Class, Status and Gender: Toward a Sociology of the Homoeopathic Patient in Nineteenth-Century Britain

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WHO WERE HOMOEOPATHY'S PATIENTS in the nineteenth century, and what reasons did they have for choosing this form of therapy? The straightforward answer to this question, which is pressed into service to a greater or lesser extent in a variety of historical accounts of homoeopathy's rise to popularity,[1] is that they were people who, having experienced the ravages of heroic medicine, were minded to try something less disagreeable when next in need of treatment. Although this is probably true in a general sense, it is not, however, an explanation which takes the understanding of the nature of homoeopathy's clientele very far, since it leaves the issue of treatment selection at the level of personal preference or individual discretion. What is needed is a way of understanding how therapeutic choices were patterned by the constraints of social structure. What is needed, in short, is a sociology of the homoeopathic patient. For the clients of homoeopaths were not randomly distributed among all social groupings: clear demographic clusterings emerge. It will be argued that these clusters were a product of three important dimensions of social stratification in Britain in the nineteenth century – class, status and gender.

The processes of industrialisation and urbanisation effected a radical change in the class structure of British society. In particular, alongside

the traditional social elites, who managed to retain a significant hold on state power, these years witnessed the emergence of a new group of wealthy industrialists and entrepreneurs, an expanding number of white collar, salaried or professional workers, and a burgeoning industrial working class. This transformation of social structure presented doctors with a variety of new opportunities. Demand for medical services expanded both in terms of kind and quantity, while the restrictions on practice imposed by the traditional Royal Colleges rapidly became anachronistic. The general practitioner, holding qualifications in both physic and surgery, and vociferous for medical reform, emerged as a key figure in the profession. In addition, hospitals became the centre of medical education and the basis from which a new elite group, the consultants, would come to exercise a growing authority over the division of labour within medicine. Hospitals, of course, as charitable institutions, also became one of the most important providers of medical and surgical care to the sick poor. Such patients were not in short supply. The conditions of life and labour experienced by Britain's early industrial proletariat meant that there was always going to be a large number of people requiring medical assistance, but who lacked the resources to pay for it. The nineteenth century, then, witnessed a dramatic expansion in hospital provision, both general and specialist. Homoeopaths were no different to their allopathic colleagues in founding institutions (dispensaries as well as hospitals) through which medical care could be delivered on a charitable basis. The number and capacity of these institutions, however, certainly began to increase once homoeopaths found themselves barred from working with regular colleagues. Here, the tone had been set by the Provincial Medical and Surgical Association (PMSA) which, perceiving the growing popularity of homoeopathy as a threat to jealously guarded occupational interests, had sought to stem the tide of competition by instituting, in 1851, a consultation ban.[2] Thereafter, no regular doctor could engage in professional intercourse with a homoeopath without risking exclusion from national and local medical associations and loss of income as the PMSA had further insisted that no doctor should consult with or refer patients to any practitioner contaminated by homoeopathic connections.

Dr William Bayes (1823–82) provides an interesting example of what was a more general situation.[3] Like many of those who were to become his homoeopathic colleagues, Bayes had begun his medical career conventionally, acquiring a variety of qualifications (in his own case, the Membership of the Royal College of Surgeons in 1844, the MD in 1850, and the Extra Licentiate of the Royal College of Physicians in 1853). Having originally practised in Brighton in the 1850s, Bayes first encountered

homoeopathy while travelling abroad in order to recuperate from a bout of ill health. Returning to England in 1856, he settled in Cambridge, and aired his support for homoeopathy in a provocative tract entitled *Truth in Medicine*, which rapidly elicited a lively debate in the local press (the *Cambridge Chronicle*).[4] In the same year, his right to practise in the town at all was questioned by the University; and then, in 1861, his application for the post of physician to the local hospital (Addenbrooke's), with which the University itself was connected, was met with dismay by the local and national medical establishments. Were Bayes to be successful, so it was alleged, then dishonour would ensue for the profession in general, not to mention severe disruption to the hospital itself. Bayes did not linger much longer in Cambridge. In 1865, he moved to Bath; and in 1869 to London. The tactics of regular ostracism, however, were helping to spread and then embed a network of homoeopathic institutions rather than undermine it: the usual response of homoeopaths to exclusion was to duplicate the apparatus of hospitals, dispensaries, journals and societies developed within the orthodox profession. Bayes's own career was merely one example of this more general tendency. In Cambridge, a homoeopathic dispensary and chemist was opened;[5] Bayes's practice in Catharine Place, Bath was complemented by the Bath Homoeopathic Hospital in Chapel Row, Queen Square and the chemist E. Capper;[6] and London, by 1869, was thickly studded with homoeopathic dispensaries, doctors, chemists and hospitals.[7]

Homoeopathic provision, then, for the sick poor of Britain's new industrial working class had, by the 1870s, extended throughout England, Wales, Scotland and Ireland. This was a combined result of its general popularity, the inability of the regular profession to outlaw what it regarded as 'quackery' in the Medical Act of 1858, and as an ironic consequence of the practice of therapeutic apartheid which had begun in 1851. The extent of this provision is manifest from the *Homoeopathic Directory of Great Britain and Ireland* for 1874.[8] By this time, homoeopathy could boast of hospitals in London (the prestigious London Homoeopathic Hospital), Bath, Birmingham, Doncaster, Hastings, Manchester and Southport, together with numerous dispensaries (112 in total), which were widely dispersed among all the major towns and cities of the country. The numbers of patients treated on an annual basis by this network of care is impossible to establish with any precision: contributors to the Directories of the period are very uneven in the provision of this kind of information. However, even in the early 1850s, before homoeopathy had fully consolidated its institutional presence, it would seem as though hospitals, on average, were each treating around 2,000 patients per year, with dispensaries seeing

approximately 500 (although this masks considerable individual variation: by 1853, the Liverpool Homoeopathic Dispensary, for example, had treated 27,450 patients since opening in 1841; and that in Manchester, 24,884 since 1842).[9] Allowing for some inflation in these rough averages as homoeopathy's popularity rose, and taking into account the expansion in number and capacity of hospitals and dispensaries (119 in total by 1874) it is fairly clear that homoeopaths were probably treating around one hundred thousand of the sick poor on an annual basis by the last third of the century.

How were hospitals and dispensaries run, however, and how did patients gain access to them? The basic principle was clear enough as far as hospitals were concerned. Subscribers or patrons, in return for a donation or annual subscription, had the right to nominate a certain number of 'in' and/or 'out' patients, and the recipients of care had to be too poor to pay for treatment. The constitution of the London Homoeopathic Hospital, for example, declared that:

> An annual subscription of 10 guineas [a guinea equals £1.05], or a donation of 50 guineas, entitles the subscriber or Donor to have one in-patient *always* in the Hospital, and ten out-patients every month, and to have ten votes; and so on for every further Annual Subscription of Ten Guineas, or Donation of Fifty Guineas.[10]

To gain access to the hospital, 'necessitous persons' (the hospital's colourful term for potential in-patients) had to present a letter of recommendation from a governor or subscriber and if '... after due examination by the Medical Board, they shall be reported as proper objects to be received into the Hospital, and the House Committee shall think fit to admit them' then they were 'signed in'.[11] Signing in took place on Tuesday mornings at 9.00 o'clock. In-patients were also expected to bring with them (except in cases of extreme destitution) '... a change of linen and a towel, also a cup, saucer, and spoon, and a knife and fork'.[12] These items would be returned to the patient when discharged. Apart from the letter of recommendation, applicants for in-patient care also needed a guarantee, on '... a prescribed form approved by the House Committee' and '... signed by a respectable householder',[13] before admission was granted. It is not hard to guess that the guarantee concerned the patient's circumstances and behaviour. As far as circumstances were concerned, the House Committee of the Hospital was keen to ensure that '... no person who is capable of paying for medical attention' should be admitted and, furthermore, that no one should gain entry to the wards '... who is capable of receiving equal benefit as an out-patient, or is merely requiring such rest and attention as a workhouse can supply'.[14]

The guarantee, then, was very much a character reference, namely that the patient was a deserving case, genuinely too poor to pay for treatment, and who could be relied on to behave with a degree of decorum in the wards. The hospital, however, did not entirely close its doors to the destitute who were unable to obtain letters of recommendation and guarantees concerning their disposition and circumstances. Provided that there were vacant beds, and provided that the Resident Medical Officer was satisfied that the case was one of 'extreme urgency',[15] patients could apply for admission at any time during the week. But it was partly serendipity. If they were suffering from 'confirmed consumption' or 'the small pox',[16] they were inevitably disappointed. The hospital resolutely closed its doors to all such patients.

Where dispensaries were concerned, greater variety of provision for the sick poor soon materialised. There were three basic plans of operation. The first characterised the public (charitable) dispensaries, i.e. those supported by patrons, with (usually) a management committee, a treasurer, secretary, medical officers and associated chemist. Here treatment was arranged on much the same basis as at the larger hospitals: as the editor of the *British Journal of Homoeopathy* (*BJH*) made clear in 1846, '... it consists in getting patrons to subscribe to the institution, and giving subscribers the right to recommend a given number of patients'.[17] The advantages and disadvantages of this arrangement were, according to the editor, that '... the number of applicants for relief is limited, but a great number of the opulent class are interested in the success of the establishment'.[18] The most successful example of a public dispensary run on these lines at the time was the London Homoeopathic Medical Institution which, '... from October 1839 to December 1844' treated 3,657 patients '... or a little more than 700 annually'.[19] The second variant of dispensary provision comprised those institutions where subscriptions were obtained unconditionally, and its services were made available to all that applied. Some of the largest dispensaries in the 1840s, like those in Liverpool and Manchester, were run on these lines. The editor of the *BJH* described the way in which patients were dealt with under this arrangement, using the Edinburgh Dispensary as a particular example:

> The number of patients admitted at the Edinburgh Dispensary from 1841 to 1844, (that is, three years) was 6,545, giving an annual average of more than 2,000. The expense of the establishment is about £50 per year. Every person who applies for advice at this dispensary gets a ticket, on which his name and number is written on one side, and on the other, rules for diet, directions for taking the medicines, with blanks, which are filled up by the physician according to the specialities of each case. On being examined by the physician

> his case is written down, and on his return he presents his card to the porter, who looks out the case corresponding to it, and arranges it along with the others in the physician's room. New and old patients are seen in different rooms, and all the cases are arranged alphabetically in three divisions, of one for men, another for women, and the third for children. This method of conducting the dispensary has been found to answer perfectly ... A considerable number of homoeopathic practitioners in this country have obtained their first instructions at this establishment.[20]

As later Directories make clear, some of the Medical Officers at public dispensaries were also willing to see patients in their own homes. For example, the Northampton Homoeopathic Dispensary, in Abington Street, records that its Medical Officers (Drs Clifton and Wilkinson) had made a total of 4,209 home visits – presumably since the Dispensary had first opened, though unfortunately it is difficult to establish the exact time frame involved from the data.[21] The third kind of principle on which dispensaries could be run involved the payment of a nominal fee. Essentially, these were 'private' rather than 'public' operations, run entirely by a Medical Officer, with no set of patrons or management committee involved. This type of provision became more and more common as the years passed in the nineteenth century. The editor of the *BJH* again usefully supplies the relevant details and relative advantages peculiar to this mode of operation:

> The third and only remaining plan we have to mention is that of self supporting dispensaries. At these patients pay a small quarterly sum for treatment and medicines. This plan has been found to answer very well in districts where there is a tolerably opulent lower class, not sufficiently rich to pay the physician's fee, and yet able to afford something for their treatment. There are several advantages connected with it. First, there is a greater value attached by patients to their treatment, and they are more regular in their attendance, and more obedient to the regulations, than when the advice, andc., are entirely gratuitous; secondly, it affords a legitimate source of raising funds for a more extensive establishment. We understand that Newcastle, where this way of conducting a dispensary has been pursued for some years, a sufficient surplus is now obtained to warrant the physician taking into consideration the propriety of establishing an hospital on the same footing.[22]

The largest patient group among homoeopathy's clientele were the sick poor, the men and women, parents and children, who did not have the resources to pay at all, or only in part, for their care. But the therapeutic allegiances displayed here were, in the great majority of cases, not really 'allegiances' at all. What determined the use of homoeopathy by those at

the lowest end of the social hierarchy was their material, class situation. Poverty meant ill health and a need to rely on charity (or something very close to it) for help during times of sickness. And those seeking charity were not in a position to exercise much choice about who delivered it, or about what and how it was provided. Where homoeopaths offered the most readily accessible care in any particular neighbourhood, poverty would inevitably ensure a steady supply of supplicants for the charity of the dispensary or the hospital.

Ironically, however, it was just these institutions which also provided homoeopaths with access to the wealthy social elites on which flourishing private practices could be established. Indeed, from its very beginnings, homoeopathy had enjoyed the benefit of aristocratic interest and patronage. Its first practitioner of significance in Britain and the man responsible for founding the British Homoeopathic Society (BHS) in 1844, Dr Frederick F.H. Quin (1799–1879), had been personal physician to the Duchess of Devonshire, as well as to Prince Leopold (1831–65, later King of the Belgians), before establishing his first practice in London (King Street, St James's) in 1832. Furthermore, at the invitation of Queen Adelaide, the homoeopaths Dr Stapf (1788–1860) and Dr Belluomini (1776–1854) had both practised, albeit briefly, at the Royal Court.[23]

Again, it is appropriate to examine the popularity of homoeopathy among the elite strata of British society (and elsewhere) in a way which takes the issue beyond one of individual choice and preference. What did the use of homoeopathy mean to the rich, and to people of rank and high social standing? Max Weber, that most subtle of sociological thinkers among the founders of the discipline, provides a potential way forward with his concept of 'status group'. Contrary to the Marxist claim that the primary social division was that of class, and that class was constituted from relations among groups of people established in the sphere of *production*, Weber protested that social influence could also be located in rival forms of exclusiveness founded, for example, in the sphere of *consumption*. Weber was signalling that social power could derive from noneconomic factors as well as from those connected more directly with the process of capitalist accumulation. By 'status situation' (of an individual) Weber meant '... the evaluations which others make of him or his social position, thus attributing to him some form of (positive or negative) social prestige or esteem'.[24] A status group, therefore, was simply a (subjectively aware) collectivity of individuals sharing a common status situation. But the key to membership of such a group was *exclusivity*, and this exclusivity was demonstrated '... through following a particular life-style ...',[25] and through the exercise (among other things) of

particular kinds of choices in the sphere of consumption. Much, in these postmodern times, is made of the apparent 'death of class' and the emergence of the radically decentred, fluid subject freely constructed from the glossy images, cultural surfaces and consumer possibilities of late capitalism. Weber would not (and could not) have gone so far, of course, never relinquishing his sense of the limitations and constraints of social structure. Thus, the sociological significance of 'life style' or 'style of life' is not quite so radical an idea as postmodern theorists sometimes suggest.

However, the concept of status group exclusiveness signalled through consumption and life style is particularly helpful in understanding a preference for homoeopathy among the social elites of European society in the nineteenth century. Issues of cost, of course, are significant. If the poor gained access to homoeopathic treatment on the basis of charity, the privileged pursued it on the basis of expensiveness. The very act of being able to employ a fashionable, sought after physician, and paying a significant fee for what was publicly celebrated as an infinitesimal dose of medicine was, for many, probably as much a statement about their exclusive social position as it was about their particular therapeutic preferences. All doctors had an interest in developing links with the rich and the fashionable. For the classically educated gentlemen of the Royal Colleges, who entered medicine with an already established family pedigree, this was not so difficult. But for most general practitioners, earning a respectable living from medicine was much harder work. The seeming ability of homoeopaths to build successful practices by rapidly attracting local elites as patients was thus a source of irritation, and one that not infrequently drew comment from medical writers and commentators.[26] Moreover, the social cachet stemming from homoeopathy's connection with the traditional elites of European society seems also to help to account for its popularity among the privileged urban strata in America during this period, for example, in the cities of Boston, New York and Philadelphia.[27] And finally, in Britain, during the time of homoeopathy's retreat in the early decades of the twentieth century, the continued connection between the doctors of the BHS and an exclusive clientele distinguished by rank and money probably goes some way in helping to account for the relative complacency with which this process of decline was received. No matter if homoeopathy had largely retreated from wider public consciousness if it still mattered to rich men and women, and if rich men and women could still bestow the benefit of lucrative private practice and elite social connections (including the Royal Family itself) among its doctors. It is perhaps no coincidence that the BHS during this period was rather scathingly referred to as a 'rich man's talking shop'.[28]

The affinity between homoeopathy and rank in nineteenth-century Britain is hinted at in terms of the distribution of doctors. Homoeopaths were certainly concentrated in centres of wealth and fashion. At the end of 1852, for example, of the 177 homoeopaths practising in Britain, 66 were based in London (with many of these occupying premises in prestigious areas such as Piccadilly, Regent Street, Grosvenor Square, Hyde Park, Bond Street and Bloomsbury). Significant concentrations of homoeopaths are also evident in expanding merchant and industrial centres such as Liverpool, Manchester, Birmingham, Leeds, Edinburgh and Dublin. Fashionable spa towns, like Bath, Cheltenham and Leamington, together with the newly popular coastal resorts, for those rich enough to 'take the sea air', like Torquay, Weston-Super-Mare, Brighton, Hastings and Scarborough, also show significant numbers of homoeopathic doctors.[29]

Such evidence is certainly suggestive but it is with the patronage of hospitals and public dispensaries that the link between homoeopathy and social rank emerges with greatest clarity. Although such institutions were designed to cater for the sick poor, their wealthy supporters provided the doctors who worked in them with a ready-made introduction to a network of desirable social connections within which a flourishing practice could be established. The clearest example is the London Homoeopathic Hospital (LHH). In 1874, the Medical Council of this institution included 22 London based doctors. Council membership, however, linked these practitioners to an aristocratic circle which included the Duchess of Cambridge (1797–1889, patroness), the Duke of Beaufort (1824–99, vice-patron), the Earl of Wilton (1839–98, president) and, as vice-presidents, the Earls of Essex (1803–92) and Albemarle (1799–1891), the Viscounts Sydney (1805–90) and Malden (1826–79), and the Lords C. Paget (1811–95), A. Paget (1816–88), G. Paget (1818–80), Kinnaird (1847–1923) and Ebury (1801–93). Among the 'lady visitors' listed are Lady Ebury (m. Robert Grosvenor, first Baron of Ebury, 1831), Lady Radstock (m. Granville Augustus William, third Baron of Radstock, 1858) and the Honourable Mrs Warren Vernon (m. George John Warren, fifth Baron Vernon, 1859).[30]

But perhaps even more compelling evidence is supplied by the patronage of more humble institutions like the public dispensaries. By 1874 there were 37 of these. Three groups feature prominently among the lists of those acting as members of management committees and/or as patrons: the aristocracy (18 names in total), the clergy (60 names) and the military (20). The Manchester Homoeopathic Institution, for example, at 28 Lower Byrom Street, had the Earl of Wilton, the then President of the London Homoeopathic Hospital, as patron and the Rev. T.H. Gill (1836–94) on

its five-man executive committee, while the Southampton Homoeopathic Dispensary had Her Grace the Dowager Marchioness of Queensbury (m. eighth Marquis, 1840) as patroness, the Lady Susanna Blunt (m. Sir John Henry Blunt, 1870) as vice-patron, the Revs. T.D. Bolton, H.H. Carlisle, F. Davidson (1841?–1916), Robert Mount, C.E. Steward (1838–93) and William Wilson (1783?–1873?), and the Captains Robert Day, Kennedy (1796?–1879?) and John Tracy, among its patrons. The Wolverhampton and South Staffordshire Homoeopathic Dispensary provides a further example: this institution was supported by patrons such as the Duchess of Sutherland (d. 1888; wife of George Granville William, third Duke of Sutherland), the Earl of Lichfield (1825–92), Sir William Biddulph-Parker, Baronet (1824–1902), and the Revs. Adelbert Anson (1840–1909), Augustus Vernon (1798?–1875?), Henry G. De Bunsen (1818–85?) and George Fisk.[31]

It is perhaps also worth noting that homoeopathy's aristocratic connections brought important political influence as well as remunerative practice. Two critical instances may be cited. The first concerns the Medical Act of 1858. Earlier drafts of this had threatened to outlaw homoeopathy by regulating the systems of medicine which doctors could practise. Lord Robert Grosvenor, however, as a vice-president of the LHH, could hardly let such a measure pass without protest, and stoutly resisted the passage of this provision into law in the House of Lords. Indeed, Grosvenor succeeded not merely in securing the deletion of the offending clause in the proposed legislation, but actually managed to substitute for it another which expressly forbade licensing bodies from insisting on a guarantee of therapeutic conformity as a condition of graduation. Homoeopaths, of course, were delighted. In celebratory mood, the *BJH* declared that:

> ... thanks to the powerful influence of parliamentary friends ... all the fangs of this serpent that threatened death and destruction to homoeopathy have been effectively drawn, and no ingenuity can pervert the Act into an instrument for our oppression or annoyance ... for in place of anything like this taking place, the Act expressly forbids any of the small powers it confers being employed against us on account of our adoption of a particular medical theory.[32]

Grosvenor was also involved in the second incident. After the cholera epidemic of 1855 in London had subsided, the President of the General Board of Health contacted all of the metropolitan hospitals that had treated patients with this disease, in order to compile statistics which would identify the most successful regime of treatment. The LHH provided its returns but these were omitted from the Board of Health's report. This might not have mattered if the Hospital's record of success with cholera

patients was poor, but the contrary was the case: it was among the best, with an apparent mortality rate for in-patients of around 17 per cent, compared to approximately 50 per cent in institutions where regular treatment had been used.[33] The Board of Health's view, when asked for an explanation for the missing data by the management committee of the LHH, was that to have included them would have compromised '... the value and utility of their averages of cure' by giving '... an unjustifiable sanction to an empirical practice alike opposed to the maintenance of truth and to the progress of science'.[34] Grosvenor, again, was determined not to let this perceived injustice pass without comment. He raised the issue of the missing data in Parliament, and eventually succeeded in eliciting a separate parliamentary report which included the returns from the LHH.[35]

Although, in the middle decades of the nineteenth century, homoeopathy was clearly popular and had powerful friends, it is easy to understate just how attractive it was to the public if the focus remains on its doctors and the institutions through which they practised. This is because the market for domestic, or 'self-prescribing', was considerable and this provides the clue for the third major group of consumers – women. Here class and gender interweave as aspects of social structure which helped to pattern therapeutic preferences. Certainly, the wife and mother, whatever the class, was in a very real sense the 'health keeper' of the family. But, if the typical customers for the texts designed to guide family treatment, and for the medicine chests designed to go with them are being sought, the need for literacy means that those sought are, almost certainly, middle-class women. A number of other concerns support this interpretation. Homoeopathic physicians were able to charge the rich and fashionable fees which would probably have put the household budgets of many middle-class families under some strain. Such costs could be avoided, however, if self-treatment was employed. Moreover, mothers were likely to be sympathetic to a system of medicine which promised safe, gentle and supportive action. Not only did this resonate with the socially constructed traits of womanhood – at least middle- and upper-class womanhood – but, more directly, it avoided the blistering, leeching and purging of more conventional methods which must have been particularly trying to infants, and to those immediately responsible for their care and comfort.

Further evidence comes from the books themselves, and from the reviews which they received in the homoeopathic press. Typically, authors would include sections on the general regimen to be followed in caring for the sick (such as dietary advice, hygiene, clothing, the organisation of the sick room etc.); the management of childbirth; the treatment of infants and

of the normal ailments of young children (colds, coughs, bruises, burns, sore throats, nose bleeds, mumps, measles, chicken pox, scarlet fever, whooping cough, etc.); and on the diseases peculiar to females.[36] These kinds of texts seemed to have been designed with women, whether caring for themselves or for children or spouses, very much in mind. This, at least, was the assumption made by the reviewers of the time. The *BJH*, for example, expressed the following thoughts on Joseph Laurie's *Homoeopathic Domestic Medicine* – a text which was to become enormously successful:

> ... we can come to no other conclusion than that our author has done good service to the cause of Homoeopathic medicine in the country; and we strenuously recommend it to the attention of our non-professional readers as a book with which the mother of every family should be provided.[37]

In any event, homoeopathic texts designed for the self-prescribing, domestic market were extremely popular. Even in 1845, only a year after the foundation of the BHS, the *BJH* was moved to comment in exasperated tones about '(T)he multitude of popular treatises about homoeopathy and works on domestic homoeopathic medicine, with which the English press now teams ...'.[38] Many of the authors, however, were already, or would become, leading homoeopathic physicians themselves. The roll call of such publications began to mount through the century. As early as 1853, the *British and Foreign Homoeopthic Medical Directory* recorded the following: *Domestic Homoeopathy* by John Epps (5th ed. in 1850); *Domestic Homoeopathy* by P.F. Curie (3rd ed., 1850); *The Homoeopathic Family Assistant* by G. Newman (2nd ed., 1847); A *Domestic Homoeopathy* by Edward C. Chepmell; *The Parent's Guide* and *Homoeopathic Domestic Medicine* by J. Laurie (6th ed., 1851); *Domestic Homoeopathy* by Drs Pulte and Epps; *The Homoeopathic Dictionary and Home Guide* by A. Henriques; *Homoeopathic Family Medicine* by J.E. Norton; and *The Homoeopathic Handbook and Clinical Guide* by G.H.G. Jahr.[39]

By 1874, this lucrative market had expanded still further. Dr Chepmell's book had reached its eighth edition; that of Dr J. Epps its sixth; Dr Newman's its third; and Dr Laurie's *Parent's Guide* its second (this, though, was by far and away his least successful venture as his *Epitome of the Homoeopathic Domestic Medicine* had reached its twenty-seventh edition by this time, while his *Homoeopathic Guide for Family Use* was in its seventy-first). To these were now added Dr G.E. Allshorn's *Handy Book of Domestic Homoeopathic Practice* (4th. ed.); Caspari's *Homoeopathic Domestic Physician* (edited by F. Hartmann); Dr J.S. Douglas's *Practical Homoeopathy for the People*; Dr John Ellis's *Family Homoeopathy*; Dr Richard Epps's *The Homoeopathic Family Instructor*; Dr H.N. Guernsey's *Homoeopathic Domestic Practice* (7th ed.); Guernsey and Thomas's

Domestic Practice (13th ed.); Dr R.S. Gutteridge's *The Woman's Guide*; Dr C. Hering's *Homoeopathic Domestic Physician*; H.R. Irwin's *Domestic Treatment of Diseases*; Dr W. Johnson's *Domestic Management of Children*; Dr A. Lutze's *Manual of Homoeopathic Theory and Practice*; Dr G.L. Moore's *Supplement to the Domestic Practice of Homoeopathy* (2nd ed.); Dr A.C. Pope's *A Medical Handbook for Mothers* and his *Popular Guide to Homoeopathy* (3rd ed.); Dr J.A. Pulte's *Woman's Medical Guide*; Dr E.H. Ruddock's *Lady's Manual of Homoeopathic Treatment* (5th ed.); Dr H. Sherrill's *Family Physician*; Dr E.B. Shuldham's *The Family Homoeopathist*; Dr J.A. Tarbell's *Homoeopathy Simplified, or Domestic Practice Made Easy*; and Dr N. Wood's *Easy Domestic Homoeopathy*.[40] And these texts represent only those where the domestic user was the intended market of the author; many more are listed which could easily have been used in the same way.

By the 1880s, however, the demand for these kinds of texts appeared to be on the wane. Of those authors listed in the 1874 Directory who were writing for the domestic market only Joseph Laurie (d. 1865) and E.H. Ruddock (1822–75) still appear to be published after 1890. Significantly, too, both authors had been dead for some years by the last decade of the century, which means that their books were being revised and updated by others.[41] The energy had, by then, apparently gone out of the market and, to a significant extent, also out of homoeopathy as a medical movement. Rates of application to join the BHS had slowed dramatically from the 1880s onwards. Existing practitioners were getting older, and they lacked the stimulation of younger colleagues keen to take up the struggles of earlier years. Increasingly incorporated and eclipsed by regular medicine, homoeopathy seemed less and less able to contest the therapeutic domain mapped out by the regular school with confidence and vigour, and so had begun to slip in significance as far as the agenda of the wider profession was concerned. And where orthodox practitioners led, the public, for once, began to follow.

Nonetheless, in its heyday domestic prescribing was matched, predictably enough, by a lively trade in medicine chests. Typically, these would be supplied by homoeopathic chemists. By the middle of the 1870s, there were 117 of these throughout Britain.[42] Among the largest companies in the trade were the famous names of Turner and Co., Gould and Son, Leath and Ross and J. Epps and Co. (all in London), and Thompson and Capper in Liverpool. Typically, too, advertisements for chests of homoeopathic medicines would indicate that they were designed to be used alongside the most popular texts written for domestic prescribing. The 1853 *Directory* carries a number of these.[43] Charles Lane, for example, of 146 Sloane Street in the Chelsea district of London, drew the attention of the public to the fact

that his shop held 'The latest editions of all the Treatises on Homoeopathic Domestic Medicine ...' together with 'A large supply of Medicine Chests and Cases for Professional or Domestic use ...' that were '... kept arranged to accompany any of the various treatises ...'. With premises in Bristol and Cheltenham, Charles Guest advertised 'Cases filled with Medicines suited to the various Domestic Works' and that 'All the works on Homoeopathy [were] constantly on hand'. W.H. Billing of 72 Sauchiehall Street in Glasgow proclaimed much the same message. He offered 'Medicine Cases and Chests of all sizes, containing from 6 bottles and upwards; adapted to the various domestic works of Drs Laurie, Chepmell, Pulte, Epps, Malan &c and suitable for Domestic or Professional purposes ...' and that 'All the Homoeopathic Works [were] kept in Stock ...'.

For a period of some 40 years, roughly between 1840 and 1880, homoeopathy had captured a significant share of the medical market, much to the chagrin, very often, of regular practitioners. No doubt each patient would have had their own, individual set of reasons for deciding to reject conventional treatment and for seeking homoeopathy in particular from among the range of alternatives (such as phrenology or hydropathy). But while it would be fascinating to trace the evolution of, and rationale for, therapeutic preferences at this micro level, even were the historical records extant, it would be a mistake to conceptualise the market for homoeopathy as *simply* the sum of individual decisions, for this would tell nothing about the way in which therapeutic choices were exercised within, and patterned by, the constraints of social structure, and nothing about the collectively significant layers of meaning inscribed within them. So homoeopathy might well have been the 'medicine of choice' for many, but not necessarily solely for medical reasons. For those of wealth and rank, it was also a mark of social honour and exclusiveness; for the sick poor, it was a badge of charity; and for middle-class wives and mothers, it was a statement of the way in which social position and gender interlinked in terms of domesticity, care and careful budgeting.

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Notes

1 See, for example, William G. Rothstein, *American Physicians in the Nineteenth Century. From Sects to Science* (Baltimore and London, 1972; 1985); Martin Kaufman, *Homoeopathy in America – the Rise and Fall of a Medical Heresy* (Baltimore and London, 1971); and Harris L. Coulter, *Divided Legacy, A History of the Schism in Medical Thought* (3 vols., Washington, 1973–77).

2 Phillip A. Nicholls, *Homoeopathy and the Medical Profession* (London, 1988), 137.

3 A more detailed discussion of this general issue can be found in Nicholls, *Homoeopathy*, esp. 138–44.

4 The details of Bayes's particular case are discussed in Mark W. Weatherall, 'Making Medicine Scientific: Empiricism, Rationality, and Quackery in mid-Victorian Britain', *Social History of Medicine* 9 (1996), 175–94, esp. 181–92.

5 Weatherall, 'Making Medicine Scientific', 189.

6 See William Bayes (ed.), *The London and Provincial Homoeopathic Medical Directory* (London, 1866), 25, 127–31; Anon. (ed.), *The Homoeopathic Directory of Great Britain and Ireland* (London, 1876), 88.

7 J. Galley Blackley (ed.), *The Homoeopathic Directory of Great Britain and Ireland and Annual Abstract of Literature* (London, 1874).

8 See Blackley, *Homoeopathic Directory*, esp. 106–49.

9 See George Atkin (ed.), *The British and Foreign Homoeopathic Medical Directory and Record* (London, 1853), 36–44; 70–78.

10 Bayes, *London and Provincial*, 124.

11 Bayes, *London and Provincial*, 125–26.

12 Bayes, *London and Provincial*, 126.

13 Bayes, *London and Provincial*, 126.

14 Bayes, *London and Provincial*, 126.

15 Bayes, *London and Provincial*, 126.

16 Bayes, *London and Provincial*, 126.

17 Editorial Address, *British Journal of Homoeopathy* IV (1846), 1–18, esp. 14.

18 Editorial Address, 14.

19 Editorial Address, 14.

20 Editorial Address, 14–15.

21 Blackley, *Homoeopathic Directory*, 118–38.

22 Editorial Address, 15–16.

23 Nicholls, *Homoeopathy*, 108.

24 Anthony Giddens, *Capitalism and Modern Social Theory* (Cambridge, 1971), 166.

25 Giddens, *Capitalism*, 166.

26 Nicholls, *Homoeopathy*, 136.

27 Nicholls, *Homoeopathy*, 201–02.

28 See Phillip A. Nicholls and Peter Morrell, 'Laienpraktiker und häretische Mediziner: Grossbritannien' in Martin Dinges (ed.), *Weltgeschichte der Homöopathie. Länder, Schulen, Heilkundige* (Munich, 1996), 185–213, esp. 204.

29 Atkin, *British and Foreign*, 24–35; 53–6.

30 Blackley, *Homoeopathic Directory*, 106–17.

31 Blackley, *Homoeopathic Directory*, 118–38.

32 See Anon, 'The Medical Act', *British Journal of Homoeopathy* XVI (1858), 534–35.

33 Nicholls, *Homoeopathy*, 145.

34 See Anon, 'Parliamentary Return of the Homoeopathic Treatment of Cholera', *British Journal of Homoeopathy* XIII (1855), 681.

35 Nicholls, *Homoeopathy*, 146.

36 See, for example, the contents pages of Constantine Hering's *The Homoeopathic Domestic Physician* (New York and Philadelphia, 1866), v–xiv.

37 Anon, 'Reviews', *British Journal of Homoeopathy* II (1844), 293–307, esp. 306.

38 Anon, 'Reviews', *British Journal of Homoeopathy* III (1845), 181–89, esp. 181.

39 Atkin, *British and Foreign*, 132–74.

40 Blackley, *Homoeopathic Directory*, 169–96.

41 The catalogue of the Wellcome Library for the History and Understanding of Medicine in London shows that, after 1890, only Joseph Laurie's *The Homoeopathic Guide, for Family Use: Carefully abridged from the Homoeopathic Domestic Medicine* (popular ed., London, 1894) and his *An Epitome of the Homoeopathic Domestic Medicine* (39th thoroughly revised ed., London, 1902), together with E.H. Ruddock's *The Lady's Manual of Homoeopathic Treatment in the Various Derangements Incident to her Sex* (12th ed., entirely revised by J.H. Clarke, London, 1930) were in publication. No details are given of who had helped to produce Laurie's revised editions. This method of determining the withering away of the market for books on domestic practice is, of course, indicative rather than definitive. However, a collapse in demand for these kinds of texts is consistent with everything else known about the general decline of homoeopathy in the last decades of the nineteenth century.

42 Anon, *Homoeopathic Directory, 1876*, 88–92.

43 See the advertisements which appear at the back (no pagination) of Atkin, *British and Foreign*.