 P. C. 7564.

42 Claude Verna, called "Bon Hérège" ("the good witch") comes from the nearby village of Challex (Ain). (cf. Consist. 3 & 10 avril 1544).

43 R. Consist. 2, f. 13v, le 26/11/1545.

certainty, but at this stage of research this seems quite improbable. Although many of the individuals mentioned as clients of irregular or reputedly “superstitious” healers are unknown and probably originated, like the baker Rolland’s widow, from the lower levels of the social ladder, this is not always the case. Gonget, described as a lark hunter, is regularly accused of healing by magic in the 1540’s. On one occasion, his alleged client was Jehan Lullin, a former member of the group of four leading the Small Council.⁴⁴ Two centuries later, Henri-Albert Gosse (1753–1816), born in an affluent family, does not hesitate to take his lame leg to a healer called Sisseran established in the Catholic village of Châtelaine, well beyond the city walls⁴⁵ and in the 1760’s, the wife of Charles Bonnet, member of Geneva’s aristocracy, is operated by an itinerant healing abbot.⁴⁶

There is apparently a high degree of tolerance for irregular and lay medical practice, both by the Consistory, the guild and the Small Council. Even the hospital regularly sends patients to be treated by specialists. In 1549 and 1559, a lady called La Guyaz treats women ill with the ringworm (“teigne” or “rache”).⁴⁷ Two centuries later, the same institution continues to send its clients to lay specialists, namely epileptic patients.⁴⁸ Irregular medical practices are not systematically associated with superstitious doings. In the 17th and 18th centuries, suspicion of Catholic and superstitious healing practices is more often than not focused on areas beyond the town walls, places where the clergy of the Counter Reformation was active.⁴⁹ In short, the Reformation of the town had the effect of prohibiting certain religious healing practices, or more generally, healing through what appeared to the Reformers as superstitious or occult means. Many Protestant inhabitants of Geneva continued to access such medical services by simply walking either to the nearest Catholic village (a few miles beyond the city walls) or by visiting any known clerical or magical healer in the vicinity of the town. Such trips are triggered by the healer’s reputation, and sometimes by pressure applied by neighbours and family.⁵⁰

Confronted by the variety of therapeutic issues available, it is difficult to understand how individual choices were made without a detailed study on each particular case. Nevertheless, overall, choices are better understood when one considers the medical marketplace not as expressing conflicting ideologies, but as seen by the patient, a place where a series of practitioners offer services and where, finally,

44 Lambert, Watt, and McDonald, 2001, f. 30v, le 4 février 1546.

45 Plan, 1909.

46 BPU, Ms Bonnet 70 ff. 140–141: Charles Bonnet to Henri-Louis Duhamel de Monceau (copy), 28/1/1760.

47 Courvoisier, 1985, pp. 28–29.

48 Louis-Courvoisier, 2000, pp. 105–107.

49 On the importance of the Counter Reformation’s healing practices: Gentilcore, 1995; Gentilcore, 1998; Walsham, 2003.

50 See for instance: AEG, R. Consist. 70, f. 74, le 02/11/1702.

examples of successful healing are both the most common and the most convincing arguments for lay onlookers.

Work and Charity

Up to this point, it is difficult to assess clearly what exactly is specific to the poor and what place domestic medicine took in dealing with their health. Present knowledge of urban poor in Geneva is limited to traces left in documents issued by the town administration, namely the hospital and the Council's records. Published research tends to confirm, as elsewhere, the presence of a high percentage of the population living close to the poverty line (8–10%) and many near enough to require assistance during any given family or collective mishap (30–60%).⁵¹ Reasons causing working-class families to cross the boundary into poverty are numerous and comparable to those found elsewhere (loss of job, death or departure of parent, etc.).⁵² Among these, illness is an important factor. Beyond the suggested existence of forms of informal help in both poor and wealthy neighbourhoods, the means by which the poor were able to help themselves are difficult to assess. The inadequacy of their means for extra expenses suggests very little possibilities to indulge in all but the simplest of medications, although, as it has already been mentioned, social pressure tends to enforce a minimum of solidarity among family members. What happened then, when poor people fell ill?

During the Early Modern period, for the working-classes (peasants and artisans), illness is not solely, as Carl Havelange puts it, “an internal transformation of the self, but a breach in one's capacity to survive”.⁵³ The ill poor are clearly recognised, from the time the distinction is enforced at the end of the Middle Ages, as “worthy poor”. When a bread-earner falls ill, early modern families are more often than not compelled to resort to charity.⁵⁴ Being ill and requesting help are here related to the incapacity to work: many clients are given relief for as long as they are ill.⁵⁵ This is particularly well documented thanks to the interesting case study undertaken by Anne-Marie Piuz on the family of Jean Vian, an immigrant labourer hired to work on the building of Geneva's fortifications in the 1710's.⁵⁶ Piuz details the continual recourse of Vian to Geneva's main charities, in spite of the fact that he is employed

51 In 1698, more than 40% of the towns inhabitants required assistance. Wiedmer, 1990; Louis-Courvoisier, 2000, pp. 21–22..

52 Gutton, 1974; Wiedmer, 1990; Louis-Courvoisier, 1985

53 I am indebted to Micheline Louis-Courvoisier for this reference. Havelange, 1990, p. 142.

54 Wiedmer, 1990, pp. 140–141.

55 Louis-Courvoisier, 1985, p. 25.

56 Piuz, 1985.

regularly during his working life; she concludes, after having compared his salary to the price of foodstuffs and accomodation, that what he earns every day is just sufficient to feed himself and his family. As soon as illness or accident forces him to stop working, he is compelled to resort to charity in order to eat. Of course, and the case of Vian is quite explicit, the most obvious and common way of mapping health services used by the poor is to study charity records. The ill and deserving poor do regularly get food and medicines through Geneva's hospital. As previous authors have noted, purveyors of charity then gave out bread and other essential commodities, but also remedies destined to heal the ill poor. This is seen as a good investment as once healed, a poor patient can get back on his feet and return to work.⁵⁷ During the Early Modern period, there are regular healers attached to the General Hospital employed to treat the poorer inhabitants of the city, be they inmates of the hospital or beneficiaries of domestic support. As from the late 1530's, a surgeon (or barber, the terms are used indistinctly) is regularly employed and, since 1558, a physician is officially taken on by the hospital.⁵⁸ As the town grows so does the fixed medical personnel. By the XVIIIth century, there are two surgeons, two physicians and two apothecaries on the Hospital's pay role.

Keeping things as rational as possible, the Hospital tends to deliver aid directly to homes. This is also true for medical support. Access to charity health care is often an indicator of social isolation, but what kind of support could the beneficiaries get? Good quality food is automatically given to inmates of the hospital when they are ill, an important medical measure in regard of the importance of diet in the understanding of individual health.⁵⁹ All things considered, one may wonder if costly medicine is not accessible to poor patients. One deterrent may be the necessity to ask for help. In a society where the honour and the position of each family group are clearly placed on a social scale, asking for charity is not easy for all but the most destitute. Cases such as that of André Sauvan suggest that even the poor are able to negotiate with some groups of health carers, ultimately avoiding public help. In 1724, André Sauvan, complained of an intestinal hernia and consulted a group of itinerant operators «in the aim, he said, of being able to improve later his capacity to work» reports his widow a few days later.⁶⁰ Such cases suggest that as the Hospital governors, the poor are prepared to engage in expensive treatment in order to get back to work. They are probably encouraged to do so by the undertakings of the operators themselves not to ask for any money before complete recovery.⁶¹ In

57 See for instance: Louis-Courvoisier, 1985, p. 28.

58 AEG, Registre du Conseil, 21 mars 1558, f. 126v.

59 Wiedmer, p. 155.

60 AEG, P. C. 7169: Déclaration d'Isabelle Sauvan, née Noblet du 19 mai 1724.

61 Many other examples suggest that among modest healers, the practice of health contracts as described by Gianna Pomata, prevail until the end of the 18th century. Pomata, 1998 (1ère éd. italienne 1994).

their statements, the operators justify having contravened the town's edicts and operated on Sauvan within the town and without a licence, because Sauvan had declared that "he was a poor man and could not afford to board at the inn where the two men were staying" in a nearby village (Grange-Canal).⁶² This and other similar cases, suggest that even the patients as devoid of means as Sauvan tended to evolve their own strategies in order to retrieve their health. They typically take responsibility for the therapies chosen, and Sauvan's widow, as others, declared that on his deathbed, her husband had not accused the men who had operated on him, considering that they had done the best they could.⁶³

It is difficult, due to the lack of documents, to ascertain what kind of family care and medicine the poor resorted to outside institutional care. Neighbours and family were probably the most obvious and accessible sources of help.⁶⁴ Indeed, as has been suggested above, some men and women actually perform particular medical services in their neighbourhood. Among them are journeymen and possibly servants working in surgeon's shops⁶⁵. Even famous charlatans⁶⁶ and travelling operators undertake free operations on the poor.⁶⁷ What is more, the physicians themselves offer free consultations for those devoid of means – in fact they have a social obligation to do so. As the medical edicts put it: "For the love of God, the physicians (docteurs-médecins) will, each in his district (quartier), care for the poor who solicit them, on the condition that the poor themselves be not taken care of by the hospital or one of the poor chests (bourses)."⁶⁸ In fact, the first physician employed at the hospital, Moudon Faulchier, was taken on after having been "seeing" the sick poor two or three times a day free of charge. Such services may well be used before appealing to the hospital, or possibly calling on the hospital may be a means of obtaining the payment of drugs or treatment counselled during a charitable consultation.⁶⁹

62 AEG, P. C. 7169: Réponses personnelles de Michel Clément de St-Etienne en Provence, du 17 mai 1724.

63 AEG, P. C. 11723, Déclaration de la veuve de feu Sieur Louis Benjamin Macaire, le 23 mai 1768; AEG, P. C. 7169: Déclaration d'Isabelle Sauvan, née Noblet du 19 mai 1724.

64 Jütte, 1996, pp. 96–99.

65 AEG, R. Consist., 72, le 3 juin 1706.

66 The most spectacular in the area is count Cagliostro: GERVASO, 1974.

67 Joseph Frédéric Hilmer, for instance, an oculist practicing in Geneva during the Summer of 1749, treats the poor free of charge. This is common practice. Rieder, 2004 (sous presse); Brockliss / Jones, 1997.

68 Text from the 1658 edicts, in substance, comparable to that of the 1569 edicts. Published in Gautier, 2001, art. 8, p. 627.

69 Drugs are rarely given free of charge.

Conclusion

Research results clearly indicate that medical practices and practitioners are legitimised by the expectations of patients and do not depend solely on the guaranties of official training. Although Geneva's ecclesiastical authorities strive to stamp-out superstitious practices, revealing how many popular healers are available in the neighbourhood, health policies are organised on the grounds of lay expectations and convictions. Like the patients, the town authorities regard all practitioners with suspicion. Poor relief includes medical commodities: the sick poor are consistently assisted and treated. Healers, officially trained or not, are paid by public funds for that purpose, both within and without Geneva's institutions. The picture remains sketchy as sources are inconsistent, and informative private documents relatively scarce, namely for the 16th and 17th centuries. The data under scrutiny here tends to suggest two ways of dealing with health: the poor way and the affluent way. This may be misleading: sources relating to each group of patients or would be patients are distinct, but in their content, they suggest, as does the quality of drugs given to the poor, that treatment finally given is often similar.

Thinking of medical practices in terms of self-help is a complex undertaking. There are, as yet, no clear models on which to base assumptions in order to explain long term trends. Beyond the question as to whether these practices were effective or not, the point of view expressed in this paper suggests that a variety of medical services were available to both the poor and the rich in Early Modern Geneva. Self-help and patient perspectives are generally seen as marginal in respect to orthodox medical practice based on traditional medical documents. Confronting this data with that found in other sources tends to suggest a different picture: an ever present lay medical culture and beyond all, the patient's control on important decisions. In a sense, the prevalence of a variety of practitioners tends to minimise the role of orthodox medical practices. Moreover, although richer patients probably consume greater quantities of medical commodities and services, one wonders if they are really different in kind. Are not, for instance, the numerous paupers cared for free by Cagliostro in Bienne in 1787,⁷⁰ treated any differently than Isabelle de Charrière, rich and famous, who travels specifically to Strasbourg to consult the same healer in 1783?⁷¹

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70 Frêne, 1993–1994, pp. 2083–2084, le 28 juillet 1787.

71 Details on this expedition are spread-out in later letters, see Rieder, 2002.

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