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Visualising Venereal Disease in London *c.*1780–1860

Harriet Palfreyman

A thesis submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy in History

University of Warwick
Department of History

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Table of Contents

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Abstract

This thesis explores the various roles that visual representations played in the theoretical understanding of, and practical approaches to, venereal disease in London's medical marketplace from around 1780 to 1860. Venereal disease was understood in a variety of ways, and conceptualised within a number of different medical disciplines, such as pathology and dermatology. The analytic lens of visual representation allows the historian to explore the complexities of these understandings. This thesis therefore contributes to the literature on the historicising of disease. The period under discussion was one of enormous change in medical theory, practice and disciplinary organisation. Disease was being conceptualised as something physical within the body, meaning images of the disease took on new meanings. Furthermore, these representations played an important role in medical education of the period, as well as in the legitimisation of new disciplines. Within these new theoretical paradigms and institutional spaces, various new meanings were created for the visual representations, and their creators and users had to employ various strategies to limit their meaning and control their interpretations. This thesis utilises a variety of visual and material representations – atlas illustrations, wax moulages, paintings, casts, models and pathological preparations – to see how meaning was negotiated for these visual representations. Venereal disease is a particularly complex case, as it was considered difficult to depict, therefore debates and disagreements over how it was to be visualised reveal much about how the disease was conceptualised. Through five chapters, the thesis explores how these representations functioned within different spaces in London's medical marketplace, such as public museums, private schools, hospitals and university medical departments.

List of Figures

Introduction

Chapter One

Chapter Two

Chapter Three

Chapter Four

Conclusion

Introduction

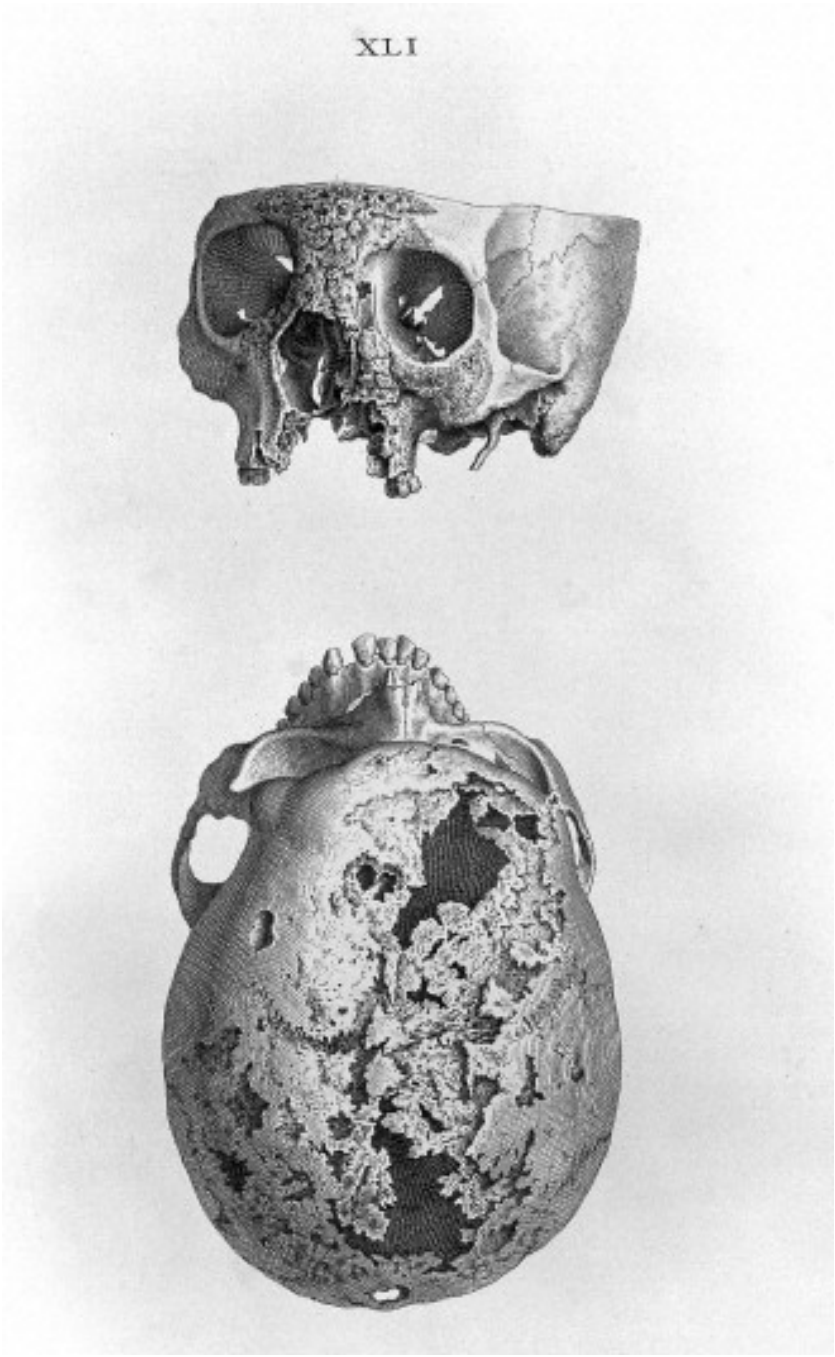

Figure i.1. Bones of the head affected by venereal disease. Engraving by Gerard Van der Gucht and Shinevoet, in William Cheselden, *Osteographia* (London, 1733), tabula XLI. Image courtesy of the Wellcome Library, London.

In 1733 esteemed London surgeon William Cheselden (1688–1752) published *Osteographia,* a large anatomy atlas composed of fifty-six images of the bones of the human body, with many drawn life sized. Though Cheselden included chapters explaining each image, his written descriptions were mostly brief as he 'thought it useless to make long descriptions, one view of such prints shewing [*sic*] more than the fullest and best descriptions can possibly do'.[1] Out of the fifty-six plates in *Osteographia*, fifteen showed bones in various states of disease or decay, with three depicting bones affected by caries brought on by venereal disease, making the bones appear eroded and almost rotten (fig. i.1). The finished product was a beautiful item, though it proved to be something of a commercial failure and only ninety-seven of the 300 copies produced were sold, with the remaining books broken up and the images sold on separately.[2] *Osteographia* also attracted severe criticism from fellow surgeon John Douglas (*bap*.1675–1743) who, in 1735 published a pamphlet devoted to denigrating Cheselden and his anatomy of bones entitled *Animadversions on a Late Pompous Book Intitluled Osteographia*. Douglas's problems with Cheselden's book were numerous, from the choice to include or exclude certain bones, inaccuracy in the information, lack of page numbers and even Cheselden's grammar was at issue. Douglas was perhaps at his most humourless when he wrote about one of the chapter tailpieces that showed the skeleton of a cat frightened by that of a dog, asking '[w]ho ever heard of a Sceleton being frighted? [*sic*]'[3] Yet it is what Douglas revealed about

[1] William Cheselden, *Osteographia, or the Anatomy of Bones by William Cheselden, surgeon to her majesty, F.R.S. Surgeon to St Thomas's Hospital and member of the Royal Academy of Surgery at Paris* (London, 1733).
[2] K. F. Russell, 'The Osteographia of William Cheselden,' *Bulletin of the History of Medicine*, 28 (1954), p. 32.
[3] John Douglas, *Animadversions on a late Pompous Book Intitluled Osteographia or The Anatomy of Bones by William Cheselden Esq…* (London: printed for and sold only by the Author in *Lad-Lane*, near *Guild-Hall,* 1735), pp. 29–30. Douglas's negative reaction to Cheselden's book may in

his attitude to the images of the diseased bones that is most interesting. After expending much ink listing Cheselden's other perceived crimes in detail, Douglas treated the images of disease in an almost offhand manner, referring in one sentence to all fifteen plates as 'a parcel of rotten bones, and all incurable cases, not worth delineating.'[4] For Douglas, the images of eroded and scarred bones were meaningless, and explained nothing about the nature of venereal disease, or how to cure it.

Little over a hundred years later Robert Carswell (1793–1857), Professor of Pathological Anatomy at the University of London, published an atlas titled *Pathological Anatomy: Illustrations of the Elementary Forms of Disease* noting that '[t]he great difficulty, and frequently the impossibility, of comprehending even the best descriptions of the physical or anatomical characters of diseases, without the aid of coloured delineations, induced me to undertake the publication of the present work'.[5] Within this atlas of general pathology is one plate that displays 'a section of a portion of the tibia with a circumscribed bony enlargement, or node, from a person affected with syphilis' (fig. i.2).[6] Carswell's images of diseased states fared significantly better than Cheselden's with *Pathological Anatomy* earning much praise from reviewers. One writer for the medical journal the *Lancet* wrote that Carswell's studious commitment to observation had thrown 'such truth into his representations as to make them not

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part be attributable to a longstanding professional rivalry between the two men with an embittered Douglas angry that Cheselden had previously plagiarised Douglas's work on lithotomy to much critical acclaim. See John Douglas, *Lithotomia Douglassiana: or, An Account of a New Method of Making the High Operation, in Order to Extract the Stone out of the Bladder. ... Invented and Successfully Perform'd by John Douglas, Surgeon* (London, 1720) and William Cheselden, *A Treatise on the High Operation for the Stone with XVII. Copper- Plates. By William Cheselden Surgeon to St. Thomas's Hospital in Southwark, and F.R.S.* (London, 1723).

[4] Douglas, *Animadversions on a late Pompous Book Intitluled Osteographia*, p. 38.

[5] Robert Carswell, *Pathological Anatomy: Illustrations of the Elementary Forms of Disease by Robert Carswell, M. D.,* (London: Printed for the Author, and published by Longman, Orme, Brown, Green, and Longman, Paternoster-Row., 1838), 'Notice'.

[6] Ibid., Plate III.

only serve as splendid illustrations, but as permanent facts for study and demonstration'.[7] In the hundred and five years between Cheselden and Carswell's publications visual representation had become invested with such explicatory power that many considered it superior to verbal description, and these pictures of rotten bones could now lay a more effective claim to a knowledge of venereal disease.

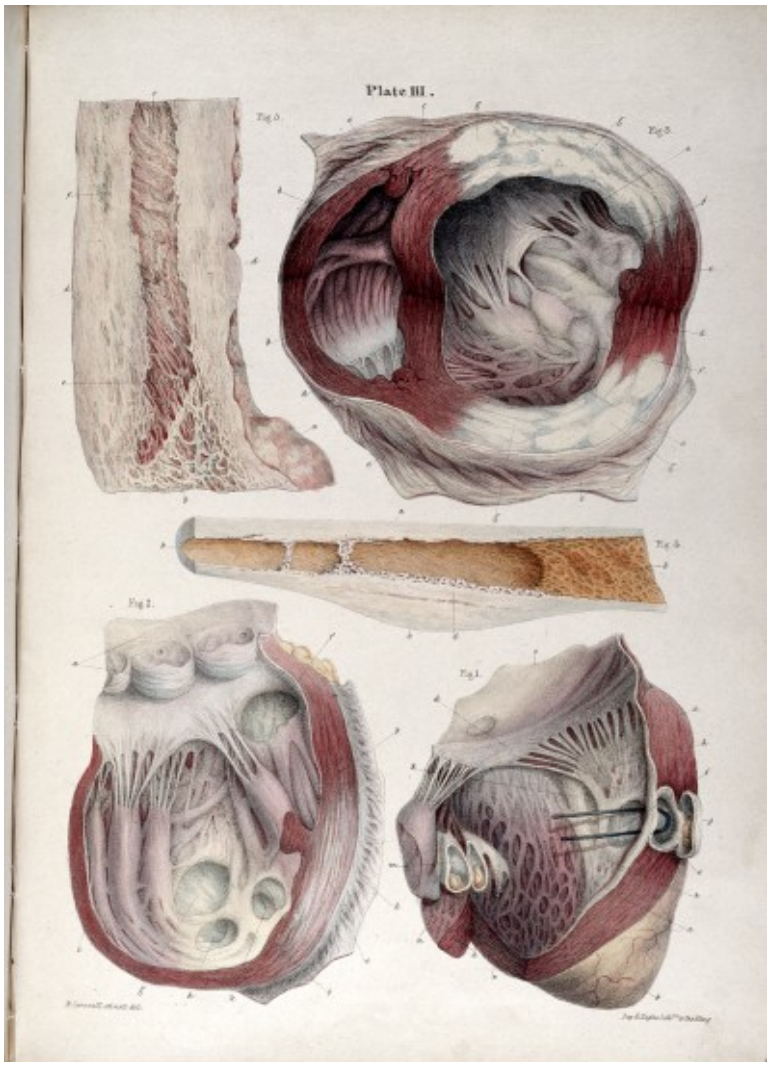

Figure i.2. Plate showing in the centre a portion of the tibia, from a person affected with syphilis. Coloured lithograph in Robert Carswell, *Pathological Anatomy*, (London, 1838), plate III. Image courtesy of the Wellcome Library, London.

[7] 'Review: Carswell on Tubercle', *Lancet,* Saturday 23 November 1833, p. 326.

Historians have noted that over those hundred and five years profound shifts in medical theory and practice occurred in Europe. When Cheselden published *Osteographia*, medical theory was characterised by a humoural paradigm that had dominated western medicine in various formulations since the ancient Greek medics and natural philosophers first posited that the human body was composed of blood, phlegm, yellow and black bile, vital fluids that were created in the organs of the body, the right balance of which would maintain an individual's good health.[8] Disease in a humoural paradigm was an invisible phenomenon, whose essential nature could only be hinted at by symptoms. Over the eighteenth century, changes in the technologies and sites of medical practice ushered in new ways of conceptualising disease in the body. The major change was the shift in medical practice from the domestic space to the hospital, posited by philosopher Michel Foucault as inaugurating the 'clinical gaze', a new way of understanding disease based on observation of large numbers of case studies and pathological investigations into the dead body.[9] Here, through the perceptual practices of looking at, touching and listening to the body, the actions of disease in the living flesh were uncovered and compared with the pathological changes seen in the dead.[10] Through these new medical practices disease took on a new identity. No longer considered as an abstract humoural essence disease came to be localised in

[8] Nancy Siraisi, *Medieval and Early Renaissance Medicine: An Introduction to Knowledge and Practice* (Chicago and London: University of Chicago Press, 1990), p. 105; see also Ian MacLean, *Logic, Signs and Nature: Learned Medicine in the Renaissance* (Cambridge: Cambridge University Press, 2001), p. 241.
[9] Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan (London and New York: Routledge, 2003).
[10] Ibid., p. 202.

specific solid parts of the body.[11] It was this new pathological conception of venereal disease that Robert Carswell was immersed in.

Historians of medicine and visual culture have often assumed, either tacitly or explicitly, that the new centrality of observation of bodies and symptoms in the understanding of disease led directly to the practice of visually representing the pathological appearances that Cheselden and Carswell depicted. Writing on a collection of nineteenth-century dermatologic wax models, historian Barbara Maria Stafford exposes her implicit assumption that representing was an inevitable consequence of observation. She writes that the models 'remind the spectator that this, of all diagnostic disciplines, was predicated from its eighteenth-century beginnings on direct observation'.[12] In an essay on the use of similar wax anatomical models in the eighteenth century historian Joan B. Landes states that 'the visual description of body parts, which accompanied the autopsy of a cadaver, was an intrinsic component of anatomy's claim to be a "science of observation"'.[13] The centrality of anatomy to the new conception of disease has been an important factor in fostering this assumption. Art historian Martin Kemp elides the practices of observing and representing within the field of anatomy writing that 'anatomical illustration lends itself to sequential, step-by-step exposition in which the visual presentation acts as a surrogate for the eye-witness

[11] Russell Maulitz, *Morbid Appearances: The Anatomy of Pathology in the Early Nineteenth Century* (Cambridge: Cambridge University Press, 1987), p. 18.
[12] Barbara Maria Stafford, *Body Criticism: Imaging the Unseen in Enlightenment Art and Medicine* (Cambridge and London: The MIT Press, 1993), p. 281.
[13] Joan B. Landes, 'Wax Fibres, Wax Bodies, and Moving Figures: Artifice and Nature in Eighteenth-Century Anatomy', in Roberta Panzanelli (ed.), *Ephemeral Bodies: Wax Sculpture and the Human Figure* (Los Angeles: Getty Research Institute, 2008), p. 41.

experience'.[14] For Stafford, Landes and Kemp, to look and to represent, were obviously products of the same epistemology.

This thesis seeks to complicate this reductive assumption in order to demonstrate the complexity of the relationship between observation and representation. The case of venereal disease in the late eighteenth and early nineteenth centuries elucidates this complexity well. The disease was the subject of seemingly endless debates and arguments between medical practitioners over its identity throughout the period. Douglas's response to Cheselden's images demonstrates that a new focus on observation as a central category of medical knowledge of the disease was not enough on its own to guarantee the legitimacy of visual representation. By Carswell's time significant theoretical shifts in medical discourse around disease ensured that visible symptoms had become crucial phenomena in understanding disease therefore it began to be useful to record these phenomena visually. Yet it is crucial to note that this use of images did not suggest, nor did it lead to, agreements over the medical understandings of venereal disease. This was a period that saw loud and bitter disputes over whether the disease could be considered as one condition which manifested in a shocking and protean variety of symptoms, or whether it could be divided into a number of separate diseases such as gonorrhoea, syphilis, chancre or *lues venerea*. Nor was the medical community wholly accepting of the ability of images to communicate such knowledge. The contested nature of venereal disease during the period highlights the fact that the meaning of images was similarly unstable.

[14] Martin Kemp, 'Temples of the Body and Temples of the Cosmos: Vision and Visualization in the Vesalian and Copernican Revolutions', in Brian Scott Baigrie (ed.), *Picturing Knowledge: Historical and Philosophical Problems Concerning the Use of Art in Science* (Toronto: University of Toronto Press, 1996), p. 43.

However, there were more than theoretical changes afoot, which of course did not occur in a socio-cultural vacuum, and the increasing appearance of visual representations of venereal disease suggests other factors prompting their emergence. Recently, historians of medicine and visual culture have begun to move beyond the mere aesthetics of visual representations, and take into account wider socio-cultural needs and attitudes that influenced the creation of such representations. Historian of science Lorraine Daston suggests that with the increasing dominance of 'observation' as a scientific practice, drawings 'now counted as essential parts of an observation' not because of any innate link between seeing and drawing, but because a disparate community of scientific observers needed a way to view natural phenomena that they may not have been able to witness first hand.[15] In a study on Italian wax anatomical models in the Enlightenment, historian of medicine Anna Maerker argues that historians have been too easily distracted by the aesthetics of such objects, leading to a neglect of the 'political, social and cultural context' of their creation and uses.[16] Thus for Daston, the image becomes a tool for the creation of a cohesive scientific community, and for Maerker, the model serves a number of political needs. I seek to follow those like Daston and Maerker who highlight the multiple identities of visual representations, arguing that representations of venereal disease played many roles in society during the period under discussion. For example, venereal disease was endemic in London during the eighteenth and nineteenth centuries, and society's fears of the disease often came to be revealed as visual discourse,

[15] Lorraine Daston, 'The Empire of Observation, 1600–1800', in Lorraine Daston and Elizabeth Lunbeck (eds), *Histories of Scientific Observation* (Chicago and London: University of Chicago Press, 2011), p. 105.
[16] Anna Maerker, *Model Experts: Wax Anatomies and Enlightenment in Florence and Vienna, 1775–1815* (Manchester and New York: Manchester University Press, 2011), p. 4.

such as popular contemporary exhibitions of wax models that depicted the dreadful outcomes of venereal disease.

Commercial interests played an important role as well. During this period, London was home to a thriving medical marketplace, unregulated by central state intervention, the medical practitioners of the capital competed amongst themselves to attract patients, meaning medical men had to become entrepreneurs as well as practitioners.[17] Whereas medical work had once been divided into a tripartite hierarchy of physicians, surgeons and apothecaries, by the late eighteenth century these distinctions were breaking down and the period saw the emergence of new categories of practitioner; the surgeon-apothecary, the dispensing druggist and the general practitioner, not to mention a newly sophisticated cadre of unlicensed practitioners.[18] As well as private practice, there were also a great number of hospitals established in the city during this period, including the London Lock Hospital, specifically for the cure of venereal disease, and several infirmaries and dispensaries. These new institutions were run as charities and needed to attract subscribers to secure funds, as well as attracting the best medical practitioners to staff them. Furthermore, London had, by the early nineteenth century, become an important site for medical education, and the teachers and medical schools founded around the capital by elite practitioners needed to compete to bring in students.[19] The changing pedagogical practices that came to utilise visual and material representations are a vital part of assessing the

[17] Roy Porter, 'William Hunter: A Surgeon and a Gentleman', in W. F. Bynum and Roy Porter (eds), *William Hunter and the Eighteenth-century Medical World* (Cambridge: Cambridge University Press, 1985), p. 21.
[18] Irvine Loudon, *Medical Care and the General Practitioner 1750–1850* (Oxford: Clarendon Press, 1986), p. 133–134.
[19] Susan C. Lawrence, *Charitable Knowledge: Hospital Pupils and Practitioners in Eighteenth-Century London* (Cambridge: Cambridge University Press, 1996).

multiple identities of these objects.[20] This thesis engages with visual representations of venereal disease as commercial rather than just intellectual phenomena that served the advertising and reputation-building necessities of the practitioners, teachers, and institutions of London's medical marketplace.

I seek to explore the various contested meanings of visual representations of venereal disease that were created in London's medical sphere during the period, arguing that these representations did not foster any agreement, standardisation or acceptance of any one theoretical understanding of the disease. Moreover, I argue that they had a multitude of meanings that went beyond their intended epistemological values; they were meaningful within wider socio-cultural concerns, such as professional medical identities, anxieties about the health of the city itself, and commercial interests of medical practitioners and institutions. The multiplicity of drawings, models, casts, prints and preparations representing venereal disease therefore held a variety of different meanings in the various medical sites and spaces of London in the late eighteenth and early nineteenth centuries.[21] Venereal disease has captured the imagination of numerous historians; it is that curiously enticing mix of the sexy and the sordid, its characters are the lowly prostitute and the distinguished genius alike; Beethoven, Baudelaire, Nietzsche and Wilde were all supposed to have suffered it.[22] Nearly two decades of scholarship have resulted in numerous historical studies of venereal disease over the five centuries since it arrived on European shores.[23]

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[20] Andrew Cunningham, *The Anatomist Anatomis'd: An Experimental Discipline in Enlightenment Europe* (Farnham and Burlington: Ashgate, 2010), p. 10.
[21] Samuel J. M. M. Alberti, *Morbid Curiosities: Medical Museums in Nineteenth-Century Britain* (Oxford and New York: Oxford University Press, 2011), p. 4.
[22] Deborah Hayden, *Pox: Genius, Madness, and the Mysteries of Syphilis* (New York: Basic Books, 2003).
[23] For the early modern period see Jon Arrizabalaga, John Henderson and Roger French, *The Great Pox: The French Disease in Renaissance Europe* (New Haven and London: Yale University Press,

Moreover, a multitude of interpretive framework; race,[24] class,[25] gender,[26] and religion,[27] have been thrust upon it; however I argue that a consideration of visual representations can offer much to the history of this disease.

Representation

Perhaps because visual representation has been so closely aligned with the observational work of medical practice and theory, the meaning of representation itself has rarely been questioned thoroughly by historians of medicine working on images. Representation though offers something new for the historicizing of disease, and is the central analytic lens of this thesis. In order to fully engage with the visual culture of venereal disease though we must first question what we mean

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1997); Laura J. McGough, *Gender, Sexuality, and Syphilis in Early Modern Venice: The Disease that Came to Stay* (Basingstoke: Palgrave Macmillan, 2011); Claudia Stein, *Negotiating the French Pox in Early Modern Augsburg* (Farnham and Burlington: Ashgate, 2009); Johannes Fabricus, *Syphilis in Shakespeare's England* (London and Bristol: Jessica Kingsley Publishers, 1994); and Kevin Siena (ed.), *Sins of the Flesh: Responding to Sexual Disease in Early Modern Europe* (Toronto: Centre for Reformation and Renaissance Studies, 2005). For the eighteenth century see Linda E. Merians (ed.), *The Secret Malady: Venereal Disease in Eighteenth-Century Britain and France* (Lexington: University Press of Kentucky, 1996); Kevin P. Siena, *Venereal Disease, Hospitals and the Urban Poor: London's "Foul Wards," 1600–1800* (Rochester, NY: University of Rochester Press, 2004). The nineteenth and twentieth centuries have been particularly well served by Mary Spongberg, *Feminizing Venereal Disease: The Body of the Prostitute in Nineteenth-Century Medical Discourse* (New York: New York University Press, 1997); Gayle Davis, *'The Cruel Madness of Love': Sex, Syphilis and Psychiatry in Scotland, 1880–1930* (Amsterdam and New York: Rodopi, 2008); Jay Cassell, *The Secret Plague: Venereal Disease in Canada 1838–1939* (Toronto and Buffalo: University of Toronto Press, 1987); and Allen Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States Since 1880* (New York and Oxford: Oxford University Press, 1985).

[24] The issue of race and venereal disease has most often been written in reference to the notorious Tuskegee clinical experiment, in which the test group of six hundred poor black sharecroppers were told they were being treated for 'bad blood' by the U.S. Public Health Service in Alabama. Treatment was withheld from half of the men in order to examine the natural course of the disease. The study ran from 1932 to 1972 when it was exposed to wide condemnation. See Susan M. Reverby, *Examining Tuskegee: The Infamous Syphilis Study and its Legacy* (Chapel Hill: University of North Carolina Press, 2009) and James Howard Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York: Free Press, 1993).

[25] Kevin Siena focuses on the effects of venereal disease on the urban poor in London. Siena, *Venereal Disease, Hospitals and the Urban Poor*.

[26] McGough, *Gender, Sexuality, and Syphilis in Early Modern Venice*, p. 8; Spongberg, *Feminizing Venereal Disease*.

[27] Stanislav Andreski, *Syphilis, Puritanism and Witch Hunts: Historical Explanations in the Light of Medicine and Psychoanalysis with a Forecast about Aids* (New York: St. Martin's Press, 1989); Theodor Rosebury, *Microbes and Morals: The Strange Story of Venereal Disease* (London: Secker & Warburg, 1971), especially chapter 14. 'Disease, Sin, and Punishment', pp. 165–176.

by 'representation' at all. At its most basic level, representation of course refers to mimesis.[28] Art historians Norman Bryson, Michael Ann Holly and Keith Moxey have argued that the academic field of visual culture studies that emerged in the late 1980s has turned away from this traditional definition of representation as imitation, and instead understood it as 'semiotic representation, that is as a system of signs' which 'exhibit the cultural values of the historical moment to which the artist belonged'.[29] Thus in visual culture studies, the image becomes not a mere reflection of how something looks or looked, but a representation of the values of a whole socio-cultural system, the way a culture saw.

It was cultural theorist W. T. J. Mitchell who first coined the term 'pictorial turn' in the 1990s as academia began to pay more attention to a visual culture that went beyond a traditional art history approach to images.[30] Mitchell contends that a new focus on the visual emerged from a conjunction of new directions in the history of art, and the new 'cultural turn' in the humanities.[31] This cultural turn inaugurated a new focus, not on the elite artistic or literary products of thought, but on the societies and cultures that these emerged within.[32] The new unease with traditional history of art saw a desire in the academy to turn away from 'the creation of aesthetic masterpieces, which constitute the canon of artistic excellence' and engage more with these wider cultural contexts and meanings that produced such works.[33] This was not just a shift that was confined to the discipline of art history though and the turn towards the visual was seen in many strands of

[28] David Summers, 'Representation', in Robert S. Nelson and Richard Shiff (eds), *Critical Terms for Art History* (2nd edn, Chicago and London: University of Chicago Press, 2003), p. 3.
[29] Norman Bryson, Michael Ann Holly and Keith Moxey (eds), *Visual Culture: Images and Interpretations* (Middletown: Wesleyan University Press, 1994), p. xviii.
[30] W. T. J. Mitchell, *Iconology: Image, Text, Ideology* (Chicago: University of Chicago Press, 1987).
[31] Margarita Dikovitskaya, *Visual Culture: the Study of the Visual After the Cultural Turn* (Cambridge and London: The MIT Press, 2005), p. 47.
[32] Ibid., p. 1.
[33] Bryson et al, *Visual Culture: Images and Interpretations*, p. xvi.

scholarship, including the history of medicine. Cultural historian Sander Gilman was one of the first to argue that cultural history should pay more attention to images as, 'the visual is intrinsic to the definition of culture (either in its narrowest sense defined as "high art" or in its broadest defined as "human production").'[34] For this new cultural history to fully contend with the history of medicine, the visual representations must necessarily have a role to play beyond the mere illustration of accepted historical narratives.[35]

The late 1980s and 1990s saw the appearance of a number of historical works devoted to such careful consideration of the visual cultures of medicine.[36] Historians such as Ludmilla Jordanova approached images 'not to display them as cultural ornaments but to demonstrate that aesthetics is constitutive of knowledge'.[37] The turn to the visual in the history of medicine has not only investigated the production of images and objects, but has also begun to explore what it means to see the things represented at all. Historian Larissa Heinrich writes that '[w]ith its attention not only to the techniques of the artist or artisan but also to the cultural and historical conditioning of vision itself, visual culture studies fills an important gap in the analysis of transmission of ideas about illness across cultures and across history.'[38] Therefore histories of vision have appeared,

[34] Sander L. Gilman, *Picturing Health and Illness: Images of Identity and Difference* (Baltimore and London: The Johns Hopkins University Press, 1995), p. 10.
[35] Ibid., p. 11.
[36] For example, Sander L. Gilman, *Disease and Representation: Images of Illness from Madness to AIDS* (Ithica and London: Cornell University Press, 1988); Ludmilla Jordanova, *Sexual Visions: Images of Gender in Science and Medicine Between the Eighteenth and Twentieth Centuries* (Madison: The University of Wisconsin Press, 1989); Stafford, *Body Criticism*; Gilman, *Picturing Health and Illness*; Lisa Cartwright, *Screening the Body: Tracing Medicine's Visual Culture* (Minneapolis: University of Minnesota Press, 1997).
[37] Jordanova, *Sexual Visions*, p. 6.
[38] Larissa Heinrich, *The Afterlife of Images: Translating the Pathological Body between China and the West* (Durham: Duke University Press, 2008), p. 9.

demonstrating the complexity of the relationship between seeing something, and visually representing it.[39]

Within these studies, the meaning of representation has to be carefully considered. A central tenet of this thesis is that representation itself, understood as more than simple mimesis, allows for a multitude of meanings and interpretations of whatever is being depicted, in this case, various symptoms of venereal disease. This builds on work that understands the multiplicity of potential interpretation of signs as the central facet of representation. Historian Brian Maidment, in his study *Reading Popular Prints*, writes that '[t]he codes, conventions, and representational traditions of the printed image are themselves as representative of ideology as anything they seek to depict.'[40] In the same vein as Maidment I argue that the medical images discussed here do not merely represent mimetically how the symptoms of a certain disease appeared on the body, they represent the way in which medicine was conceptualising that disease. Images were not the result of unmediated observation; they were the products of a culture-specific way of seeing. An essential argument of this thesis is that during this period visual representation did not have the epistemological power to standardise or unify conceptions of venereal disease. The virtue of the study of representation here is its instability. It allows us to explore the multitude of meanings attached to visual representations and thus to disease.

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[39] Stuart Clark, *Vanities of the Eye: Vision in Early Modern European Culture* (Oxford: Oxford University Press, 2007); Martin Jay, *Downcast Eyes: The Denigration of Vision in Twentieth-Century French Thought*, (Berkeley and London: University of California Press, 1994).
[40] Brian Maidment, *Reading Popular Prints, 1790–1870* (2nd edn, Manchester: Manchester University Press, 2001), p. 8. See also Callum G. Brown, *Postmodernism for Historians* (Harlow: Pearson Education Limited, 2005), p. 111–112.

In his study of the history of syphilis, historian Claude Quétel writes that '[n]o testimony is more valuable than that of visual images'.[41] This is a throwaway line as Quétel's is a traditional historical narrative inherently disinterested in visual culture, and he goes no further than using a couple of images to illustrate his analysis of the stigma surrounding the disease. However, there is truth in his casual claim; representation, in all its multiple uncertainties offers the historian of venereal disease an important lens through which to reveal the contested claims and constructed knowledge about the disease in the period considered here. The study of representation allows the historian of venereal disease access to debates and practices that traditional textual accounts conceal. Particularly evident are contemporary concerns about how important it was to be able to visually represent a disease for medical disciplines in which images played a central role, such as dermatology. The protean range of symptoms provoked by venereal disease complicated any such attempts at representation, leading to uncertainty about the identity of the disease as well as the value of images. Gilman has argued that images are particularly meaningful in considering disease, as they do not just represent what is seen on the patient as symptoms, but also their very creation and existence represents an attempt to control the disease itself; he asserts that society manages anxieties about disease by localising them within images.[42] Gilman uses his own study *Picturing Health and Illness* to show that 'the images can seem to be controlled, while the "illnesses" constructed seem always to be beyond control'.[43] This thesis explores this theme, seeking to show that any medical enthusiasm for the ability of images to create and communicate

[41] Claude Quétel, *A History of Syphilis*, trans. Judith Braddock and Brian Pike (London: Polity Press, 1990), p. 13.
[42] Gilman, *Picturing Health and Illness*, p. 32.
[43] Ibid., p. 32.

knowledge about venereal disease was matched by intense unease about how the images themselves were to be interpreted and controlled. The anxiety about the interpretation of images of venereal disease reveals fundamental uncertainties about the disease itself, which historians of venereal disease have often overlooked.

The study of representation also allows us to explore how we might methodologically approach images to excavate some of their various interpretations and meanings. It is obviously important to first recognise the immediate contexts within which images were created. Historians Roger Cooter and Claudia Stein have written that it is not necessary that 'the visual must be interpreted only *from* the visual'.[44] Therefore, whilst focusing on images we must not forget that they were often created alongside texts, and this use of text represented a crucial method of controlling the interpretation of images once they entered a discursive field. Mitchell argues that the term 'representation', 'has the virtue of simultaneously linking these visual and verbal disciplines within the field of their differences'.[45] Text and image serve different purposes and interpreting images through their texts necessitates moving beyond the idea that the image merely illustrates the text. Often, the relationship between the text and image is one way of revealing the attempts by image creators to control the way their pictures were understood. As an example, the first image of this thesis, William Cheselden's venereal disease riddled skulls, was part of an atlas that also included textual discussion of the parts represented visually. Cheselden wrote in *Osteographia* that '[t]he venereal disease… rarely attacks any but the hardest

[44] Roger Cooter and Claudia Stein, 'Visual Imagery and Epidemics in the Twentieth Century', in David Serlin (ed.), *Illness: Public Health and Visual Culture* (Minneapolis: The University of Minnesota Press, 2010), p. 172.
[45] W. J. T. Mitchell, *Picture Theory: Essays on Verbal and Visual Representation* (Chicago and London: The University of Chicago Press, Ltd., 1995), p. 6.

parts of the bones, very soon raising large tumours and caries or mortification'.[46] The text was a way of attempting to control how the image was interpreted, Cheselden wanted the reader to look at the picture and recognise an important facet of a disease. However, we have already seen that the image was interpreted by Cheselden's contemporaries in many other ways, most notably as, 'a parcel of rotten bones… not worth delineating'.[47]

As well as interrogating accompanying texts, it is important to look at the actual processes of creating these images, including the power relationships involved in their genesis, what Jordanova refers to as the 'patronage situation' of image creation.[48] To take Cheselden as an example again, we can see how his visual representations were firmly embedded within the social relationships of numerous actors. Eager that *Osteographia* should depict the bones exactly as they appeared Cheselden instructed his artists to create the pictures by drawing them in a camera obscura.[49] However, the surgeon believed that no form of mechanical aid could surpass the skill and reasoned knowledge of the dissector himself, so Cheselden was not shy of directing his artists and engravers, and even taking over to ensure the correct appearances were captured.[50] Cheselden wrote in the introduction to *Osteographia* that 'where particular parts needed to be more distinctly expressed on account of the anatomy, there I always directed; sometimes in the drawings with the pencil, and often with the needle upon the

[46] Cheselden, *Osteographia, or The Anatomy of the Bones*.
[47] Douglas, *Animadversions on a late Pompous Book Intitluled Osteographia*, pp. 29–30.
[48] Ludmilla Jordanova, 'Medicine and Visual Culture', *Social History of Medicine*, 3:1 (1990), p. 94. In her masterful study of Gray's Anatomy, historian Ruth Richardson provides an example of how the understanding of the social relationships of all the actors involved in the creation of Gray's atlas illuminates much about its identity. Ruth Richardson, *The Making of Mr. Gray's Anatomy* (Oxford: Oxford University Press, 2008).
[49] Cunningham, *The Anatomist Anatomis'd*, p. 263.
[50] Lorraine Daston and Peter Galison, *Objectivity* (New York: Zone Books, 2007), pp. 77–79.

copper plate'.[51] Highly aware of the contested nature of images, Cheselden recognised that controlling the reception of his images necessitated his constant involvement in their creation.

There is another level at play here, Cheselden knew that the objects he had instructed his artists to draw, the preserved diseased bones, could themselves be subject to numerous interpretations. This thesis considers not just the visual but the material representations of venereal disease such as pathological preparations (fig. i.3). Models and preparations have often been neglected by historians of medicine's visual culture, the result of a tacit assumption that these objects are somehow less meaningful than images.[52] On a theoretical level, many historical studies have pointed to a paradox at the heart of material culture studies, situating 'materials' as something base and mundane while 'culture' takes on the loftier qualities of the intellectual and abstract.[53] The problem with this bifurcated approach is that it assumes base materials are somehow culturally inert, that they only take on meaning when moulded and shaped into an object of study. Daston rebuts this, seeking to 'confront the paradox head-on and to take it for granted that things are simultaneously material and meaningful'.[54] Throughout this thesis I explore the meanings attached to various materials used to create representations of venereal disease, from the physical flesh of the corpse that was preserved as preparations, to wax, that was formed into dermatological moulages.[55]

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[51] Cheselden, *Osteographia, or The Anatomy of the Bones*.
[52] Nick Hopwood, *Embryos in Wax: Models from the Ziegler Studio* (Cambridge: Whipple Museum of the History of Science, University of Cambridge, 2002), p. 3.
[53] Jules D. Prown, 'Material/Culture: Can the Farmer and the Cowman Still be Friends', in W. David Kingery (ed.), *Learning from Things: Method and Theory of Material Culture Studies* (Washington and London: Smithsonian Institute Press, 1996), p. 19.
[54] Lorraine Daston, 'Speechless' in Lorraine Daston (ed.), *Things That Talk: Object Lessons from Art and Science* (New York: Zone Books, 2004), p. 17.
[55] 'Moulage' comes from the French 'mouler', meaning to mould or imprint. A moulage is a wax model, usually made from a plaster cast of a cutaneous symptom. Thomas Schnalke, *Diseases in*

Figure i.3. A cranium showing a large lesion across the left frontal bone, with a smaller lesion on the right side, as a result of a chronic syphilitic infection. Dry preparation, *c*.1760–1793. © The Hunterian Museum at the Royal College of Surgeons, RCSHC/P 720.

As with images, in order to fully appreciate the various meanings of materials we must look not only at the products, but also the processes by which they were created. As Daston advises '[s]hifting attention from being to becoming can undermine seemingly obvious assumptions about thingness'.[56] History, as it is wont to do, borrows heavily from the social sciences when it comes to material culture methodologies. Looking at process and product involves studying the ways an object moves in and out of different contexts in the process of becoming. The germinal work in this vein is anthropologist Arjun Appadurai's 1986 edited collection *The Social Life of Things*, which focuses on commodities as a category

Wax: The History of the Medical Moulage, trans. Kathy Spatschek (Berlin: Quintessence Publishing Co., 1995), p. 9.
[56] Daston, 'Speechless', p. 20.

of things. Appadurai writes that 'from a *methodological* point of view it is the thing-in-motion that illuminates their human and social context.'[57] In the same volume, anthropologist Igor Kopytoff explores the idea of 'biographies' of things. Similar in their questioning to biographies of people, biographies of things ask about the origins of the thing, the intended uses for the thing, uses that diverge from the intention, the lifespan of the thing, and its subsequent disappearance.[58] For my purpose, the biographical approach allows us to see the multiplicity of meanings and interpretations of material and visual representations of the disease, allowing us to look outside of the aesthetics of the thing discussed and see that it is meaningful in numerous other ways.

This thesis asserts that what is directly presented of venereal disease visually, as images, models and specimens, was never the sum total of what was being represented. I recognise that visual and material representations are meaningful in a variety of different ways. As Maidment writes '[i]n seeking to represent the immediate, the topical, and the ephemeral within their own culture, these images instead describe for us the complex and not entirely conscious exchange of cultural values which is characteristic of discourse.'[59] Moreover, I accept that contemporary awareness of the instability of the image required those creating them to employ various strategies of control, whether as text or direct intervention in their creation as Cheselden had done. These strategies of representation indicate much about the contested nature of venereal disease, with

[57] Arjun Appadurai, 'Introduction: commodities and the politics of value' in Arjun Appadurai (ed.), *The social life of things: Commodities in cultural perspective* (Cambridge: University of Cambridge Press, 1986), p. 5.
[58] Igor Kopytoff, 'The cultural biography of things: commoditization as process', in Arjun Appadurai (ed.), *The social life of things: Commodities in cultural perspective* (Cambridge: University of Cambridge Press, 1986), pp. 66–67.
[59] Maidment, *Reading Popular Prints*, p. 19.

anxieties over the interpretation of images becoming almost metonymic for anxieties over the very nature of venereal disease itself.

Histories of Disease

This thesis seeks a historicised understanding of venereal disease that is thoroughly specific to a time and place, in this case, London in the late eighteenth to the mid nineteenth century. The historicity of disease would not have been a consideration without the turn in the humanities towards seeing the body as a historical construct.[60] The so-called 'corporeal turn' of the 1980s saw historians displacing the body from its position as assumed ahistorical, biological constant, and reconceptualising it as a historically constituted phenomenon.[61] Various disciplines seized on the newly destabilised identity of the body, and historians of medicine were no exception. Bodies had in many ways always been present in history of medicine – medicine after all serves to keep the body healthy – but the new uncertainty about its ontology offered new opportunities for a more historical approach to all aspects of the history of medicine, especially one which, in historian Mark Jenner's words, 'transcends research agendas structured by anatomically-defined twentieth-century biomedical specialisms'.[62]

Before the historicized body, histories of disease relied on a retrospective diagnosis, which assumed a biological and ahistorical identity to all disease. This is typified by historian William H. McNeill in his *Plagues and Peoples*, originally published in 1976, which explored 'the history of humanity's encounters with

[60] Barbara Duden, *The Woman Beneath the Skin: A Doctors Patients in Eighteenth-Century Germany*, trans. Thomas Dunlap (Cambridge and London: Harvard University Press, 1991), p. vii.
[61] Adam Bencard, 'History in the Flesh: Investigating the Historicized Body' (unpublished doctoral thesis, University of Copenhagen, 2007), p. 11.
[62] Mark S. R. Jenner, 'Body, Image, Text in Early Modern Europe', *Social History of Medicine*, 12:1 (1999), p. 144.

infectious disease, and the far-reaching consequences that ensued whenever contacts across disease boundaries allowed a new infection to invade a population that lacked any acquired immunity to its ravages.'[63] Historian Andrew Cunningham has demonstrated that the coming to prominence of the laboratory as the site of biomedical endeavour in the twentieth century has deeply affected our understandings of previous concepts of disease.[64] This has often manifested as histories of disease that began with a modern day biomedical description of what the disease *really was* before moving on to discuss past responses to whatever bacterium or virus has been identified as its cause. This is a trend that has been particularly obvious in the case of infectious and epidemic diseases. In his 1985 book, *The Impact of Plague in Tudor and Stuart England*, historian Paul Slack begins a section titled 'Plague and its history' with '[i]t is necessary to begin with some explanatory account of plague itself. The bacillus responsible for the disease is *Pasteurella pestis*, or *Yersina pestis* as it is now more commonly called.'[65] The insistence on beginning any history of a specific disease with how we know it now persisted, and histories of venereal disease were certainly no exceptions to this fashion.[66]

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[63] William H. McNeill, *Plagues and Peoples* (New York: Anchor Books, 1998), p. 22.
[64] Not only were they completely different from laboratory concepts of disease, Cunningham also takes pains to point out that neither were they simply less developed forerunners of the laboratory concept. Andrew Cunningham, 'Transforming Plague: The laboratory and the identity of infectious disease', in Andrew Cunningham and Perry Williams (eds), *The Laboratory Revolution in Medicine* (Cambridge: Cambridge University Press, 1992), p. 209.
[65] Paul Slack, *The Impact of Plague in Tudor and Stuart England* (London: Routledge and Kegan Paul, 1985) p. 7–17. See also Paul Slack, 'Introduction', in Terence Ranger and Paul Slack (eds), *Epidemics and Ideas: Essays on the Historical Perception of Pestilence* (Cambridge: Cambridge University Press, 1992), p. 3.
[66] Donald R. Hopkins began his history of smallpox, originally published in 1983, with a description of Elizabeth I's experience of smallpox before explaining that '[t]he deadly cause of Queen Elizabeth's illness is now known to be a diminutive, brick-shaped virus, *Variola major*.' Donald R. Hopkins, *The Greatest Killer: Smallpox in History, with a New Introduction* (Chicago: University of Chicago Press, 2002), p. 3. In a similar fashion historian Robert John Morris, begins his book on cholera by describing a case of a person who died of cholera in 1832. Asking what exactly this disease was he explains '[t]he immediate answer to the question may, with present-day medical knowledge, be given very simply. The keel man died from the effects of a micro-

There is a commonly repeated narrative that begins many of the histories of venereal disease, typically beginning with the arrival in Europe, in the very last years of the fifteenth century, of the French pox. On their return from America, Christopher Columbus and his crew were supposed to have brought back, along with the bountiful treasures of the new world, a new disease, which, thanks to the French army's activities – military and recreational – in Italy at the time, spread rapidly and gained the designation 'the French Disease', or *Morbus Gallicus*.[67] What was immediately obvious was the method of its transmission, which came to characterise and eventually formally denominate the disease as 'venereal'.[68] By the eighteenth century it was commonly referred to as *lues venerea*, and it was widely accepted that this was the same as the former 'French disease', just under a new name.[69]

The nineteenth century saw various attempts to distinguish between gonorrhoea and syphilis but none successfully until the work of French physician Phillippe Ricord (1800–1889).[70] In the early twentieth century zoologists Fritz Schaudinn (1871–1906) and Erich Hoffmann (1868–1959) discovered the causative microbe of syphilis, *Treponema pallidum*, a spirochete that infects the body through sexual contact.[71] Finally, we now understand syphilis as progressing through three temporally and spatially distinct stages. The primary stage is characterised by the appearance of a hard ulcer called a *chancre* on the genitals,

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organism, the *cholera vibrio* which established itself in his intestines.' Robert John Morris, *Cholera 1832: the Social Response to an Epidemic* (London: Croom Helm Ltd., 1976), p. 14.
[67] McGough, *Gender, Sexuality, and Syphilis in Early Modern Venice*, p. 1. See also, 'Quarantining Beauty: The French Disease in Early Modern Venice', in Kevin Siena (ed.), *Sins of the Flesh: Responding to Sexual Disease in Early Modern Europe* (Toronto: Centre for Reformation and Renaissance Studies, 2005), p. 216.
[68] Quétel, *History of Syphilis*, p. 10.
[69] Arrizabalaga et al., *The Great Pox*, p. 5.
[70] Roger Davidson and Lesley A. Hall, 'Introduction', in Roger Davidson and Lesley A. Hall (eds), *Sex, Sin and Suffering: Venereal Disease and European Society Since 1870* (London and New York: Routledge, 2001), p. 5.
[71] Brandt, *No Magic Bullet*, p. 40. See also Hayden, *Pox*, p. 25.

the initial site of infection. After a few weeks, secondary manifestations appear, usually as cutaneous rashes or small lesions. The disease can then remain latent in the body for years before the patient becomes aware of any tertiary stage symptoms, which affect the heart, lungs, brain and bones.[72] It is the microbe alone that causes the disease, so without the existence of *Treponema pallidum* in the blood, there can be no syphilis. This represents our modern aetiological understanding of infectious disease.[73] Quétel's study typifies this narrative. Although *History of Syphilis* is in many ways a more nuanced understanding of different ideas of the disease than many historians have written Quétel essentially sees developments in the ways disease was known as changes in nomenclature only, with the microbe remaining a stable and constant historical presence.[74]

In light of this, many histories have polluted past conceptions of venereal disease with modern designations of syphilis or gonorrhoea before any division of these conditions became apparent, useful or even interesting. Attempts to impose modern order on past complexities has led to a dry teleology, with historians waiting impatiently and judgmentally for the past to catch up. Writing in 1994, Johannes Fabricius bemoaned that it was impossible to discern the number of people suffering from syphilis in the sixteenth century as '[t]he difficulties of diagnosis in an age that confused syphilis and gonorrhoea, which was without the Wassermann test, and which tended to cover up occurrences of the "foul disease", make such a task impossible.'[75] Whilst Fabricius's is perhaps a tacit

[72] World Health Organization, *Guidelines for the Management of Sexually Transmitted Infections* (Geneva: World Health Organization, 2003), p. 39.
[73] Cunningham, 'Transforming Plague', p. 218; K. Codell Carter, *The Rise of Causal Concepts of Disease: Case Histories* (Aldershot: Ashgate, 2003).
[74] Adrian Wilson, 'On the History of Disease-Concepts: The Case of Pleurisy', *History of Science*, 38 (2000), p. 4.
[75] Fabricius, *Syphilis in Shakespeare's England*, p. xiv. Fabricius is not the only historian guilty of such anachronism. See also Andreski, *Syphilis, Puritanism and Witch Hunts*.

retrospectivism, other historians have seen value in diagnosing historical figures with syphilis long before the category emerged. Deborah Hayden, in her 2003 book *Pox: Genius, Madness, and the Mysteries of Syphilis*, legitimises her retrospective diagnoses of figures such as Beethoven, Flaubert and van Gogh by asking '[i]f syphilis defined one as an outsider ("ghastly miserable and hated in society"), how can knowledge of being infected not be reflected thematically in the work?'[76]

A word on my own terminology; I have used the designation 'venereal disease' in the singular, both in the title of, and throughout this thesis. Though it covers the period in which the conception of a single *disease* gave way to a focus on a variety of *diseases* I have chosen the singular, in part to distance myself from the oft-assumed inevitability of this separation into multiple diseases. Indeed the category 'venereal disease' continued to be used throughout the period under consideration here, as a sometimes explicit, sometimes tacit, organizing category. Surgeon John Hunter's (1728–1793) influential 1786 work on the subject was entitled *A Treatise on the Venereal Disease* despite his claim that there were multiple stages and forms of the disease. Even in the mid nineteenth century, when practitioners were commonly separating venereal disease into distinct conditions such as syphilis and gonorrhoea, they were still covered by the rubric 'venereal disease'. Surgeon Samuel Armstrong Lane (1802–1892) referred to 'the venereal disease' in a series of lectures he gave 'on syphilis' 1841.[77] Whilst I use the singular as a general term, I do not mean to suggest that this represented one

[76] Hayden, *Pox*, p. 68.
[77] Samuel Lane, 'Lecture III: A Course of Lectures on Syphilis', *Lancet*, Saturday 18 December 1841, p. 393.

universally accepted disease, and where historical actors use different terms, and distinguish between different diseases, I shall follow and use their nomenclature.

With a tendency to ignore contemporary medical theories of venereal disease in the light of the discovery of the syphilis spirochete, historians have often succumbed to an unfortunate tendency to write the complex history of venereal disease as a series of key points that brought understandings gradually closer to our biomedical understanding of sexually transmitted infections. Hence many studies focus on the work of Phillippe Ricord who, after a series of experiments in 1838, was said to have proved once and for all that gonorrhoea and syphilis were separate diseases bred from different poisons. When historians focus on the medical understandings of venereal disease they often begin with Ricord, taking him as medical science's first triumph over syphilis. Historian Jay Cassell, studying venereal disease in Canada begins in 1838 'the year in which the course and symptoms of syphilis and gonorrhoea were clearly differentiated, marking the beginning of "modern" understanding of venereal disease'.[78] After this, historians such as Cassell assume a modern conception of the disease based on a twentieth century aetiological definition. Cassell's description of the period of blinding illumination initiated by Ricord's experiments, suggests a view of the medical profession prior to this period that is patronising and dismissive at best. Cassell writes that after the medical breakthroughs of the late nineteenth century,

> doctors were now able to explain things in terms of established fact – venereal disease became a biological phenomenon with features that could be described in dispassionate textbook terms just like so many other ailments. The mystique of a little-understood menace was evaporating. Doctors grew confident in their ability

[78] Cassell, *The Secret Plague*, p. 10.

> to cope with the problem because at last it was understood and could be described: VD became a known entity.[79]

The assumption of a pre-1838 group of nervous doctors, overwhelmed by the lack of 'facts' explicative of a nebulous and amorphous disease is erroneous. As historians Jon Arrizabalaga, John Henderson and Roger French have argued, the multiplicity of theoretical understandings of venereal diseases before the discovery of the *Treponema* 'did not represent confusion, for confusion is a muddling of extant categories, and our categories did not exist then'.[80] This thesis writes against the reductive assumptions of those such as Cassel, arguing that whilst it could be said that the medical practitioners of the eighteenth and nineteenth century lacked many things, what they certainly did not want for was confidence. There was no one dominant view of venereal disease in the medical disciplines, but most everyone had their theories and they argued vociferously for them. In 1786 John Hunter wrote that chancre was caused by venereal matter irritating the body, causing it to produce its own matter in an attempt to expel the venereal poison.[81] Fellow surgeon Jesse Foot (1744–1826) had other ideas and responded caustically, '[f]or God's sake, Mr. Professor, do not persuade yourself that, although I am now irritated to the very "certain degree" which it is possible for man to be, I shall get rid of the irritation by the formation of matter.'[82] Foot and Hunter's escalating antipathy demonstrates that although the eighteenth-century medical sphere was in profound disagreement as to the nature of venereal

[79] Ibid., p. 24.
[80] Arrizabalaga et al., *The Great Pox*, p. 2.
[81] John Hunter, *A Treatise on the Venereal Disease. By John Hunter* (London: sold at No. 13, Castle-Street, Leicester-Square, 1786), p. 18.
[82] Jesse Foot, *Observations upon the New Opinions of John Hunter, in his Late Treatise on the Venereal Disease, Treating on Chancre, Bubo, and Lues Venerea. Also, a full Investigation of some Recent and Serious Cases of Lues Venerea, Conveyed by Transplantation of Teeth. Part III By Jesse Foot, Surgeon.* (London: Printed for T. Becket, Pall-Mall, Bookseller to his Royal Highness the Prince of Wales, 1787), p. 10.

disease, this disagreement did not represent any confusion on the part of each individual regarding their specific theories.

Other historians have highlighted how retrospective diagnosis represents a blind alley of historical study that oversimplifies the history of disease. Arrizabalaga, Henderson and French have eloquently noted the dangers of referring to venereal disease as syphilis before the term began to be commonly used in the late eighteenth century.[83] I seek to build on this work, using the lens of representation to explore the contemporary conceptions of venereal disease on their own terms arguing that the various conceptualisations of the disease extant during the period of my thesis were historically and culturally constituted; the spirochete here is irrelevant.

The idea that diseases are socially and culturally constructed came to command much scholarly attention in the 1980s. An important progenitor of this field was bacteriologist Ludwik Fleck's 1939 book, *The Genesis and Development of a Scientific Fact*, translated into English in 1979. Fleck demonstrated that scientific facts were not natural phenomena discovered by scientists but were products of social and historical construction.[84] 'Concepts', he wrote, 'are not spontaneously created but are determined by their "ancestors"'.[85] Although the basis for Fleck's book was his study of the historical development of syphilis, it was not historians of medicine who initially adopted his ideas, but historians of science, producing now famous works on the processes of knowledge creation and transformation, such as Thomas Kuhn's 1962, *The*

[83] Arrizabalaga et al., *The Great Pox*, p. 18. See also Stein, *Negotiating the French Pox*, p. 3 and David Harley, 'Rhetoric and the Social Construction of Sickness and Healing', *The Society for the Social History of Medicine*, 12:3 (1999), p. 419.
[84] Ludwik Fleck, Thaddeus J. Trenn and Robert Merton (eds), *Genesis and Development of a Scientific Fact*, trans. Fred Bradley and Thaddeus J. Trenn (Chicago and London: University of Chicago Press, 1981) p. xxvii.
[85] Ibid., p. 20.

Structure of Scientific Revolutions.[86] Following Fleck's work, scholars have turned their attention to the practical daily activities that makes up scientific discourse and produces ideas, rather than merely the ideas themselves.[87] Historians of science Steven Shapin and Simon Schaffer have demonstrated the value of questioning assumed natural scientific concepts such as truth, facts, and experimentation in revealing the embeddedness of scientific thought in social action and relationships.[88]

The idea of the social construction of knowledge has proved more problematic to those studying diseases in the past, though many have used the terminology. In their book *Gender and the Social Construction of Illness*, sociologists Judith Lorber and Lisa Jean Moore write that the bodily manifestations of illness 'are often influenced by feelings of stress, anxiety, and depression, but the symptoms or causes are primarily physical'.[89] Though they use the phrase 'social construction', Lorber and Moore essentially argue that while society's experiences of being ill are culturally constructed, their 'illness' has an ahistorical, biological cause. We have seen this trend too often in the histories of venereal disease discussed above. This assumption has been the basis for the best-known attack on social constructionist theories, the idea propounded by historian Charles Rosenberg that diseases have a biological ontology that society then

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[86] Thomas S. Kuhn, *The Structure of Scientific Revolutions* (3rd edn, Chicago: University of Chicago Press, 1996).
[87] Nelly Oudshoorn, 'A natural order of things? Reproductive sciences and the politics of othering', in George Robertson, Melinda Mash, Lisa Tickner, Jon Bird, Barry Curtis and Tim Putnam (eds), *FutureNatural: Nature, Science, Culture* (London: Routledge, 1996), p. 122.
[88] Steven Shapin and Simon Schaffer, *Leviathan and the Air Pump: Hobbes, Boyle, and the Experimental Life* (Princeton: Princeton University Press, 1985). See also Steven Shapin, *Never Pure: Historical Studies of Science as if It Was Produced by People with Bodies, Situated in Time, Spaces, Culture, and Society, and Struggling for Credibility and Authority* (Maryland: The Johns Hopkins University Press, 2010), p. 5, and Ludmilla Jordanova, 'The Social Construction of Medical Knowledge', *Social History of Medicine*, 8 (1995), p. 364.
[89] Judith Lorber and Lisa Jean Moore, *Gender and the Social Construction of Illness* (Walnut Creek: Altamira Press, 2002), p. 3.

merely 'frames'. Rosenberg argues that social constructivist approaches negate the real suffering of past societies, writing that, '[i]n one of its primary aspects, disease must be construed as a biological event little modified by the particular context in which it occurs. As such it exists in animals, who presumably do not socially construct their ailments and negotiate attitudinal responses to sufferers, but who do experience pain and impairment of function.'[90] This entails a view of disease as something with an ontology that society merely responded to in different ways; whilst society's responses varied from period to period and place-to-place, the diseases themselves were stable.[91]

Jordanova has identified this anxiety about social constructionist claims as particularly evident within histories of disease. Social constructionism, she says 'is often caricatured by critics, who impute to it the claim that diseases are not real'.[92] Philosopher Ian Hacking shows that the problem many historians have had with the idea that diseases are socially constructed is precisely this problem of the 'real'. Quoting philosopher Hilary Putnam, Hacking writes that 'Putnam hit the nail on the head, when he wrote about a "common philosophical error of supposing that 'reality' must refer to a single super thing, instead of looking at the ways in which we endlessly renegotiate – and are *forced* to renegotiate our notion of reality'.[93] This necessitates a thorough historicisation of the 'biological'.[94] Historian Adrian Wilson contends that historians of medicine need to move beyond the false dichotomy of the biological and the social, asserting that

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[90] Charles E. Rosenberg, 'Introduction: Framing Disease: Illness, Society and History', in Charles E. Rosenberg and Janet Golden (eds), *Framing Disease: Studies in Cultural History* (New Brunswick: Rutgers University Press, 1992), p. xiv.
[91] Wilson, 'On the History of Disease-Concepts', p. 282.
[92] Jordanova, 'The Social Construction of Medical Knowledge', p. 368.
[93] Ian Hacking, *The Social Construction of What?* (5th printing, Cambridge and London: Harvard University Press, 2000), p. 101.
[94] Michael Worboys, *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865–1900* (Cambridge: Cambridge University Press, 2000), pp. 12–13.

'diseases are not simply "biological" entities in Nature but human constructs, as of course are the very concepts of the "biological" and the "biopathological"'.[95] Wilson's approach is to study the histories of disease concepts themselves, which he does within a history-of-ideas, reconstructing medical thinking about pleurisy from the ancient to the early modern periods through the writings of medical authorities such as Galen and Vesalius. Wilson allows that this is just one method of tracing disease concepts and that it would add much to the discussion for historians to broaden their attention to influencing social factors such as 'practices of healing and of pedagogy, corporate relationships, patronage networks, religious and philosophical allegiances'.[96]

Taking up this theme, historian Andrew Cunningham looks not at 'concepts' as Wilson had treated them, as products of the mind alone, but instead focuses on '*how diagnosis happens*'.[97] Cunningham asserts that 'it is by the act of diagnosis that disease identity is given or established. The operations that humans perform in making diagnosis are not just the key to disease identity, but the source of disease identity. The only identity disease has is this *operational* identity.'[98] Historian Claudia Stein has adopted Cunningham's notion of 'disease concepts in action' to explore the specific ideas and understandings of the French Pox in the German town of Augsburg in the late fifteenth and early sixteenth century, focusing on 'the questions that are asked and answered during the act of diagnosis' and 'the practices applied by those involved in this operation', as the key entry points for the historian to uncover contemporary attitudes to the

[95] Wilson, 'On the History of Disease-Concepts', p. 282.
[96] Ibid., p. 304.
[97] Andrew Cunningham, 'Identifying Disease in the Past: Cutting the Gordian Knot', *Asclepio*, 54 (2002), pp. 15–16.
[98] Ibid., p. 16.

disease.[99] By seeking to fully historicize diseases, not merely social responses to those diseases, Wilson, Cunningham and Stein have offered a more sophisticated analysis, not only of the history of the diseases they study, but also of medical work more generally, as Wilson asserts that investigations into disease concepts raises 'the problem as to how medical consensus was established, if indeed such consensus was established at all.'[100]

My thesis seeks to contribute to the discourse on the socio-cultural construction of diseases, arguing that representation was an important facet in the construction and understanding of disease concepts in this period. Building on the work of Wilson, Cunningham and Stein, I seek to demonstrate that the variety of social, cultural and medical responses to venereal disease were conditioned by historically and locally specific notions of what exactly the disease was. Furthermore, the use of visual representations, which by necessity allows for a multitude of interpretations and meanings, demonstrates that there never was one universally accepted concept of venereal disease in London during this period.

London's Medical Marketplace

I am not only seeking to explore conceptions of disease that were created in a specific time, roughly 1780 to 1860, but also a specific space, that of the city of London. In doing this I engage with yet another theme in the history of medicine that arose during the 1980s, that of the medical marketplace. Before the late twentieth century turn to social history, historians of medicine mostly saw early modern medical practice as operating as distinct, bounded identities such as those of the traditional tripartite hierarchy of practitioners, the physician, the surgeon

[99] Stein, *Negotiating the French Pox*, p. 14.
[100] Wilson, 'On the History of Disease-Concepts', p. 304.

and the apothecary, with any other irregular medical practice dismissed as 'quackish'.[101] In the 1980s, historians such as Roy Porter began to focus more on the patient's experiences of medicine, taking great pains to point out that at least until the mid nineteenth century, the lay public's understanding of their own health and medicine in general was much more involved and active than has often been assumed, and that medical activities were far from being controlled by the traditional triumvirate.[102] For example historian Ginnie Smith has argued that most of medicine's day-to-day practice was prevention, not cure, and that this has largely been overlooked by historians as it was more subtle than the obvious heroics of the hospital.[103] From this, the conception of medical practice as a 'marketplace', a commercial system in which a diverse set of medical practitioners and institutions competed together for patients, developed.[104] Focusing on London between the late eighteenth and mid nineteenth centuries, this thesis is firmly grounded in this marketplace.

Though I mainly focus on the explicitly medical sphere and its representations of venereal disease, it is a central contention of this thesis that this was not a rigidly delimited sphere outside of culture, therefore it is necessary to engage with representations circulating in wider-society. It was not just the various medical discourses that formulated conceptions of venereal disease, but other, ostensibly non-medical sectors of society. In her 1999 PhD thesis, historian Joanne Townshend seeks to demonstrate that knowledge about the disease was

[101] Mark S. R. Jenner and Patrick Wallis, 'The Medical Marketplace', in Mark S. R. Jenner and Patrick Wallis (eds), *Medicine and the Market in England and Its Colonies,* c.*1450*–c.*1850* (Baskingstoke: Palgrave Macmillan, 2007), p. 1.
[102] Roy Porter, 'Introduction', in Roy Porter (ed.), *Patients and Practitioners: Lay perceptions of medicine in pre-industrial society* (Cambridge: Cambridge University Press, 1985), pp. 1–22.
[103] Ginnie Smith, 'Prescribing the rules of health: Self-help and advice in the late eighteenth century' in Roy Porter (ed.), *Patients and Practitioners: Lay perceptions of medicine in pre-industrial society* (Cambridge: Cambridge University Press, 1985), p. 249.
[104] Jenner and Wallis, 'The Medical Marketplace', p. 1.

created and contested within many 'disparate discourses of activists, politicians, and doctors' and was influenced by and reflective of understandings of class, race and gender.[105] Townsend's conception of contemporary culture is one that allows medical discourse as an ingrained part of it, rather than as an external factor to culture. She demonstrates that discourse surrounding venereal disease was not limited to one section of society, be it lay, political or medical, but that a multitude of different voices constructed accepted discourse on, and responses to, venereal disease. These different discourses are an important part of this thesis, although I would argue that these discourses were not as 'disparate' as perhaps Townsend argues. The model of the medical marketplace demonstrates that it is in the overlaps and interrelations of sectors of society that historians once deemed as 'disparate' that knowledge and representations were created and contested.

One commonly recurring theme in histories of venereal disease that elucidates the integration of medical and lay ideas of venereal disease is that of the stigma surrounding the disease. Venereal disease became interesting to historians in the eighties and nineties, a period when the western world was facing up to the AIDS crisis. Most historians writing on venereal disease mention the prevalence of AIDS as both the heir apparent to their historical venereal diseases, and the motivating factor for their investigations of the past.[106] Some writers have been more personally influenced; literary scholar Peter Lewis Allen introduces his book *The Wages of Sin* with an extended introduction detailing his personal recollection of the beginnings of the AIDS crisis in America, recounting how this

[105] Joanne Townsend, 'Private Diseases in Public Discourse: Venereal Disease in Victorian Society, Culture and Imagination' (unpublished doctoral thesis, University of Melbourne, 1999), p. 2.
[106] Annet Mooij, *Out of Otherness: Characters and Narrators in the Dutch Venereal Disease Debates 1850–1990* (Amsterdam and Atlanta: Rodopi, 1998), p. 10. See also Brandt, *No Magic Bullet*, p. 3.

sparked his academic interest in the ways diseases, especially those bound up with sex, have historically been conceptualised as a punishment from God.[107] The AIDS crisis came about at a time when academia, influenced by the works of Foucault on sexuality and deviance, was embracing new cultural histories of illness and the body.[108] Historian Kevin Siena has written that venereal disease lies at the intersection of these histories of the body, sexuality, disease and deviance.[109] The influence of the AIDS pandemic on the explosion of historical studies of venereal diseases has led to a predominance of one particular theme, that of morality, shame and stigma surrounding the disease. Hayden, for instance, writes that '[s]yphilis carried with it the stigma of five hundred years of sexual shame, beginning with the epidemic in Naples in 1495.'[110] The problem with such broad pronouncements on the stigma of the disease is that it assumes, alongside an ahistorical disease, a similarly ahistorical notion of shame, unchanging across countries and chronology. I do not mean to deny the fact that those diagnosed with venereal disease had to bear the weight of social stigma along with the pain of the disease; rather I hope to complicate the causes of this stigma. The historicising of disease that historians such as Wilson, Cunningham and Stein have argued for, and that I build on in this thesis, must involve a concomitant historicised view of social attitudes rather than just medical concepts and diagnostic practices.[111]

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[107] Peter Lewis Allen, *The Wages of Sin: Sex and Diseases, Past and Present* (Chicago and London: University of Chicago Press, 2000).
[108] See for instance, Michel Foucault, *Discipline and Punish: The Birth of the Prison,* trans. Alan Sheridan (London: Penguin Books, 1991), and *The Will to Knowledge: The History of Sexuality Volume 1*, trans. Robert Hurley, (London: Penguin Books, 1998).
[109] Siena, 'Introduction', p. 10.
[110] Hayden, *Pox*, p. xvii.
[111] Wilson, 'On the History of Disease-Concepts', Cunningham, 'Transforming plague', and Stein, *Negotiating the French Pox*.

Perhaps because both diseases ostensibly appeared as if from nowhere and spread rapidly, both being communicated by sexual contact, the responses to AIDS have echoed the language and imagery previously used to conceptualise syphilis. Cultural theorist Susan Sontag has noted that in the case of AIDS the focus on the venereal mode of transmission of the disease has meant that it has been bound up with pollution, 'an older metaphor, reminiscent of syphilis'.[112] Gilman has shown that ways of visually representing the person with AIDS initially adopted older iconographic strategies that had been used to visually represent syphilitics, such as depicting them as isolated, or melancholic.[113] However, in saying how AIDS is like syphilis, we must be wary of the tacit anachronism of assuming that syphilis was like AIDS and that the only source of stigma could be the sexual mode of transmission. The focus on the supposed immorality of sex oversimplifies the issue of shame attached to venereal disease. Focusing on the interrelated conceptions of disease within medical and lay spheres that visual representation offers, I argue that the issue of shame was more complex. The main theme I introduce in this thesis to demonstrate the complexity of the stigma attached to venereal disease is one that becomes particularly obvious when focusing on visual culture, namely its disturbing physical effects. From its first appearances there was a persistent fascination with the extremely disfiguring symptoms. A concern over these effects was clearly seen in medical and non-medical visual representations, from William Cheselden's image of the eroded skull to publicly available images of disease such as those found in museums of quacks. The similarities in visual discourse further complicates the struggles over

[112] Susan Sontag, *Illness as Metaphor and AIDS and its Metaphors* (London: Penguin Books, 2002), p. 103.
[113] Sander L. Gilman, 'AIDS and Syphilis: The Iconography of Disease', *October*, 43 (Winter, 1987), pp. 90–98.

controlling images, not only over what could be depicted and what should be depicted, but where it should be seen.

London itself was becoming a celebrated centre of medical knowledge, practice and education in the eighteenth and nineteenth centuries. While in the early eighteenth century, the accepted centre of medical excellence in Britain had been Edinburgh University, the perception of Edinburgh medical teaching by the late century was that it was in decline following the retirement of celebrated teachers such as William Cullen (1710–1790) in 1789, and undermined by the nepotistic hiring practices of the university which resulted in the instigation of lacklustre anatomy professor Alexander Monro tertius (1773–1859), purely because he was the latest scion of a family of highly regarded anatomy teachers such as Alexander Monro primus (1697–1767) and Alexander Monro secundus (1733–1817), who had made the university's name in the earlier part of the century.[114] London's emerging private medical schools and numerous hospitals were increasingly attracting students from Britain and the continent.[115] London was particularly important in the development of pathology in the late eighteenth century, especially due to the presence of elite medical practitioners and theorists such as John Hunter. Thanks to this, one nineteenth-century commentator wrote of London that 'perhaps there is no city in the world, where the attentive practitioners of the several branches of medicine, act with greater certainty to themselves, and safety to their patients, than in this metropolis'.[116]

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[114] Roy Porter, 'Medical Lecturing in Georgian London', *British Journal for the History of Science*, 28 (1995), p. 97; L. S. Jacyna, *Philosophic Whigs: Medicine, Science and Citizenship in Edinburgh, 1789–1848* (London and New York: Routledge, 1994), p. 1.
[115] Toby Gelfand, '"Invite the Philosopher, as well as the charitable": Hospital teaching as private enterprise in Hunterian London', in W. F. Bynum and Roy Porter (eds), *William Hunter and the Eighteenth-century Medical World* (Cambridge: Cambridge University Press, 1985), p. 139.
[116] John Baptist Morgagni, *On the Seats and Causes of Diseases Investigated by Anatomy, in Five Books, containing A Great Variety of Dissections, with Remarks. To which are added Very*

By limiting the local focus of this thesis to London it allows us to see in greater detail how medical knowledge was a local production. Historians have increasingly turned to local studies to elucidate the importance of site to the construction of knowledge; questioning the assumption that ideas are products of mental faculties entirely disconnected from social or geographical context, instead arguing for a consideration of what historians Steven Shapin and Adi Ophir have called 'the situatedness of knowledge'.[117] This approach by no means precludes an awareness of larger contexts. Writing about neurosyphilis and the psychiatric category of General Paralysis of the Insane (GPI), historian Gayle Davis focuses on a relatively small geographical area, concentrating on the records of four asylums in central Scotland. Davis argues that there is much value in focusing such a study on a close examination of one regional area, whilst also bringing in broader contexts.[118] By focusing my thesis on London I do not wish to suggest that the city was an isolated site; indeed its status as capital city suggests a large element of its identity was that it was the centre of a much larger picture. London then, represents a fascinating coalescence of a bounded locality that was at the same time a site within a larger national and international medical discourse. So whilst I concentrate on London, its thriving marketplace of publics, practitioners and institutions, there are also frequent looks outward, notably to Edinburgh and Paris, two other important locations for medical practice and the creation of knowledge.

Accurate and Copious Indexes of the Principal Things and Names Therein Contained. Translated from the Latin of John Baptist Morgagni, Chief Professor of Anatomy, and President of the University at Padua, by Benjamin Alexander, M. D. In three Volums. VOL. III. (London: Printed for A. Millar; and T. Cadell, his Successor, in the Strand; and Johnson and Paynes, in Pater-noster Row, 1869), 'dedication'.

[117] Adi Ophir and Steven Shapin, 'The Place of Knowledge: A Methological Survey', *Science in Context*, 4:1 (1991), p. 4.

[118] Davis, *'The Cruel Madness of Love'*, pp. 16–17.

The visual representations discussed in this thesis were becoming crucial elements in the medical marketplace by the late eighteenth century. They were necessary for practitioners to attract students to their schools and museums, they were reproduced in the grand atlases of new disciplines like pathology, and they were ever popular in public museums around the capital. The medical image was big business. The geographical location of London allows an exploration of how they functioned simultaneously as commercially and epistemologically significant objects and how they were deployed and controlled by a variety of figures seeking legitimacy for their claims about venereal disease.

Structure of this Thesis

The first chapter, 'Landscapes of Venereal Disease in London', is predominately a contextual piece, introducing the changing social, cultural and intellectual theories and spaces in London. It explores the grimy realities of London's disease riddled streets, and considers a variety of contemporary conceptualisations of, and attitudes towards venereal disease. This chapter does at numerous points explore society's 'responses' to disease, however this does not imply an ontological real disease that society merely 'framed', and I first examine just what it is society thought it was responding to, exploring the various ways lay and medical society conceptualised venereal disease, particularly through the idea of 'pollution'. This chapter, though not directly concerned with an in-depth analysis of imagery argues for a high degree of cultural visibility to venereal disease in London, recognisable in contemporary public discourse, both textual and visual.

Chapter two, 'Seeing and Representing Venereal Disease in Medical Discourse', focuses on the atlases of London's elite medical writers and how they

chose to represent venereal disease. The very first elite work of pathological anatomy published in Britain, physician Matthew Baillie's *Morbid Anatomy of Some of the Most Important Parts of the Human Body*, was followed in the next years with the publication of an accompanying atlas. The new nineteenth-century medical disciplines of pathology and dermatology relied heavily on the use of images, however this chapter argues that visual representations were not necessarily guaranteed the job of defining or explaining the disease. There needed to be significant changes in how disease was known, as well as changes in representational practices in medicine. The instability of the image is especially relevant in the case of venereal disease, which was still considered as a protean and confusing disease with multiform appearances that perplexed the practitioner. This chapter explores the various ways medical practitioners attempted to use images to visually represent their theories. The third chapter, 'Medicine, Art and Venereal Disease at the London Lock', explores the particular understandings of, and approaches to the disease within the Lock, focusing on a set of watercolour illustrations made by artist J. Holt between 1849 and 1850. This chapter looks at the images themselves alongside the medical work of the hospital, exploring how practitioners used the hospital to formulate their theories on venereal disease, and negotiate the realities of the medical marketplace, especially focusing on the role that images played within this work.

Chapter four, 'Meanings of Materials: Venereal Disease on Display', turns to material representations, both as preparations and models, in medical schools and public museums. Here I explore the coalescence of representational strategies in orthodox and quack medical cultures, but argue that this aesthetic similarity did not suggest intellectual agreement over the nature of venereal disease. Taking the

example of one particular medical museum, belonging to a mysterious figure called Joseph Kahn, I show that these material representations were so epistemologically contested partly because of who was using them, and how they were used, not because of what they showed. Finally, chapter five, 'Venereal Disease Institutionalised', builds on the discussion of these public and private museums focusing on the period from the early nineteenth century when calls for medical reform were leading to the emergence of new institutions such as the London University in 1827. These new institutions wanted to legitimise themselves and sought to emulate the form of the successful private schools and hospitals of the eighteenth century, often by building elaborate museums containing preparations, drawings and models. The chapter considers the role of two figures employed to build these collections, Robert Carswell at London University and wax modeller Joseph Towne at Guy's Hospital school. This chapter looks at how institutions responded to representations of venereal disease, suggesting that their response often demonstrated an indifference to how venereal disease was represented, instead concentrating on an uncritical accumulation of these objects. This represents a further interpretation of such representations, one that understood them purely as commercial, rather than intellectual, phenomena vital to advertise new institutions and disciplines within a competitive medical marketplace.

Throughout this thesis, I argue that the analytic lens of representation has much to offer the historian of disease, demonstrating the complex and contested, but not confused, understandings of venereal disease in London during the late eighteenth and early nineteenth centuries.

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Landscapes of Venereal Disease in London

One Sunday evening in the very late eighteenth century, a young medical student spent a rare free evening walking around the city with friends.

> We had a pleasant walk last Sunday, and as we passed the New River Head at Islington, and saw the Pipes ramifying from it, one of our companions took occasion to observe that all the works of art seemed to have a close Analogy with the human system. This Reservoir he compared to the Heart distributing it's [*sic*] Fluid to various parts, passing through many glands for various purposes, and it's [*sic*] focal parts being afterwards expelled through an excretory pipe into a common sewer.[119]

Continuing both the walk and the analogy, the student remarked on his friend's observation that '[t]his river it seems is brought to Islington and conveyed from thence by pipes into the Cisterns of the houses in London, from whence after serving culinary and other purposes it is carried by waste pipes into a common Sewer, which passes under the pavement of every street, and empties itself into the Thames; and thus far his comparison holds pretty close'.[120] To these aspiring

[119] *The Hospital Pupil's Guide Through London, in a series of Letters; from a Pupil at St. Thomas's Hospital to his Friend in the Country; Recommending the best manner of a pupils employing his time, and interspersed with amusing anecdotes relative to the History and Oeconomy of Hospital's* (London: Printed by A. Seale, Fitzroy Place, New Road, Fitzroy Square; For West and Hughes, Paternoster-Row; Hughes, Wig-more-Street; Cox, St. Thomas's Street, and Callow, Crown Court., 1800), p. 42.
[120] Ibid., pp. 42–43.

medics London was a dynamic body, kept alive by the flow of water, and the management of dirt. And, like the human body, the city was subject to entropy, sickness and decay. The idea of London as a sick city permeated late eighteenth and nineteenth-century discourses on health, hospitals, medical reform, sanitary management and town planning.[121] The population of the capital had grown exponentially over the eighteenth century and the city struggled to serve a growing population with an outdated infrastructure. The centre of London was crowded and stagnant, home to ramshackle buildings, narrow streets filled with sewage and rotting waste, widespread poverty, and endemic cholera and typhus.[122] By the nineteenth century, grandiose new buildings and wide, straight roadways had been built in attempts to create a cityscape that reflected London's new status as a centre of empire; but these clean new constructions contrasted with a still extant maze of dark, twisting alleyways, slums and dirt.[123] Wealthy philanthropists founded grand new hospitals to eradicate sickness and London's finest medical minds were ever occupied by the problem of disease, yet it was a constant presence on the streets of the city. Nineteenth-century London was thus a jarring juxtaposition of progress and history, of health and sickness.

Venereal disease was one such disease endemic within the capital; whilst it may have often been referred to as 'the secret disease', it was so prevalent that practitioners often cited it as the most common complaint they dealt with, and it

[121] On sanitary reform see Michelle Elizabeth Allen, *Cleansing the City: Sanitary Geographies in Victorian London* (Athens: Ohio University Press, 2008), and Lawrence Goldman, *Science, Reform and Politics in Victorian Britain: The Social Science Association 1857–1886* (Cambridge: University of Cambridge Press, 2004), especially 'Chapter 6; Victorian socio-medical liberalism: the Social Science Association and State Medicine', pp. 174–200.
[122] Geoffrey Rivett, *The Development of the London Hospital System 1823–1982* (Oxford: Oxford University Press, 1986), p. 18.
[123] Lynda Nead, *Victorian Babylon: People, Streets and Images in Nineteenth-century London* (New Haven and London: Yale University Press, 2000), p. 4.

was the subject of a prodigious number of medical publications.[124] Rapid urbanisation and the growth of street prostitution in the eighteenth century meant that venereal disease spread rapidly and indiscriminately over the period, with all sectors of London society touched by its effects.[125] This chapter examines the changing social, institutional and intellectual landscape of the city over the eighteenth and early nineteenth centuries that affected the socio-cultural responses to the threat of venereal disease; such as the emergence of voluntary hospitals, and changing paradigms for understanding disease.

The first half of this chapter explores how the problem of venereal disease was conceptualised in the city, arguing that the most obvious form this conceptualisation took was the rhetoric of pollution. As the city was often likened to a body, sickness became a metropolitan pollutant, and the source of this bodily pollutant was localised in specific deviant social groups or figures.[126] Two key characters implicated in the venereal polluting of London were the prostitute and the masturbator, agents of venereal disease who, by their wanton or selfish licentiousness were seen by the general population as contaminating the very city itself. Historians have focused heavily on the figure of the prostitute in relation to venereal disease, especially in the period following 1864, which saw the instigation of several Contagious Diseases Acts focused on regulating women's sexuality to prevent the spread of disease.[127] Conversely, historians have never

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[124] Philip K. Wilson, *Surgery, Skin and Syphilis: Daniel Turner's London (1667–1741)* (Amsterdam: Rodopi, 1999), p. 150.
[125] Randolph Trumbach, *Sex and the Gender Revolution Volume One: Heterosexuality and the Third Gender in Enlightenment London* (London: University of Chicago Press, 1998), p. 196.
[126] Erin O'Connor, *Raw Material: Producing Pathology in Victorian Culture* (Durham and London: Duke University Press, 2000), p. 13.
[127] See for instance Judith Walkowitz, *Prostitution and Victorian Society: Women, class and the state*, (Cambridge: Cambridge University Press, 1980) and *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (London: Virago, 1992); E. M. Sigsworth and T. J. Wyke, 'A Study of Victorian Prostitution and Venereal Disease' in Martha Vicinus (ed.), *Suffer and be Still: Women in the Victorian Age* (London: Methuen & Co. Ltd, 1980), pp. 77–99; Frank

seriously considered the masturbator as a similar source of fear of venereal disease in the capital. Obviously this has much to do with the fact that we now know diseases such as syphilis and gonorrhoea to be spread by sexual congress alone, and it is therefore difficult for us to take seriously the idea that masturbation could cause venereal disease. However it was commonly asserted in numerous populist medical works on masturbation, especially during the mid nineteenth century, that self-abuse could bring about venereal disease. Certainly much of the anti-masturbation discourse used similar rhetoric to that which addressed the problem of prostitution, often asserting that the masturbator was not just injuring their own health, but that they were polluting the city, the nation, and the human race itself. I do not suggest that the masturbator was considered as equally threatening a source of venereal contagion as the prostitute, I seek merely to expand historical discussion of the role of illicit sexual practices in contemporary attitudes towards venereal disease beyond the prostitute, and to highlight other threatening behaviours which were thought to play a role in the spread of venereal disease.

The second half of the chapter covers the various attempts at finding solutions to this pollution. First I examine the creation of the London Lock Hospital, arguing that the foundation of this specialist institution was not only a medical response that sought to cure individuals, but also an attempt by an emerging cadre of wealthy philanthropists to heal the city as a whole and guarantee the strength of the nation. Furthermore, the Lock Hospital was an important site in the production of new medical knowledge and practices aimed at

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Mort, *Dangerous Sexualities: Medico-Moral Politics in England since 1830* (2nd edn, London and New York: Routledge, 2000); and Paula Bartley, *Prostitution: Prevention and Reform in England, 1860–1914* (London and New York: Routledge, 2000).

tackling the venereal disease that so rampantly befouled the capital. The emergence of the voluntary hospital movement, and its attendant opportunities for clinical observation of patients, was one of the most important factors in changing understandings of disease that occurred in the eighteenth century. Over the eighteenth century, physicians and surgeons began to pay more attention to the symptoms of disease in both the living and dead bodies, leading to a move away from what had been a longstanding theoretical view of disease as an imbalance of humours, an invisible phenomenon, whose essential nature could only be hinted at by symptoms. Over the eighteenth century, new concentration on symptoms, both dynamic and morbid, led to diseases being reconceptualised as distinct entities that had physical locations within the very flesh of the body.[128]

Whilst this chapter, unlike the following four, is not explicitly based on an analysis of visual culture, I do explore the various meanings of several contemporary images that address the issues explored. Though both were ostensibly private vices, an important part of the discourse on prostitution and masturbation was visual. The life of the common prostitute, and her ignominious venereal fate, was detailed in a popular series of prints by William Hogarth (1697–1764), and the figure of the masturbator was the subject of repeated visual representations in the public medical museums of the capital run by a new, sophisticated group of 'quacks', unlicensed practitioners who used orthodox medical theories in order to convince the public that they needed cures for venereal diseases they often did not have.

This chapter argues that throughout all the social, institutional and intellectual change devoted to eradicating the threat of venereal pollution, the

[128] Foucault, *Birth of the Clinic*.

disease was actually gaining greater cultural visibility within London. Societal anxieties over the presence of the prostitute on the street were articulated through visual representations such as Hogarth's plates, which in turn served to further advertise the constant presence of the disease. Though established in an attempt to quash venereal disease, the position of the Lock Hospital in the medical marketplace meant it had to constantly advertise for donations to keep it open, and for staff to work its wards. The public museums devoted to masturbation depended completely on loudly marketing the alarming presence of venereal disease in London. Despite its euphemistic epithet, venereal disease was in fact the worst kept 'secret' in London.

London

At the dawn of the eighteenth century there was no one 'London', but two ostensibly separate cities; the City of Westminster where the monarchy and government resided, and the City of London, which was the bustling centre of trade and commerce.[129] Over the course of the century, wealthy merchants new to the city built up the Bloomsbury area, gradually forging a physical link between the two cities.[130] These new inhabitants were brought to the capital by the impact of industrialisation that transformed the basis of London's economic power. Up until the eighteenth century, the economic fortunes of the city had rested on trade and shipping, the burgeoning consumer market, and government.[131] With the onset of industrialisation in Britain in the early eighteenth century, London initially

[129] Erik Bond, *Reading London: Urban Speculation and Imaginative Government in Eighteenth-Century Literature* (Columbus: Ohio State University Press, 2007), p. 4.
[130] A. E. Clark-Kennedy, *The London: A Study in the Voluntary Hospital System Volume One, The First Hundred Years 1740–1840* (London: Pitman Medical Publishing, 1962), p. 13.
[131] Gareth Stedman Jones, *Outcast London: A Study in the Relationship between Classes in Victorian Society* (Oxford: Clarendon Press, 1971), p. 19.

appeared at a disadvantage. It was geographically distant to mining centres like Newcastle rendering fuel expensive, and the layout of the city made large factories impractical within its boundaries.[132] As previously London-based manufacturing, such as textiles and cutlery, moved out into the provinces though, the city turned to consumerism, its other dominating economic strength, to fill the gap, and London's shops and markets soon became celebrated all over Europe.[133] One commentator extended the analogy of London as a human body to encompass this new reliance on consumerism in an 1801 guide to the city that stated that '[t]he progress of this *queen of cities* has been like the growth of man from infancy to maturity. As the arterial blood flows into the heart, and is thence propelled through the veins for the invigoration of the human frame, so trade in this immense emporium circulates for the support of the body politic.'[134]

Over this period the population of the city exploded. In 1750 there were 675,000 inhabitants, and by the first year of the nineteenth century there were 900,000 people crammed into the capital.[135] From the early eighteenth century commentators were alarmed and concerned by the effects of the deeply unsanitary nature of the city on the health of this swelling population. When in the early 1720s an outbreak of plague struck the French town of Marseille, many Londoners, concerned that it could easily make its way across the channel, began to assess what could be done to make their own city more sanitary.[136] For centuries previous, bad smells had equated bad health, thus the locus of much of

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[132] Ibid., p. 20.
[133] Roy Porter, *London: A Social History* (Cambridge: Harvard University Press, 2001), pp. 142–144.
[134] *A Satirical View of London at the Commencement of the Nineteenth Century by an Observer* (London: Printed for G. Kearsley, Fleet-Street; T. Hurst, Paternoster-Row; Ogilvy and son, Holborn: R. Ogle, Turnstile; and Ogle and Aikman, Edinburgh, 1801), p. 4.
[135] Porter, *London*, p. 131.
[136] Mark Jenner, '"Nauceious and Abominable"? Pollution, Plague, and Poetics in John Gay's *Trivia*' in Clare Brant and Susan E. Whyman (eds), *Walking the Streets of Eighteenth-Century London: John Gay's* Trivia *(1716)* (Oxford: Clarendon Press, 2007), p. 93.

this pollution was thought to be the overcrowded slums, filled with rotting waste that created poisonous miasmas thought to be responsible for the spread of diseases such as the plague.[137] Cholera and typhus were endemic, most frequently breaking out in the poorest areas of London. Perhaps unsurprisingly, those who lived in these areas became inextricably elided with disease to such an extent that they were thought by some to be the very source of contagion.[138] The poor were considered as not merely inhabiting diseased and dirty environments, but were assumed to be innately diseased and dirty themselves.[139] This became a more pressing issue as the eighteenth century wore on and poverty continued to increase exponentially.

As the population of London was nudging the one million mark at the dawn of the nineteenth century, the city was struggling to keep pace with its own growth, and the ones who lost out in this equation were the working poor, who were more and more being reduced to extreme deprivation. Social order was a pervasive issue at the time and this teeming city was stratified by an omnipresent awareness of this hierarchy.[140] The process of industrialisation in Britain had created a rapidly expanding group of workers, as well as a clearly demarcated industrialist bourgeoisie.[141] By the mid century the working poor had grown into a large group and were increasingly viewed with deep suspicion by the bourgeoisie and established upper echelons of society, intensely wary of an emerging

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[137] Richard Barnett and Mike Jay, *Sick City: Two Thousand Years of Life and Death in London* (London: Strange Attractor Press, 2008), p. 129.
[138] William A. Cohen, 'Locating Filth', in William A. Cohen and Ryan Johnson (eds), *Filth: Dirt, Disgust, and Modern Life* (Minneapolis: The University of Minnesota Press, 2005), p. xx.
[139] Steve Macek, *Urban Nightmares: The Media, the Right, and the Moral Panic over the City*, (Minneapolis: The University of Minnesota Press, 2006), p. 44.
[140] Jerry White, *London in the Nineteenth Century: 'A Human Awful Wonder of God'* (London: Jonathan Cape, 2007), p. 4.
[141] For a critique of this narrative see Dror Wahrman, *Imagining the Middle Class: The Political Representation of Class in Britain, c.1780–1840* (Cambridge: Cambridge University Press, 1995), especially the chapter 'Imagining the 'middle class': an introduction', pp. 1–18.

amorphous pauper group, which historian Gareth Stedman Jones has termed 'outcast London', after an 1883 publication by Reverend Andrew Mearns (1837–1925) titled *The Bitter Cry of Outcast London*.[142] The poor were increasingly seen as polluting the city with disease, criminality and vice, and perhaps no figure bore the brunt of this fear and hatred so much as that of the prostitute. As the curious medical students had noted on their walk, the city of London functioned almost as a body, and, like a body, it was subject to disease. As the diseases of the city came to be associated with groups of people, so venereal disease came to be localised in select deviant figures, who were forced to shoulder the blame for the epidemic instances of venereal disease in the capital.

The Great Social Evil and the Solitary Sinner

The rapid urbanisation London underwent during the eighteenth century and the attendant poverty it brought resulted in the growth of street prostitution, euphemistically referred to as 'the great social evil'.[143] Pollution was not limited to the physical dirt and waste clogging up the streets of the capital, but the moral health of the city, and the prevalence of prostitutes indicated that the moral health of the population was failing. The prostitute was understood by the city's upper orders to be the most to blame for spreading venereal disease and she thus became a particularly evocative symbol of pollution.[144] The industrial middle ranks of society were growing increasingly concerned over the perceived depravity and villainy of the poor. Historian Paula Bartley has argued that the poor were seen not only as criminal, but immoral, with large families sharing small living spaces

[142] Steadman Jones, *Outcast London*, p. 1.
[143] Walkowitz, *Prostitution and Victorian Society*, p.70.
[144] Allen, *Cleansing the City*, p. 63.

which many commentators saw as making 'the cultivation of chastity impracticable'.[145] Though the common prostitute generally came from the working poor, the real fear was that her clients transcended social rank, allowing her to spread venereal disease rapidly and indiscriminately to all sectors of London society, from the gentleman to the pauper.[146]

Not all commentators insisted on the wanton malevolence of the prostitute in spreading the disease, and some even painted her as a tragic figure, undone by society and fated to peddle her plague back to it. William Blake's 1794 poem 'London', a bitter ode to an ailing city, lamented the spread of venereal disease, the 'harlots curse', in the last stanza.

> But most thro' midnight streets I hear
> How the youthful Harlots curse
> Blasts the new-born Infants tear
> And blights with plagues the Marriage hearse [147]

Blake's prostitute, although she infects healthy marriages, is an object of pity. Her disease is a 'curse' that has been foisted upon her by a corrupt society.[148] Surgeon Michael Ryan (1800–1840) published an extensive investigation into prostitution in London in 1836 in which he denounced, not the prostitute, but the men around her.

> According to our contradictory, anomalous, and absurd laws, statute, common, ecclesiastical and civil – women are most shamefully and inhumanly exposed to

[145] Bartley, *Prostitution*, p. 10.
[146] Trumbach, *Sex and the Gender Revolution Volume One*, p. 196.
[147] William Blake, 'London', in David V. Erdman (ed.), *The Complete Poetry and Prose of William Blake* (Berkeley and London: University of California Press, 2008), pp. 26–27; see also Stewart Crehan 'On the Social System of "London"', in Harold Bloom (ed.), *William Blake* (New York: Infobase Publishing, 2003), p. 56.
[148] Ronald Paulson, *Hogarth's Harlot: Sacred Parody in Enlightenment England* (Baltimore: the Johns Hopkins University Press, 2003), p. 332.

> seduction, prostitution, adultery and ruin; they seem to be considered the lawful prey to the lust, treachery, cruelty, and artifices of licentious and profligate men, who may seduce and then abandon them at will…[149]

However, historian Judith Walkowitz has argued that to many contemporary Londoners, whether the prostitute was considered an object of pity or a source of contagion, she was inevitably seen as a pollutant of the city, in the same vein as the cholera epidemics that frequently ravaged the capital, or the factory smoke that choked the streets.[150] Though reviled on a societal level, there was very little governmental response to prostitution during the period covered by this thesis. England was a curious anomaly in its treatment of prostitution. Historian Steven Marcus has shown that whereas prostitution on the continent was regulated and licensed, the English chose merely to take no notice of it until the mid nineteenth century, by which time it had become impossible to ignore.[151] By the same time, the French, for example, had implemented regulations ensuring that prostitutes were registered, and underwent regular medical checks, with a place in the state run hospitals assured for those found to be diseased.[152] Meanwhile, in England there would be no official legislation until the first Contagious Diseases Act in 1864, leaving prostitution rife.

The extent of the phenomenon in Britain was especially evident in these large cities such as London, where the most notorious areas for street prostitution

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[149] Michael Ryan, *Prostitution in London with a Comparative View of that of Paris and New York: As Illustrative of the Capitals and Large Towns of All Countries: and Proving Moral Deprivation to be the most Fertile Source of Crime and of Personal and Social Misery with an Account of the Nature and Treatment of the Various Diseases, Caused by the Abuses of the Reproductive Function. Illustrated by Numerous Plates, by Michael Ryan, M.D.* (London: H. Bailliere, 219, Regent Street. Paris: J. B. Bailliere, Rue de L'ecole de Medecine. Leipsig: J. A. G. Weigel, 1839), p. v.
[150] Walkowitz, *City of Dreadful Delight*, p. 22.
[151] Steven Marcus, *The Other Victorians: A Study of Sexuality and Pornography in Mid-Nineteenth-Century England* (New Jersey: Transaction Publishers, 2009), p. 4.
[152] Ronald Pearsall, *The Worm in the Bud: The World of Victorian Sexuality* (London: Weidenfeld & Nicolson, 1969), p. 266.

were Charing Cross, Haymarket, Regent Street and the West End.[153] It is difficult now to accurately gauge how many prostitutes there were in the city at any given time. One 1797 estimate said that there were around 50,000 in London, and by the 1830s, a figure of 80,000 was suggested by Ryan, supported by numerous other prominent figures such as the Bishop of Oxford.[154] Prostitution in the capital was widespread for a number of reasons. Rampant urban poverty was one, which was compounded in 1834 when the Poor Law Amendment Act was implemented, meaning that the poor could no longer supplement a meagre wage with 'outdoor relief' but instead had to enter the workhouse, or face destitution.[155] Faced with the grim reality of the workhouse, many women turned to casual prostitution in order to supplement the money they earned from low paid jobs such as needlework or domestic service.[156] As well as poverty, industrialisation had brought changes in social patterns of relationships, and a new industrial bourgeoisie who tended to marry later in life. A longer wait for marriage meant a longer wait for socially sanctioned sex, causing men to seek gratification elsewhere.[157] Historians E. M. Sigsworth and T. J. Wyke have argued that prostitution was thus tolerated for so long as it served to satiate the sexual needs of the unmarried bourgeois man, while protecting the unmarried woman from the shame of extramarital sex, as well as to shield married women from 'the grosser passions of their husbands'.[158]

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[153] Bartley, *Prostitution*, p. 3.
[154] Police estimates were far more cautious noting 6371 known prostitutes in London in 1839 rising to 9409 in 1841. These diminished by the mid-century, with 6940 noted for 1860. The police estimates though only counted those women known to the police which would have been a very limited fraction of the actual phenomenon. Sigsworth and Wyke, 'A Study of Victorian Prostitution and Venereal Disease', pp. 78–79.
[155] Bartley, *Prostitution*, p. 8.
[156] Mort, *Dangerous Sexualities*, p. 60.
[157] Sigsworth and Wyke, 'A Study of Victorian Prostitution and Venereal Disease', p. 85.
[158] Ibid., p. 87.

That men were thought to need sex whilst women were ideally sexually passive was an ingrained nineteenth-century gender norm that the figure of the prostitute threatened. This though was a relatively recent development as, until the early eighteenth century, it had been more widely assumed that women were the more sexually avaricious.[159] Over the course of the eighteenth century though women's sexual desires began to be pathologised as unnatural.[160] By the mid nineteenth century women were supposed to repress any unnatural desires and approach sex with little more than a passive indifference.[161] In an increasingly complex industrial world, women were held as the guardians of a moral purity that society seemed to lack.[162] The mania regarding the effects of prostitution on London society was part of a larger discourse on the meanings of sex. Noting the proliferation of pornography lurking beneath the respectable façade of Victorian society, historian Steven Marcus has identified the nineteenth century as the period in which the historic 'problem' of sex became 'part of the general educated consciousness'.[163] Sex then emerged as a concern that preoccupied multiple levels of society; this new awareness was in part characterised by a shift in the social spheres that had discursive control of sex. Foucault has shown that it was the eighteenth century when 'a completely new technology of sex' emerged, one which wrenched control of discourses on sex from the hands of the religious institutions and placed this control into the hands of the state.[164] Sex became a phenomenon explicitly linked to the health of the country, and the human race,

[159] A. D. Harvey, *Sex in Georgian England: Attitudes and Prejudices from the 1720s to the 1820s* (London: Hoxton, 1994), p. 38.
[160] For instance, the mid eighteenth century saw the emergence of the pathology of 'Nymphomania', making it seem unnatural for women to enjoy sex. Harvey, *Sex in Georgian England*, p. 44.
[161] Mort, *Dangerous Sexualities*, p. 61.
[162] Joan N. Burstyn, *Victorian Education and the Ideal of Womanhood* (London: Croom Helm, 1980), p. 31.
[163] Marcus, *The Other Victorians*, p. 2.
[164] Foucault, *The Will to Knowledge*, p. 116.

through new national concerns such as population, when the state became fixated on establishing official institutional responses to social problems 'aimed at maximizing national vitality'.[165] However, as mentioned above, there would not be a state response to prostitution before 1864, and prior to this, prostitution remained a frustrating, but tolerated everyday reality on London's streets.

Walkowitz writes that in the nineteenth century the prostitute was an integral and highly visible part of London life and had become 'a central spectacle in a set of urban encounters and fantasies'.[166] Of course there was no one definitive model of the prostitute and the various types, from those women who engaged in it casually to supplement a wage earned in a more respectable fashion, to those who lived in brothels, further unnerved city society. The women who walked the fashionable and affluent West End dressed like respectable ladies upset a society that preferred its poor to appear poor.[167] Prostitutes in the less prosperous East End were less subtle, bawdily soliciting outside music halls and pubs.[168] Some prostitutes could feasibly walk the streets unnoticed, assumed to be respectable ladies, and conversely any respectable woman could then potentially be a prostitute.[169] Ryan reported that procuresses often located women to trick into becoming prostitutes by visiting shops and markets to identify their targets, whilst dressing and acting 'as most respectable persons' so as not to arouse suspicion.[170] The idea of the clandestine prostitute entranced and arguably unnerved society as much as the 'spectacle'.

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[165] Majia Holmer Nadesan, *Governmentality, Biopower, and Everyday Life* (New York: Routledge, 2008), p. 94.
[166] Walkowitz, *City of Dreadful Delight*, p. 21.
[167] Pearsall, *The Worm in the Bud*, p. 260.
[168] Walkowitz, *Prostitution and Victorian Society*, p. 13.
[169] Nead, *Victorian Babylon*, p. 64.
[170] Ryan, *Prostitution in London*, p. 181.

Whether covert or conspicuous, contemporary London society was obsessed with the problem of prostitution. Famously, the life story of a prostitute featured in a series of six prints by William Hogarth entitled *A Harlot's Progress*, first published in 1732 and continuing to enjoy great popularity well into the nineteenth century. The series was the first example of Hogarth's moral satires on contemporary London, each of which focused on a different aspect of city society, whether the doomed life of the idle wealthy in *A Rake's Progress* (1735), the bad consequences of the upper classes who married solely for money in *Marriage à-la-mode* (1743–1745), or the inevitable punishments for eschewing hard work in *Industry and Idleness* (1747). Hogarth considered that these series sat somewhere between the tragic and the comedic as 'modern moral subjects', visual reflections on an often immoral city.[171] *Harlot's Progress* tells the story of Moll Hackabout, a young woman who arrived in London from the provinces, detailing the various affairs that led to her becoming a prostitute, being arrested and put in Bridewell prison, before eventually dying of venereal disease. Throughout the plates, Moll's disease is hinted at with small blemishes on her face and medicine bottles standing near cosmetics, hinting that she has been attempting to cover the external symptoms with powders and creams.[172] In the penultimate plate we see Moll wrapped in blankets by the fire undergoing a mercurial sweating, thought to drive the disease out of the body (fig. 1.1). The pain and indignity of syphilis was, for Hogarth and his legions of admirers, the natural and inevitable reward for her morally corrupt life.

[171] Werner Busch, 'Hogarth's *Marriage A-la-Mode*: The dialectic between precision and ambiguity' in Frédéric Ogée, David Bindman, Peter Vagner (eds), *Hogarth: Representing Nature's Machines* (Manchester and New York: Manchester University Press, 2001), p. 196.
[172] Paulson, *Hogarth's Harlot*, p. 101.

Figure 1.1. Moll undergoing the mercurial sweating. Engraving after William Hogarth (1733). Image courtesy of the Wellcome Library, London.

Harlot's Progress was immensely popular in London, with 1240 official sets of the prints sold in the city upon its publication in 1732.[173] The widespread fear of the venereal pollution of the city meant that images that encapsulated and bounded this fear were incredibly popular. For the upper orders of society, such images underscored the assumption that venereal disease was localised in the poor prostitute, that this was a disease of 'the other'.[174] Demand for copies outstripped the official print run though, and alongside the official versions, various pirated reprints appeared regularly.[175] The images proved so popular because of the sophisticated visual literacy of their audience. No detail is meaningless in the

[173] Peter Jan de Voogd, *Henry Fielding and William Hogarth: the Correspondences of the Arts* (Amsterdam: Rodopi, 1981), p. 59.
[174] Gilman, *Disease and Representation*, p. 1.
[175] David Bindman, *Hogarth and his Times: Serious Comedy* (Berkeley: University of California Press, 1997), p. 74.

image so even those viewing the prints with no accompanying texts would have recognised symbols that indicated the identity of the characters, and referenced topical concerns of the day.[176] That Moll was suffering from venereal disease and undergoing a mercurial cure would be immediately obvious from the blankets in which she is wrapped, but there are further clues to reaffirm this. For instance, in the bottom right corner of the image is a piece of paper on top of a stool, upon which rests several teeth lost by Moll as a result of the high doses of mercury she had taken; this detail reasserts the distressing and disfiguring consequences not just of venereal disease, but also the treatment.[177] The two men arguing in the print represent the real quack doctors Misaubin and Rock, two celebrity figures who would have been easily recognisable to a London audience eager to see Hogarth's witty lambasting of their own immoral society.[178]

The creation and circulation of prints such as these fuelled a new market emergent alongside the nascent bourgeoisie. Mass produced copies of popular artworks were aimed at the new bourgeois consumer who wished to decorate their houses tastefully and fashionably.[179] Caricatures such as those of Hogarth and popular political satirists such as Thomas Rowlandson (1757–1827) were not intended as high art, and were created for print publishers to sell from specialist shops.[180] Print shops were popular in the city from the seventeenth century, with some of the more famous, such as Boydell's becoming integral parts of the

[176] Ibid., p. 74.
[177] Fiona Haslam, *From Hogarth to Rowlandson: Medicine in Art in Eighteenth-century Britain* (Liverpool: Liverpool University Press, 1996), p. 97.
[178] de Voogd, *Henry Fielding and William Hogarth*, p. 61. See also Haslam, *From Hogarth to Rowlandson*, pp. 94–96.
[179] Gillen D'Arcy Wood, *The Shock of the Real: Romanticism and Visual Culture, 1760–1860* (New York and Basingstoke: Palgrave, 2001), pp. 71–72.
[180] Tamara L. Hunt, *Defining John Bull: Political Caricature and National Identity in Late Georgian England* (Aldershot and Burlington: Ashgate, 2003), p. 2.

spectacle of London's consumer society.[181] The windows of these shops were filled with prints, and these displays became events in and of themselves, attracting large crowds eager to catch a peak at the latest scathing satire on London life.[182] Art historian Fiona Haslam has shown that medical satires such as Hogarth's were a peculiarly metropolitan subject, as they often highlighted the hierarchy of physicians, surgeons and apothecaries, which was less visible in provincial towns and cities, and the quacks that the prints depicted were frequently London-based.[183] This further demonstrates the increasing commercialisation of venereal disease in London, with a wide public audience eager for images of venereal disease through which to tacitly manage their fears of the pollutant.

The contemporary attitude towards the prostitute demonstrated that although, as Foucault has shown, sex had become a predominately secular concern by the nineteenth century, it still retained elements of religious rhetoric demonstrated by a discursive emphasis on morality and the notion of sin.[184] This not only manifested as loud denunciations of the prostitute as immoral, and venereal disease as a punishment for this immorality, but also a condemnation of those who engaged in more solitary, yet still illicit, sexual practices. The spectre of masturbation had haunted Europe since around 1712 when an anonymously authored tract entitled *Onania; or, The Heinous Sin of Self Pollution* appeared, linking the practice of masturbation with the biblical crime of Onan, who, rather than impregnate his dead brother's wife, 'spilled his seed upon the ground.'[185] The

[181] Porter, *London*, p. 144.
[182] Hunt, *Defining John Bull*, p. 13.
[183] Haslam, *From Hogarth to Rowlandson*, p. 6.
[184] Foucault, *The Will to Knowledge*, pp. 116–117.
[185] Thomas W. Lacquer, *Solitary Sex: A Cultural History of Masturbation* (New York: Zone Books, 2003), p. 15.

text quickly became very influential and several more works on the subject appeared over the next decades of the eighteenth century, perhaps most famously that of Swiss physician Samuel Auguste Tissot (1728–1797) who published his *L'Onanisme* in 1758, translated into English in 1766. In the bible, the punishment for Onan's act of depravity was death, and Tissot proved to be as unforgiving as the Old Testament, asserting that the practice would certainly lead to bodily breakdown and an eventual painful death.[186] The continued reference to the practice as 'self pollution' is particularly relevant and I would argue was an extension of the idea of the prostitute as a venereal pollutant of the city of London. The masturbator too was polluting not just his own body and soul with the practice, but also potentially adding to the sexual danger of London, as it was often asserted that excessive masturbation could bring on venereal disease.[187]

Historian Thomas Lacquer has argued that masturbation was considered as a depraved and unnatural act because of three fundamental characteristics; firstly, it was an action that was stimulated by no physical object of desire; secondly, whilst it was supposed to be a private act, it was recognised that children often learned it from peers or immoral adults; finally, it was an appetite which could never be truly satiated, leading to repeated practice.[188] For early nineteenth-century Londoners though, these fears were couched in the language of concern over the physiological effects of the practice. Masturbation was said to be so dangerous to the individual's body because of the loss of the vital fluid – semen – that was thought to leave the body wasted. One populist publication on the subject

[186] Harvey, *Sex in Georgian England*, p. 119.
[187] This anti-masturbation rhetoric would grow more hysterical in the later nineteenth century when the country witnessed a period of 'masturbation panic'. Alan Hunt, 'The Great Masturbation Panic and the Discourses of Moral Regulation in Nineteenth- and Early Twentieth-Century Britain', *Journal of the History of Sexuality*, 8:4 (Apr., 1998), p. 579.
[188] Lacquer, *Solitary Sex*, p. 210.

asserted that '[t]he seminal fluid is the very essence of the vital principle; the most essential part of the blood', going on to warn that 'the frequent repetition of the vice above described, produces a wanton waste and overflow of this most nutritious secretion, and brings on all the evils, which we shall further dwell on'.[189] This concern with what Lacquer refers to as the 'moral physiology of semen' persisted through several popular works on masturbation.[190] One of these detailed the case of a young man who began his unfortunate habit at school and turned idiot as a result. The practice did not just affect his mental prowess though, and he wound up physically decrepit; '[h]is eyes became prominent, his pupils dilated, he had pains in his head and down the course of his spine, loss of memory and a silly unmeaning expression of the countenance, and a tottering gait'.[191]

As well as this general physiological wasting, the practice could bring about venereal disease. One popular tract on the subject recorded the most horrendous results the inveterate masturbator could expect.

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[189] R. J. Brodie and co., *The Secret Companion, A Medical Work on Onanism or Self-Pollution, with the best mode of treatment in all cases of nervous and sexual debility, impotency, etc. and on Venereal and Syphilitic Diseases, containing Plain and Simple Directions for the Cure of Gonorrhoea, Gleets, Stricture, Secondary Symptoms, and every disorder of the Urethra, without the use of Mercury, or Loss of Time from Business, Followed by Observations on Marriage; with Directions for the Removal of Generative Incapacity Illustrated by Full Length Engravings by R. J. Brodie & Co., Consulting Surgeons, 27, Montague Street, Russell Square, London* (London: Published by the Authors and sold by Sherwood, Gilbert, and Piper, Paternoster Row; Hanway & Co., 63, Oxford Street; Purkis, Compton Street, Soho; Noble, Chancery Lane; Gordon, 146, Leadenhall Street; and by all Booksellers in Town and Country, 1845), p. 12.

[190] Lacquer, *Solitary Sex: A Cultural History of Masturbation*, p. 194.

[191] R. J. Brodie and co., *Brodie's Medical Work on Virility; and the Disorders Produced by the Dangerous Effects of Onanism, with all its dreadful consequences considered, including nervous and sexual debility, impotency &c. and on Venereal and Syphilitic Diseases, with Plain directions for the removal of secondary symptoms, gonorrhoea or clap, gleets, strictures, whites, and all diseases of the urinary passages, without the use of Mercury, Confinement of Hinderance from Business; Followed by General Instructions for the perfect restorations of those who are incapacitated from entering into the holy state of Marriage, by the evil consequences arising from early abuse, or syphilitic infection: Illustrated with Engravings. By R. J. Brodie and Co. Consulting Surgeons, No. 4, Great Charles Street, Four Doors from Easy-Row, Birmingham.* (London: Published by the Authors, and sold by Strange, 21, Paternoster-row; Purkiss, Compton-street, Soho; J. Clement, 21, & 22 Little Pulteney-street; and by all Booksellers in the United Kingdom, 1844), p. 23.

> I have known instances of gonorrhoea, and even symptomatic syphilis, ensue from excess of this practice, blindness, though an uncommon, is not an impossible result, paralysis, epilepsy, and consumption, are the invariable effects, after a gradual progress through the various stages of weakness of intellect, torture of conscience, decay of the bodily energies, racking physical pain, external eruptions, and lastly, internal disorganization.[192]

This is largely a lay perception of venereal disease and the medical elite did not tend to trifle themselves with overtly moral discussions of masturbation and the potential for the practice to bring on the divine punishment of venereal disease. However this is not to suggest that beliefs surrounding the destructive nature of masturbation were solely a lay concern. In 1786 physician Duncan Gordon addressed a letter to John Hunter after reading some of his thoughts on venereal disease. Gordon was alarmed to find that Hunter had asserted that masturbation could not cause impotence, further adding that his '*only true objection to this selfish enjoyment* is the probability of its being repeated too frequently.'[193] Gordon was horrified by what he saw as Hunter's cavalier response to masturbation, but chose to frame his objections as purely medical, rather than moral concerns. 'My principal design, in addressing you,' he began 'is to treat upon the *disorders* occasioned by masturbation, or self-pollution, and not upon the *crime* of

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[192] I. A. Jacques and company, *The Secret Preceptor; or, the Grandeur & Vigour of Man, Physically, Mentally, and Morally Vindicated, Illustrated & Displayed, showing, in a Popular Treatise, The Various Concealed and Physical Causes, and Disqualifying Impediments in Connection with the Duties & Obligations of Marriage; Practical Observations on the Nature, Origin, and Cure of Local Weakness, and Generative Debility. The Injurious Effects of Solitary and Sexual Indulgence; with a familiar explanation of Gonorrhoea, Gleet, Stricture, and Syphilis, Illustrated with coloured engravings. By I. A. Jacques and Company, consulting surgeons, No. 19, Carliol-street, Newcastle-upon-Tyne; two doors from New Bridge-street.* (Newcastle: Published by the Authors, 1852), p. 27.

[193] Duncan Gordon, *A Letter to John Hunter, Esq. F. R. S. Surgeon Extraordinary to his Majesty, Surgeon to St George's Hospital, Member of the Royal Medical Society of Paris &c. &c. &c. Respecting his Treatise on the Venereal Disease; Shewing him to be highly erroneous in his Observations on Impotence, and more particularly pointing out the Absurdity and Immorality of his Doctrine in Favour of Onanism or Masturbation. By Duncan Gordon, M. D.* (London: Printed for R. Randell, No. 116 Shoe-Lane, the first Door from Fleet-Street, 1786), p. 7.

masturbation.'[194] Gordon went beyond the physical symptoms visited on the individual patient by this lowly practice, and advised Hunter that 'should your doctrine be adopted, the whole human race would shortly be annihilated.'[195] Thus, even when the consequences of masturbation were considered only as physical, rather than moral results, many medical practitioners agreed that the masturbator posed a threat not just to himself but to wider society.

Indeed London society was frequently exposed to the threatening figure of the masturbator. Though not as readily visible on London's streets, the onanist was the subject of far more visual representations than the prostitute. One form of common entertainment around the capital by the mid nineteenth century were museums and exhibitions devoted to displaying the debilitating effects of self-abuse.[196] These museums held grotesque models in wax or plaster which detailed the dreadful consequences of masturbation. They were often operated by groups of unlicensed medical practitioners who specialised in peddling cordials and balms to treat venereal diseases and restore the 'manly vigour' of customers who had become alarmed after seeing the terrifying models, and were convinced that they too could be at risk.[197] The models contained in these museums were designed to instil not just a fear of the disease but also its most common cure, with one museum containing a bust of a man undergoing mercurial salivation which

[194] Ibid., p. 7.
[195] Ibid., p. 16.
[196] Elizabeth Stephens, *Anatomy as Spectacle: Public Exhibitions of the Body from 1700 to the Present* (Liverpool: Liverpool University Press, 2011), p. 54. Chapter four of this thesis entails a detailed exploration of these museums and exhibitions.
[197] C. J. Lucas and co., *Manly Vigour: A Popular Inquiry into the concealed causes of its premature decline with instructions for its complete restoration, addressed to those suffering from the destructive consequences of excessive indulgence in solitary and delisive habits, youthful imprudence, or infection; with Remarks on the treatment of gonorrhoea, gleet, stricture and syphilis. Illustrated with cases, by C. J. Lucas and Co. Consulting Surgeons, 60 Newman Street, Oxford Street, London*. (London: Published by the authors: Sold at Brittain, 11, Paternoster Row; Wilson, 18, Bishopgate Street, Pattie, 4, Brydges Street, Covent Garden; Burgess, 28, Coventry Street, Haymarket, and by all booksellers in the United Kingdom., 1842).

one visitor described as 'most horrible', designed to remind visitors that mercury was destructive, and to not-so-subtly suggest a milder treatment option, which could be purchased right then and there.[198]

Also frequently available, for a fee of course, were pamphlets and treatises on the dangers of masturbation and the nature of venereal diseases, several of which were heavily illustrated with grotesque figures, distorted and dehumanised by their vices. One common visual trope was the figure of the wasted body of the masturbator, a result of a loss of the vital fluid (fig. 1.2). The figure's face is gaunt, his cheeks hollow, his posture is stooped and he must walk with the aid of a cane; the viewer sees that even though he is ostensibly well dressed, he cannot hide these tell-tale signs of his depraved and unnatural habit. Images like this one represented one of contemporary society's overarching fears, that the weak body of the masturbator was a metonym for a weak nation and race, crippled by a sick army and navy brought low by venereal disease. Like the prostitute, the masturbator was a secular sinner, one who selfishly squandered his vital powers, weakening not just his own soul, but risking the health of London, the nation, and the human race as a whole by spreading his venereal contagion. Unlike the images of the prostitute however, the images of the masturbator in these museums marketed venereal disease not as bounded in a figure ostensibly safely removed from polite society, but as a potential outcome for all viewers.

[198] A. W. Bates, '"Indecent and Demoralising Representations": Public Anatomy Museums in mid-Victorian England', *Medical History*, 52 (2008), p. 18.

Figure 1.2. Representing the debilitated state of the body from the effects of Onanism or Self-pollution. Coloured engraving, in R. J. Brodie, *The Secret Companion, A Medical Work on Onanism or Self-pollution, with the Best Mode of Treatment in all Cases of Nervous and Sexual Debility, Impotency, etc* (London, 1845), plate 1. Image courtesy of the Wellcome Library, London.

The City Responds

By the eighteenth century venereal disease was endemic in London and this certainly did not let up in the nineteenth century. Surgeon William Acton (1812–1875) claimed in 1846 that almost half of the surgical outpatients he dealt with at St Bartholomew's, one of London's oldest hospitals, were venereal.[199] Public calls for efforts to eradicate the disease became more vocal from the 1840s onwards. One 1846 editorial in the *Lancet* expressed dismay that although efforts had been

[199] Mary Wilson Carpenter, *Health, Medicine, and Society in Victorian England* (Santa Barbara: ABC-CLIO, LLC, 2010), p. 73.

made in London to clean up the sewers that polluted the metropolis, there had been no similar governmental action to halt the spread of venereal disease that threatened the city. 'We must no longer confine our attention to the drains and sewers', the article cried, 'we wish to eradicate syphilis, and must not let it lurk in the dark corners.'[200] Before there was any state response though, many sections of London society were at work attempting to bring light to these dark corners.

One group frustrated by the lack of state intervention were the wealthy philanthropists of the capital who decided to take matters into their own hands. On 4 July 1746 surgeon William Bromfeild (1713–1792) called to order the first meeting of a charitable committee he named the 'Society for erecting and supporting by voluntary contributions an Hospital called the Lock Hospital, near Hyde Park Corner'. Twelve other well-intentioned philanthropists were present, mostly local tradesmen as well as another surgeon, two physicians and an apothecary.[201] Bromfeild was an ambitious man; already on the medical staff of St George's hospital as well as personal surgeon to the Prince of Wales, he was a persuasive character, and between the first and second meetings of the charity committee he had managed to secure thirty subscribers and a total sum of 138 pounds, 1 shilling and 6 pence in donations.[202] By January 1747, after securing premises and staff, the London Lock Hospital for the cure of venereal diseases opened. However, the Lock was just one of a number of institutions appearing across the capital as part of the eighteenth-century voluntary hospital movement.

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[200] Quoted in Sigsworth and Wyke, 'A Study of Victorian Prostitution and Venereal Disease', p. 92.
[201] David Innes Williams, *The London Lock: A Charitable Hospital for Venereal Disease 1746 – 1952* (London: Royal Society of Medicine Press Limited, 1995), p. 19.
[202] Royal College of Surgeons, London Lock Hospital and Rescue Home, MS0022/6/7. An Account of the Lock Hospital taken from the minute books, p. 1.

Until the early eighteenth century, London's medical care was generally not sited in hospitals and London had only two, St Bartholomew's and St Thomas's, originally established as religious institutions in 1123 and *c*.1200 respectively. Both were dissolved by Henry VIII between 1535 and 1540 but after campaigns by the people of London, they were refounded, and endowed by the monarchy around five years later.[203] The two endowed hospitals remained the main bastions of hospital care from this point until the eighteenth century, both of them admitting venereal patients. St Bartholomew's had separate accommodation for venereal patients in the old Lazar houses owned by the hospital, while at St Thomas's they were treated in the main house at Southwark.[204] However, eighteenth-century London was a world away from the city it had been at the time of the refounding of the royal hospitals. The unprecedented population increase meant that the city was striving desperately to stay healthy in the face of frequent epidemics of smallpox, typhus, consumption and endemic alcoholism taking its toll on the population.[205] With poverty seen as an unavoidable feature of social composition and the state unwilling to step in, it fell to those who could afford the luxury of philanthropy to make sure the poor were at least a healthy and useful part of city society.[206] The first of these men to act was educational reformer John Bellers (1654–1725) who proposed the establishment of a system of hospitals for the benefit of London's sick poor. Enlisting other like-minded characters to form a governing body, Bellers established the Westminster Infirmary in 1719, the first of the London voluntary hospitals.[207]

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[203] Clark-Kennedy, *The London,* p. 6–7.
[204] Siena, *Venereal Disease, Hospitals and the Urban Poor*, p. 68.
[205] Williams, *The London Lock,* p. 1.
[206] Clark-Kennedy, *The London,* pp. 17–18.
[207] Ibid., p. 19.

The voluntary hospital movement was inspired in part by the earlier establishment of a number of charitable schools where the Society for the Propagation of Christian Knowledge had played a key role.[208] Both these schools and the nascent voluntary hospital movement represented a new attitude to charity emergent in the eighteenth century combining the assets of a number of wealthy individuals unsupported by any central control.[209] Unlike the endowed hospitals that received a stipend from the government, these voluntary hospitals relied solely on charity to remain open and all shared similar institutional structures. Boards of governors who managed the affairs of the hospital were made up of wealthy subscribers to the charity. There were slight differences in donation requirements between the hospitals, but in general it took a subscription of around five guineas per year to become a governor, and a lump sum of over thirty pounds could guarantee a governorship for life. In return for this governors could ensure their charity was helping the less fortunate of their sick city although less altruistic motives also prevailed of course, and a place on the board of a hospital presented an easy way for wealthy gentlemen to display power and prestige in the upper echelons of London society.[210] Tradesmen were particularly keen to become governors, as the hospitals would often provide lucrative contracts for such men when choosing suppliers or workmen.[211] The main incentive to become a governor though seems to be the considerable degree of control they gained over who entered the hospital. With the exception of emergency cases, patients were only

[208] Williams, *The London Lock,* p. 9.
[209] Bronwyn Croxson, 'The price of charity to the Middlesex Hospital, 1750–1830', in Martin Gorsky and Sally Sheard (eds), *Financing Medicine: The British Experience Since 1750* (London and New York: Routledge, 2006), p. 25.
[210] Martin Gorsky and Sally Sheard, 'Introduction' in Martin Gorsky and Sally Sheard (eds), *Financing Medicine: The British Experience Since 1750* (London and New York: Routledge, 2006), p. 3.
[211] Clark-Kennedy, *The London,* pp. 80 – 81.

admitted to the hospitals if they could produce a letter of recommendation from a governor. Like many of the other hospitals, the Lock rules stated that governors could only admit one patient at a time, though this did not stop some using this privilege in a less than philanthropic manner. In 1772, Carolina Williams, a wealthy lady who had donated funds to the hospital for the creation of a ward exclusively for married women, was found to be selling letters of recommendation after she was reduced to poverty.[212]

After the establishment of the Westminster Infirmary, it was not long before other hospitals began to appear. In 1720 bookseller Thomas Guy (1644–1724), one of the governors of St Thomas's hospital, donated the not insubstantial funds necessary for the building of an annexe to St Thomas's, which would come to be known as Guy's Hospital. By the 1746 inception of the Lock, Guy's and the Westminster had been joined by St George's (1733), the Foundling Hospital (1739), the London (1740), the Middlesex (1745) and the Smallpox Hospital (1746). Out of these institutions, Guy's, St George's and the London all accepted venereal patients, with the London even opening a special house for venereal patients at Prescott Street in 1742 which they also called the Lock.[213] The Prescott Street Lock house was not closed until May 1850, after which the London would continue to treat those with venereal diseases as outpatients.[214] St Bartholomew's and St Thomas's also had Lock houses for venereal patients; the Kingsland Lock in Islington did not close until 1760, likewise the Southwark Lock run by St

[212] Williams, *The London Lock,* p. 31.
[213] Clark-Kennedy, *The London,* p. 39.
[214] Siena, *Venereal Disease, Hospitals and the Urban Poor,* p. 219–222.

Thomas's.[215] Another, albeit short lived, venereal disease hospital, known as the Misericordia was opened in 1774 but was closed in 1789.[216]

Alongside the abundance of hospitals in London that accepted venereal patients, there were a multitude of treatment options within the thriving medical marketplace of London catering to all sectors of society. From the confidential ministrations of physicians and surgeons in private practice for those who could afford it, to the more dubious care of the workhouse for the destitute poor, cures for the disease were widely available around the city. However, many of these options excluded the poor. In his study of the treatment options available for London's poxed paupers, Kevin Siena closely examines the attitudes of the general hospitals to venereal patients. Siena demonstrates the economic barriers many faced when seeking hospital admission, pointing out that several institutions such as Guy's, the London, and both royal hospitals charged higher admission fees for venereal, or 'foul', patients than 'clean'.[217] By the late eighteenth century St Thomas's fees were three shillings six pence for most patients and ten shillings six pence for venereal cases.[218] The Lock on the other hand, charged nothing.

The Lock Hospital's establishment was as much a response to the growing poverty of London as it was to the immeasurable incidences of venereal disease, understandable in a society that often elided the poor with disease. The hospital advertising material and annual reports for governors and subscribers relentlessly highlighted their charitable response to the poor, often melodramatically bemoaning the plight of patients applying to the Lock. Patients were, they stated,

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[215] Williams, *The Lock,* p. 9.
[216] Siena, *Venereal Disease, Hospitals and the Urban Poor,* p. 207.
[217] Ibid., p. 222.
[218] John Howard, *An Account of the Present State of the Prisons, Houses of Correction, and Hospitals in London and Westminster Taken from a late Publication of John Howard, Esq. F.R.S. By Permission of the Author…* (London: Printed by Order of the Society lately instituted for giving Effect to his Majesty's Proclamation against Vice and Immorality, 1789), p. 23.

'[f]riendless through misconduct, and reduced to extreme indigence, in part by vainly trying other methods of cure, many never seek admission into an Hospital, till their last garment is pledged, the rags excepted in which, scarcely covered, they appeared at the Board'; this homily went on to state that in extreme cases the Lock would sometimes even provide patients with clothing, summarily claiming that '[t]hus many are snatched from the jaws of death, and recovered to health'.[219] However, whilst the requirement of payment might have deterred some poorer patients, no hospital, including the Lock, was ever intended for the completely destitute with most institutions aiming their services at the 'industrious poor'.[220] The Lock in fact, though it required no payment from patients, stipulated that they were expected to bring with them 'two shirts or shifts and two pair of stocking.'[221] The need to attract subscribers though meant that the governors had to advertise their venereal patients as suitable pathetic objects of charity.

It was not just the cure of symptoms that the Lock was eager to demonstrate. The promise to reform the moral characters of those lascivious enough to contract venereal disease was what appeared to really attract donors, and so the Lock advertised itself as a healing institution not just for bodies, but also for souls.[222] The approach to moral reformation was detailed minutely in the centenary report of the hospital, and emphasized in every other form of advertisement and subscribers report. All wards had copies of religious texts, and every Sunday patients would receive religious instruction 'calculated to awaken in

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[219] *Centenary report of the Lock Hospital & Asylum: With the proceedings of the Building Committee, and an abstract of the income and expenditure, and a list of the governors and subscribers* (Paddington: L. Chapman, 1846), p. 6.
[220] Clark-Kennedy, *The London,* p. 95.
[221] Royal College of Surgeons, London Lock Hospital and Rescue Home, MS0022/6/7 Rules and Orders made at a general court of governors of the Lock Hospital Held 28 November 1754 and confirmed with additions and alterations by the general court held 28 April 1814.
[222] Susan C. Lawrence, *Charitable Knowledge: Hospital Pupils and Practitioners in Eighteenth-Century London* (Cambridge: Cambridge University Press, 1996), p. 34.

them a deep sense of their guilt and danger'.[223] A Chapel capable of holding around an 800-strong congregation was attached to the Lock in 1762 under the auspices of the first Chaplain of the hospital Martin Madan (1726–1790). However, while patients were certainly expected to attend Sunday worship here, sitting in a special sectioned off area of the church which concealed the deformed patients from the healthy congregation, the reality of religious instruction on the wards proved to be a bone of contention throughout the hospital's history.[224] Over the course of his tenure as Chaplain, Madan began to visit wards less and less as the offensive smell of the patients proved too much for him.[225] Later, Madan's successor Edward de Coetlogon (*bap*.1747–1820) managed to infuriate founder Bromfeild by also refusing to visit wards unless his salary was increased.[226] This seems to have been a common complaint about many of the hospitals across London, all of which were expected to have chapels and provide religious instruction for their patients. In 1789 prison reformer John Howard (1726–1790) published an account of the state of prisons in England to which he added a report on hospitals. One of Howard's many gripes was that he had 'never found any clergyman administering consolation and admonition to the sick; and prayers are usually attended by very few'.[227]

Despite the Lock's advertising rhetoric, Siena too cautions that moral reform was not a major concern of the Lock until the 1780s when the hospital began plans to erect the Lock Asylum for the Reception of Penitent Women, a sister institution where women could go after they were cured to learn skills that

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[223] *Centenary Report of the Lock Hospital & Asylum*, p. 8.
[224] Howard, *An Account of the Present State of the Prisons, Houses of Correction, and Hospitals,* p. 32.
[225] Williams, *The London Lock,* p. 39.
[226] Ibid., pp. 44–48.
[227] Howard, *An Account of the Present State of the Prisons, Houses of Correction, and Hospitals,* p. 36.

would enable them to secure a better job than their former profession.[228] The Lock Asylum was opened in 1792, funded by a separate charity to the main hospital.[229] Early official statements regarding the Asylum asserted the necessity of such an endeavour in order to counteract the evils spread by the prostitute. This was not a compassionate, philanthropic view of the fallen woman; rather the prostitute was to be considered as a dangerous source of pollution, who needed to be isolated from the city she sought to infect.[230] Women admitted to the Asylum generally stayed for around two years, confined to the institution while undergoing a course of religious instruction, manual work such as laundry, and training for jobs deemed suitable for them upon their release.[231] As the prostitute was often seen as transgressing socially accepted gender norms, the pseudo-domestic environment of the Asylum was intended to restore these traditional gender roles and transform women who had fallen into prostitution into productive and healthy members of London society.

Despite the epithet 'Lock', the hospital was not a closed site isolated from wider society.[232] The hospital regularly advertised for subscribers in magazines and newspapers. One such advertisement in the *St. James's Chronicle or the British Evening Post* declared that

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[228] Siena, *Venereal Disease, Hospitals and the Urban Poor,* p. 183.
[229] María Isabel Romero Ruiz, 'Fallen Women and the London Lock Hospital Laws and By-Laws of 1840 (Revised 1848)', *Journal of English Studies*, 8 (2010), p. 148.
[230] Linda E. Merians, 'The London Lock Hospital and the Lock Asylum for Women', in Linda E. Merians (ed.), *The Secret Malady: Venereal Disease in Eighteenth-Century Britain and France* (Lexington: University Press of Kentucky, 1996), p. 137.
[231] Ruiz, 'Fallen Women and the London Lock Hospital Laws and By-Laws of 1840 (Revised 1848)', p. 155.
[232] The word 'Lock' in this context probably did not come from the English word but rather was a derivation of the old French word 'loque' meaning 'rag'. French leper houses were thus referred to as Loques because of the rags that sufferers used to dress their sores. As many early venereal disease hospitals and wards in England had previously been designated as leper houses, the word stuck. See Philippa Levine, *Prostitution, race, and politics: Policing Venereal Disease in the British Empire* (London and New York: Routledge, 2003), p. 70.

> [t]he Benevolence of this Institution is so conspicuous from the Number of miserable Objects in general relieved by it, and most especially from the great Number of helpless Innocents, redeemed from the most loathsome Disease and Misery, that it stands in need of no further Arguments to recommend it to the Charitable and Human than its apparent Utility.[233]

The hospital also publically celebrated the anniversaries of its creation with feasts for governors and prospective middle and upper class subscribers.[234] In 1846, *Bell's Life in London and Sporting Chronicle*, a weekly broadsheet, recorded that '[t]he centenary festival of this admirable institution will take place on Wednesday, at the London Tavern, Bishopsgate-street, his Royal Highness the Duke of Cambridge, the patron, in the chair.'[235] Such celebrations worked to encourage current subscribers to keep giving to the hospital, as well as to advertise to prospective new donors, however they also served to advertise the hospital as an integrated part of London society.

The hospital building itself was situated in a fairly prosperous area of London on Grosvenor Place, at Hyde Park Corner. The house, surrounded by fields for much of the eighteenth century, and facing St James' Park seemed an ideal situation for a new hospital. While many of the older institutions, such as St Bartholomew's and St Thomas's, were clustered near the centre of London, the Lock's placement had, until the nineteenth century at least, the advantage of cleaner air and less overcrowding.[236] The Hyde Park corner site was also an important one in the city. Westminster was a busy and affluent area, the home of the House of Lords, House of Commons and the royal residences, in contrast to

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[233] 'News', *St. James's Chronicle or the British Evening Post*, 11 June – 13 June, 1761.
[234] Merians, 'Lock Hospital and Asylum for Women', p. 135.
[235] 'Lock Hospital and Asylum', *Bell's Life in London and Sporting Chronicle*, Sunday 7 June 1846, p. 8.
[236] Rivett, *The Development of the London Hospital System,* p. 18.

the more commercial City of London.[237] Contemporary images of the hospital show the building as part of an upmarket street, with a well-dressed and respectable public passing by the house (fig. 1.3). Though the Lock benefitted greatly from such cultural visibility, gaining subscribers and public praise for its mission, attitudes towards the hospital amongst the general public were by no means all favourable. From its 1746 inception, the Lock had trouble attracting as many governors as the other voluntary hospitals.[238] The hospital was, however, supported by numerous well-known philanthropists, including the Drummond and Hoare banking families, who had been involved in financing the hospital from its inception; yet the Lock frequently relied heavily on the generosity of these banks as, for much of its early history, it was in debt and operating at a loss.[239]

Figure 1.3. The Lock Hospital, Hyde Park Corner, Westminster. Engraving by Thomas Hosmer Shepherd (London, mid-nineteenth century). Image courtesy of the Wellcome Library, London.

[237] Lawrence, *Charitable Knowledge,* p. 10.
[238] Merians, 'The Lock Hospital and Asylum for Women', p. 129.
[239] Williams, *The London Lock,* p. 62.

Figure 1.4. A satire on the refurbishment (or building) of a Lock Hospital. Coloured etching by J. Williamson (London, 1 July 1802). Image courtesy of the Wellcome Library, London.

As well as relatively low subscriber numbers the general public were often antagonistic towards the institution. A satirical cartoon published by a J. Williamson in 1802 entitled 'the Opening of Pandora's Box', seems to sum up a widespread negative attitude to the establishment of venereal disease hospitals (fig. 1.4). In the foreground we can see several men displaying various ailments often connected with the Lock. The figure fourth from the left, shown in a kilt and tartan beret scratching himself, is suggestive of a patient with Sivvens, a disease that was recognisably prevalent in Scotland and was frequently thought to be a form of venereal disease.[240] The emaciated figure stepping out of the box and leaning on a walking stick looks similar to visual representations of men wasted away by the effects of venereal disease brought on by masturbation discussed

[240] Robert Thomas, *The Modern Practice of Physic Exhibiting the Character, Causes, Symptoms, Prognostics, Morbid Appearances, and Improved Method of Treating the Diseases of All Climates By Robert Thomas, M. D.,* seventh edn. (London: Longman, Hurst, Rees, Ormes, and Brown; Cadell and Davies; Baldwin, Cradock, and Joy; T., and G. Underwood; S. Highley; G. and W. B. Whittaker; Burgess and Hill; E. Cox, Borough; and Adam Black, Edinburgh, 1821), p. 655.

above. These ailing figures demonstrate a contemporary worry that the presence of the Lock Hospital might actually promote vice and lead to more venereal patients wandering around London.[241] The patients at the London Lock did indeed have a physical presence on the streets of the city. Though they were supposed to remain on their wards unless they had leave from a surgeon, assistant surgeon or house pupil, they were allowed out regularly to take fresh air across the road in St James's or Green Park.[242] The presence of the obviously venereal on the streets of the capital is suggested elsewhere during the period. For instance, in 1765, surgeon J. Becket wrote that whilst out walking in the street he saw a man whom he recognised as a former patient, recalling that 'I should not have recollected him, but the Circumstance of his having but one Leg, and one Arm, struck my Eye immediately; and his Face being much distorted with the Distemper, made me the more certain he was the sam [*sic*] Person'.[243] The extent of the presence of the deformed and afflicted on the streets of London is difficult to assess with any degree of certainty, yet from such anecdotal sources it seems likely that the obviously diseased were at times quite evident in London's streets.

Williamson's print also suggests a specific awareness of the London Lock Hospital's history and place in the medical world of London. In the background of the print is a Lock Hospital under construction or refurbishment; indeed, Williamson may have been inspired by the almost continuous rebuilding of the London Lock over the eighteenth century. Demand for beds in the hospital had

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[241] Merians, 'The Lock Hospital and Asylum for Women', p. 129.
[242] RCS, MS0022/6/7, Rules and Orders made at a general court of governors of the Lock Hospital Held 28 November 1754 and confirmed with additions and alterations by the general court held 28 April 1814.
[243] J. Becket, *A New Essay on the Venereal Disease, and Methods of Cure; Accounting for the Nature, Cause and Symptoms of that Malady. By J. Becket, M. D.* (London: Printed for the Author, and sold by J. Williams, Bookseller, in *Fleet Street;* and J. Dixwell, in *St. Martin's Lane,* near *Charing-Cross*, 1765), 'Preface'.

grown quickly; 695 patients had been seen between January and September of the Lock's first year, and it was becoming clear that the Grosvenor Square building was not fit to house so many.[244] The building was expanded in 1754, the roof was repaired and another floor added in 1766, four additional wards were added in 1798 and finally in 1849 the hospital moved site, erecting a new building at Westbourne Green facing Harrow Road. Also suggested in Williamson's print is a critical attitude towards the hospital medical staff. To the right of the image is a yellow carriage in which a smiling man, probably a physician, looks out over the scene of sickness and decrepitude. The medical staff of the Lock was composed of two surgeons and two assistant surgeons, as well as two physicians and a number of live-in medical students known as house-pupils. For physicians, a hospital placement was usually treated as a means to a more lucrative private practice and they generally remained as medical officers for only a couple of years. The ostentatious display of wealth signified by the physician's carriage and the presence of two footmen suggests a condemnation of physicians who visited the hospital rarely, seeking only money and reputation, and then retreating into comfortable private practice.

Up until the mid eighteenth century, regular medical practice had been divided into the strict tripartite hierarchy of physicians, surgeons and apothecaries. The physicians were the elite, they diagnosed patients from a distance, usually by listening to the patients' descriptions of their own maladies, sometimes by smelling their urine, but rarely by touching them, in order to assess the state of their constitution and balance of humours. Surgeons practiced the more manual side of medicine; setting bones, cutting for bladder stones, letting blood or

[244] RCS, MS0022/6/7, An Account of the Lock Hospital taken from the minute books, p. 4.

amputating limbs. Finally, the apothecaries mixed and dispensed cures that would be prescribed by physicians or used by surgeons. This division of medical practice was instituted from the very start of their education. Physicians were generally trained at the universities of Oxford or Cambridge where they predominately studied the classics, before taking their MD.[245] Surgeons were likely grammar school educated, and trained mostly by apprenticeship to other surgeons. An apprenticeship consisted of shadowing the surgeon and carrying out everyday tasks such as changing bandages, setting fractures, and looking after the surgeon's equipment.[246] Apothecaries were also trained by apprenticeship. Over the eighteenth century, it was the surgeons' educational practices that changed the most, with a stint in a London hospital and attendance at a number of private lecture courses becoming a requirement for licensing by the Company of Surgeons.[247] Patterns of medical education over the eighteenth and nineteenth centuries were changing enormously, and voluntary hospitals like the Lock provided medicine new sites for observation, teaching and learning about disease.

London was becoming the central hub for medical education in England by the late eighteenth century, as the old universities of Oxford and Cambridge still refused to admit religious dissenters and only taught medical courses for physicians.[248] The alternative for medical education had been the universities of the continent or Scotland, however these were falling out of favour by the late

[245] W. F. Bynum, 'Physicians, hospitals and career structures in eighteenth-century London', in W. F. Bynum and Roy Porter (eds), *William Hunter and the Eighteenth-century Medical World* (Cambridge: Cambridge University Press, 1985), p. 114.
[246] Joan Lane, 'The Role of Apprenticeship in Eighteenth Century Medical Education in England' in W. F. Bynum and Roy Porter (eds), *William Hunter and the Eighteenth-century Medical World* (Cambridge: Cambridge University Press, 1985), p. 77.
[247] Loudon, *Medical Care and the General*, p. 35.
[248] Adrian Desmond, *The Politics of Evolution: Morphology, Medicine, and Reform in Radical London* (Chicago and London: The University of Chicago Press, 1989), p. 34.

eighteenth century.[249] Looking to attract students to London, elite practitioners established well-known private schools in the city during the eighteenth century; physician William Hunter (1718–1783) founded the Great Windmill Street School in 1764 and surgeon Joshua Brookes (1761–1833) set up his Great Marlborough Street School in 1787.[250] These schools hired the best teachers from London's medical elite, and were usually well equipped with large museums of drawings, preparations in spirit, and models demonstrating both standard and pathological anatomy. Lessons at the schools would have been hugely performative, with teachers lecturing before a background of models, preparations, skeletons and other visual representations.[251]

The private schools though could not offer a complete medical education and students needed to supplement private courses with stints in hospitals and infirmaries in order to gain necessary clinical experience.[252] Students became an accepted and indispensable part of the medical staff of London's hospitals. For surgeons, a placement at a hospital was highly rewarding, as they essentially operated as private teachers within the institution, with pupils paying them directly rather than the hospital.[253] At the Lock, students were charged twenty guineas a year for visiting pupils and fifty for 'home' pupils, those who lived in the hospital.[254] Whilst resident at the hospital, pupils would perform the day-to-day practices of the house such as changing patient dressings. They watched operations and treatments performed by the house surgeons, attended extra

[249] Porter, 'Medical Lecturing in Georgian London', p. 97; L. S. Jacyna, *Philosophic Whigs: Medicine, Science and Citizenship in Edinburgh, 1789–1848* (London and New York: Routledge, 1994), p. 1.
[250] Porter, 'Medical Lecturing in Georgian London', pp. 95–96.
[251] Anne Carol Darlington, 'The Royal Academy of Arts and its Anatomical Teachings; with an Examination of the Art-Anatomy Practices During the Eighteenth and Early Nineteenth Centuries in Britain' (unpublished doctoral thesis, University of London, 1990), p. 64.
[252] Porter, 'Medical Lecturing in Georgian London', p. 97.
[253] Bynum, 'Physicians, hospitals and career structures in eighteenth-century London', p. 118.
[254] Porter, 'Medical Lecturing in Georgian London', p. 99.

courses at the private schools, and visited the capital's several medical museums to supplement their clinical instruction.[255] The Lock Hospital, and the other voluntary hospitals of the city, were not only passively responding to the ill health of the city, they were central factors in a reshaping of the business of medicine, how it was taught, and, what was learned.

The emergence of the hospital movement was a central factor in a paradigmatic shift from a humoural conception of disease, where ill health was seen as the product of an imbalance of the four humours, to a pathological view, where diseases were given physical identities as lesions in the body's flesh. Vital for this shift was the increased centrality of clinical observation of patients in hospitals, though this did not immediately overturn the commitment to a humoural system. Renowned Dutch physician Herman Boerhaave (1668–1738) was a keen exponent of a scientific ethos of direct observation as the best source of knowledge, yet he did not question the veracity of a humoural doctrine of disease. From 1714 he worked as a physician at St Augustine's Hospital in Leyden where he had ample opportunity to observe patients labouring under various conditions and symptoms.[256] For Boerhaave, knowledge of the disease could only come from a strict observation of bodily symptoms alone, placing very little store in any theoretical discussion of disease.[257] However a humoural rhetoric persisted meaning that the visible symptoms observed in the clinical environment were still ostensibly ancillary to the effects of the constitution and the humours in

[255] Lane, 'The Role of Apprenticeship in Eighteenth Century Medical Education in England', p. 85.
[256] Samuel Johnson, 'The Life of Dr Herman Boerhaave', in Donald Johnson Greene (ed.), *Samuel Johnson: The Major Works* (Oxford: Oxford University Press, 1994), p. 62.
[257] Historian Andrew Cunningham has argued that Boerhaave was the 'turning-point after which the majority of anatomists began to see anatomical pathology of one kind or another as part of their disciplinary roles', as his teaching was essentially still grounded in a traditional doctrine of humours and fluids, but he also embraced practices of clinical observation and a certain amount of attention to the solid as well as the fluid body. Cunningham, *The Anatomist Anatomis'd*, p. 198.

diagnosing and managing disease. This did not mean symptoms were unimportant, only that they merely suggested the presence in the body of an invisible and intangible disease, and were not considered a fundamental character of that disease.

Boerhaave was fascinated by the sheer variety of symptoms often visible in patients suffering from venereal disease. 'The new Symptoms which arise daily in the self same Disease, and the wonderful Disparity among the usual ones, must necessarily leave a Physician in the greatest Doubt and Perplexity', he bemoaned of this multitude.[258] His confusion regarding the matter persuaded him to research the subject further, and eventually publish *A Treatise on the Venereal Disease*, translated into English in 1729, in which he focused on 'this *Proteus* of a Disease' hoping to uncover its elusive nature and assess how it had such a transformative effect on the body. 'Such is the Condition of our Humours even in the best Health,' he wrote, 'that the introducing a very few Particles of an exceeding small Size into the Veins, will cause our whole Nature to undergo such a Change that every Action of the Body becomes entirely different from what it was before, and each single Humours is of a new Nature.'[259] Thus, the external symptoms were clues only to the presence of an invisible disease, which had engendered this alteration of the humours, not indicative of its essential nature.

Over the course of the eighteenth century, with the rise of voluntary hospitals, medical discourse moved away from a discussion of humours and took up a focused examination of symptoms alone. As a practical ferment for gaining access to the nature of disease, the rubrics of clinical observation and experience

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[258] Herman Boerhaave, *A Treatise on the Venereal Disease and its Cure in all its Stages and Circumstances. By Herman Boerhaave, Professor of Physick in the University of Leyden. Englished by J. B. M. B. of Christ-Church College, OXON*. (London: Printed for T. Cox at the *Lamb,* and J. Clarke at the *Bible* under the *Royal-Exchange,* 1729), pp. 3–4.
[259] Ibid., pp. 8–9.

were firmly cemented in London's medical culture by the mid-eighteenth century. By the time the Lock Hospital opened in 1747 there were already numerous institutions in the capital that admitted venereal patients affording attending physicians and surgeons ample opportunities for repeated observation the symptoms of venereal disease.[260] Large numbers of patients labouring under the same condition in one place provided practitioners with an unprecedented opportunity for intensive clinical observation.[261] In 1798, Lock Hospital surgeon William Blair (1766–1822) published extensive investigations into several newly proposed cures for venereal disease, stating that '[m]y situation, as a Surgeon of an establishment *exclusively* appropriated to the cure of the *Lues Venerea*, affords me daily opportunities of treating a greater variety of cases than falls to the lot of practitioners in general.'[262]

Alongside the availability of patients in which to observe the changing symptoms and states of venereal disease in the living patient, the hospitals also often provided corpses on which surgeons could perform post mortem dissections.[263] On producing one of the first learned works devoted to pathological anatomy in 1803, physician Matthew Baillie (1761–1823) noted that '[b]eing physician to a large hospital, and engaged in teaching anatomy, I have also very

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[260] Siena, *Venereal Disease, Hospitals and the Urban Poor*, p. 220.
[261] Bynum, 'Physicians, hospitals and career structures in eighteenth-century London', p. 117.
[262] William Blair, *Essays on the Venereal Disease and its Concomitant Affections, Illustrated by a Variety of Cases. Essay I. – Part I. On the antivenereal effects of nitrous acid, oxygenated inuriate of potash, and several analogous remedies, which have been lately proposed as substitutes for mercury. By William Blair, A. M. Surgeon of the Lock Hospital and Asylum and of the Old Finsbury Dispensary*. (London: Published and sold by J. Johnson, St. Paul's Church-Yard; Messrs. Murray and Highley, Fleet-Street; Cuthell, Holborn; Boosey, Broad-Street; Becket, Pall Mall; Bell, Oxford Street; Cox, St. Thomas's Street; and Callow, Crown-Court, Great Windmill-Street. June, 1798), p. v.
[263] Hospitals providing cadavers of patients for dissection was not strictly legal during the eighteenth century and public outcry against the practice was prevalent. Helen MacDonald, *Human Remains: Dissection and its Histories* (London: Yale University Press, 2006), p. 29.

frequent opportunities of examining diseases in dead bodies.'[264] Thus the hospital afforded the eighteenth-century medical practitioner a unique space where the actions of disease in the living body, and the subsequent pathological appearances of the dead, intersected. More and more medical practitioners were focusing on the appearance of diseased flesh in the process of dissecting cadavers. This new 'pathological anatomy' was one of the major elements that overturned the conception of disease as something external to the body, and instigated the body itself as the site of action and origin of disease.[265]

The shift to a pathological paradigm meant understandings of venereal disease were moving away from humoural conceptions like Boerhaave's. As argued in the introduction to this thesis, there was never a universally accepted theory of venereal disease during this period; there was no agreement as to the specificity of gonorrhoea and syphilis, no consensus over how many stages of the disease there were, and absolutely no consistency in naming the host of diseases identified under the rubric 'venereal'. However, practitioners' pathological investigations were leading to changes in their understandings of the logic of the disease. One area where the impact of pathological anatomy was clear was debate over how to differentiate between gonorrhoea and syphilis. The debates over whether the two conditions were caused by the same poison or two distinct pollutants had raged since the first appearances of the disease in Europe and showed no signs of letting up by the eighteenth century. Surgeon John Andree (*c*.1749–1833) thought that gonorrhoea, usually characterised by a discharge from

[264] Baillie quoted in 'No. XV Matthew Baillie, M.D. Fellow of the Royal Societies of London and Edinburgh; Fellow of the Royal College of Physicians in London; Honorary Fellow of the Royal College of Physicians in Edinburgh, &c.', *The Annual Biography and Obituary for the year 1824* (London: Printed for Longman, Hurst, Rees, Orme, Brown, and Green. Paternoster-Row., 1824), p. 325.
[265] Foucault, *Birth of the Clinic,* p. 1.

the urethra or vagina, was merely a first symptom of venereal disease, which he saw as then progressing through three separate stages. '[T]he first is the Gonorrhoea and its effects' he wrote in 1799, 'the second, Chancre, its immediate consequences, and some other symptoms: the third is the confirmed, or constitutional *Lues Venerea*.'[266]

Esteemed surgeon John Hunter meanwhile saw the gonorrhoea and *lues venerea* as two different diseases that were nevertheless caused by the same poison. His theory was based on clinical observation of patients coupled with post-mortem dissection, but was also contingent on experimentation. Pathology sought to ascertain the actions of disease via a linking of the living and dead appearances and symptoms of the body, however this often entailed recourse to experimentation to fill in the gaps between these appearances, and elucidate the actions that caused them. Experiment had long been a facet of anatomical investigation and this emphasis continued with the emergence of the pathological anatomy.[267] We can see Hunter's commitment to this practice when he discussed those practitioners who claimed that both gonorrhoea and *lues venerea* were caused by different poisons acting in the body. He wrote that,

> their opinion seems to have some foundation, when we consider only the different appearances of the two diseases, and the different methods of cure; which in judging the nature of many diseases is too often all we have to go by. Yet if we take up this question upon other grounds, and also have recourse to experiments, the result of which we can absolutely depend upon, we shall find this notion to be erroneous.[268]

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[266] John Andree, *Observations on the theory and cure of the Venereal Disease by John Andree, Member of the Corporation of Surgeons of London, and Surgeon to the Magdalen Hospital* (London: Printed for W. Davis, Ludgate-Street, 1779), p. 5.
[267] Cunningham, *The Anatomist Anatomis'd*, p. 149.
[268] Hunter, *A Treatise on the Venereal Disease,* p. 13.

Beyond the observation of similar symptomatic appearances, Hunter sought to prove the common source of infection by recourse to experimentation. This he did by introducing matter from a gonorrhoeal sore to a patient who subsequently contracted both gonorrhoea and lues, proving to Hunter that both were bred from the same venereal poison.[269] The inoculation of patients with venereal matter was a common and important experiment many practitioners engaged in to prove their theories on the specificity, or unity, of these diseases.[270]

To account for the different symptoms of the two diseases, Hunter posited that it was the site of infection that caused the venereal poison to produce the different conditions. When the matter was applied to 'secreting surfaces', those parts of the body that were 'passages for extraneous matter' such as the urethra or vagina, the poison would produce a gonorrhoea; when the poison was applied to a cutaneous surface, then it would bring about a chancre that could lead to constitutional *lues*.[271] Hunter was a respected authority on venereal disease in London, yet this by no means meant that medical practitioners immediately fell into line with his views. Physician George Wallis (1740–1802) agreed that the two diseases were produced by the same poison, but instead of the site of infection being the key differential, Wallis claimed that gonorrhoea was 'matter acting in its simplest state, and the *lues venerea* in its more diffused and confirmed state'.[272] Thus while Hunter fixated on differences arising primarily out

[269] Ibid., p. 13–15.
[270] For an example of therapeutic experimentation in the case of gonorrhoea and syphilis see Alex Dracobly, 'Ethics and Experimentation on Human Subjects in Mid-Nineteenth-Century France: The Story of the 1859 Syphilis Experiments', *Bulletin of the History of Medicine*, 77:2 (Summer 2003), pp. 332–366.
[271] Hunter, *A Treatise on the Venereal Disease*, p. 16.
[272] George Wallis, *The art of preventing diseases, and restoring health, founded on rational principles, and adapted to persons of every capacity. By George Wallis, M.D. S.M.S. editor of the last edition of Motherby's medical dictionary, and Sydenham's works, with notes, &c. &c, [Four line of verse]*. (New-York, 1794), p. 479.

of the differing absorbent qualities of parts of the body, Wallis saw the difference as attributable to a varying virulence of the poison.

Others completely disagreed with the 'unicist' theory and claimed that gonorrhoea and syphilis had their own distinct poisons. Surgeon Francis Balfour (*d*.1816) in his 1767 Edinburgh University dissertation claimed they were the results of two separate poisons, and fellow surgeon Benjamin Bell (1749–1806) concurred in 1797, after witnessing many of the same inoculation experiments as Hunter had performed, though evidently with different outcomes.[273] It would not be until the 1830s that these arguments would die down – though not disappear completely – when French physician Phillippe Ricord effectively demonstrated the specificity of gonorrhoea and syphilis.[274] Ricord's *Traité pratique des maladies vénériennes* was published in 1838 and recounted his findings after completing hundreds of inoculations, demonstrating that only the pus from a chancre produced syphilis, thus proving that there was specific cause of syphilis, distinct from gonorrhoea.[275]

These new theories on venereal disease did not remain solely in an elite, intellectual sphere and filtered into a public consciousness primarily through discussions of cures. With gonorrhoea being considered more and more as a separate disease, gentler cures than mercury were suggested. Although it had been considered as a specific against venereal disease from the sixteenth century, mercury was now falling out of favour for the treatment of gonorrhoea, and consequently its efficacy as a treatment for other forms of venereal disease was

[273] John Thorne Crissey and Lawrence Charles Parish, *The Dermatology and Syphilology of the Nineteenth Century* (New York: Praeger, 1981), p. 82.
[274] Quétel, *A History of Syphilis*, p. 111.
[275] Alex Dracobly, 'Theoretical Change and Therapeutic Innovation in the Treatment of Syphilis', *Journal of the History of Medicine and Allied Sciences*, 59: 4 (2004), p. 539–540.

brought into question.[276] A print by well known satirist Thomas Rowlandson published in 1789, shows one London practitioner promoting a venereal panacea called 'Velnos syrup' in front of a hoard of furious surgeons all claiming that mercury was the only sure cure (fig. 1.5). The image shows well known London doctor Isaac Swainson, ostensibly a well dressed and respectable gentleman, proffering a bottle of Velnos' syrup; behind him, on the wall of his shop is a list of cures, recording that in 1788 he cured 5,000 patients and in 1789, 10,000. The surgeons, in contrast to Swainson's sure serenity, look monstrous, their faces deformed with fury as they demonstrate the implements commonly used to administer mercury; a grotesquely enlarged syringe and barbaric looking knives and scissors. In the sky behind them flies the Roman god Mercury, his winged shoe just visible; his inclusion serves to underline the bravery of Swainson, not only was he going against established medical authority of the time, he was also challenging the medical dogmas of the ancients, almost challenging the gods. Isaac Swainson was an unlicensed practitioner, a prolific writer on venereal disease and a confirmed adversary of all those who proffered mercury as the only specific for venereal disease. He spent several years in a practice on Frith Street selling his syrup, frequently penning a variety of invectives against those who used mercury.[277] Swainson proudly proclaimed himself a 'quack' and wrote that,

> [i]n physic, all changes of medical impositions have been forced on the regulars by the quacks; and all the great and powerful medicines are the discoveries of quacks. The introduction and improvements of inoculation; the use of mercury,

[276] Ibid., p. 527.
[277] Marie E. McAllister, 'John Burrows and the Vegetable Wars', in Linda E. Merians (ed.), *The Secret Malady: Venereal Disease in Eighteenth-Century Britain and France* (Lexington: University Press of Kentucky, 1996), p. 91.

antimony, opium, and the bark, like all the bold innovations in religion and policy, are owing to quacks.[278]

Figure 1.5. Isaac Swainson promoting his 'Velnos syrup', facing an onslaught of rival practitioners. Etching by Thomas Rowlandson (London, 29 November 1789). Image courtesy of the Wellcome Library, London.

By the nineteenth century, London's irregular practitioners, or quacks like Swainson, were attracting greater ire from the regular medical institutions and practitioners, and calls for medical reform, specifically in licensing and education, grew more and more vociferous. The traditional clearly demarcated hierarchy of physicians, surgeons and apothecaries was beginning to break down by the mid-eighteenth century. Surgeons were becoming more respected and moving in elite circles, publishing respected papers and books and even attending universities during their training. New categories of practitioner such as the 'surgeon-apothecary', 'druggist', or 'general practitioner' were emerging, practicing more

[278] Isaac Swainson, *Directions for the Use of Velnos' Vegetable Syrup, prepared by Isaac Swainson, Sole Proprietor of the Genuine Medicine and Successor to Mr. De Velnos, in Frith-Street, London* (London: Printed by James Ridgway, *c.*1780), p. 9.

than one of the branches of medicine, diagnosing and dispensing cures. By the dawn of the nineteenth century, the Company of Surgeons, Royal College of Physicians and the Society of Apothecaries, the three corporations of London that upheld the traditional hierarchy, were coming under increasing criticism for failing to respond to these changing structures of medical practice.

The unlicensed practitioner can also be seen as a potential threat to London society in a similar vein to the prostitute or the masturbator, except, instead of being seen by lay society to be spreading the disease around the city, the quack was viewed by the medical elite as compounding the problem of venereal disease by failing to treat it properly. When the Lock Hospital advertised that its patients were '[f]riendless through misconduct, and reduced to extreme indigence, in part by vainly trying other methods of cure,' it was the methods peddled by the quacks, at often extortionate prices, to which they were referring.[279] These unlicensed practitioners were not the flamboyant mountebanks of previous centuries, flogging snake oil to a credulous public, but were a more conservative group with cures and therapies ostensibly based on widely accepted medical theories and practices, and who often specialised in venereal diseases.[280] These men had impressive practices, often setting themselves up with museums and exhibitions of the kind discussed earlier in this chapter showing the debilitating effects of venereal disease. Elite medical practitioners, threatened by these sophisticated quacks attempted to undermine them in print. Surgeon John Profily addressed his 1748 essay on venereal disease to the general public, bemoaning that 'the unfortunate Sufferers in this Distemper having no notion of the Nature, Cause, or proper Remedies, are still imposed upon by Quacks and

[279] *Centenary Report of the Lock Hospital*, p. 6.
[280] Loudon, *Medical Care and the General Practitioner*, pp. 210–212.

Ignorant pretenders.'[281] As well as taking pains to alert the public to these dangerous quacks, the established medical community sought reform at a governmental level to eradicate the threat.

The Apothecaries Act, passed in 1815, was the first piece of medical reform legislation to engage with the problem of these unlicensed practitioners. Part of the growing discontent with the state of medicine in eighteenth-century London was the power exerted by the three medical corporations. Whilst these institutions played almost no role in training the practitioners of their respective fields, they were the only institutions legally responsible for examining and licensing practitioners in London.[282] Whilst practitioners were growing frustrated with the corporations, the corporations were also feeling increasingly threatened by the rise of druggists and general practitioners. The Society of Apothecaries considered the dispensing druggist a particular threat; they were not licensed by the Society, generally had not served apprenticeships to an apothecary and frequently undercut the prices of London's regular apothecaries.[283] Therefore calls for reform came from both sides, with the Society wanting the unlicensed druggists done away with, and the druggists and general practitioners wanting legal recognition.[284]

The Apothecaries Act imbued the Society with new powers that it did not really want, including greater control over qualifications, with a court of

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[281] John Profily, *An Easy and Exact Method of Curing the Venereal Disease in all its different appearances: with an account of its nature, causes and symptoms…* (London: 1748), 'preface'.
[282] The other institutions with these powers in Britain were the universities of Oxford, Cambridge, Edinburgh, Glasgow, St Andrews, Aberdeen and Dublin, as well as the Royal College of Surgeons of Edinburgh, the Faculty of Physicians and Surgeons of Glasgow, the College of Physicians of Ireland, the Royal College of Surgeons of Ireland and Apothecaries Hall of Ireland. Loudon, *Medical Care and the General Practitioner*, p. 132.
[283] Ibid., pp. 133–134.
[284] Thomas Neville Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750–1945* (Baltimore: The Johns Hopkins University Press, 1995), p. 182.

examiners established to systematize and regulate the licensing of apothecaries, which stated strictly what courses had to be taken before a student could take the exams.[285] Whilst at the time the Apothecaries Act was frequently held up as an example of progress and improvement in the medical community, historian Susan Lawrence has characterised it as 'a flawed compromise'.[286] Focusing on how it affected practitioners after it was enacted, Lawrence argues that the Act merely served to codify already established teaching practices, even encouraging students to attend fewer courses than they would have done before 1815 as they sought to do the bare minimum to become qualified; furthermore, Lawrence shows that the powers granted to the Society to prosecute London's proliferating quacks were severely limited and proved largely ineffective.[287]

Conclusion

London was a strange phenomenon in the early nineteenth century. At once a burgeoning centre of trade, industry and empire, it was home to mass poverty and widespread sickness. Venereal disease was just one pollutant that ravaged the capital, affecting the wealthy and the poor alike. Fear of contagion was managed by localising the disease to certain key figures on London's streets, notably the prostitute and the masturbator. These were the figures that granted venereal disease such a cultural visibility in London. The threat of the onanist was recognised to varying degrees by moralising quack doctors and elite medical authors alike, and exhibited to the city's inhabitants in museums of 'lost

[285] Loudon, *Medical Care and the General Practitioner*, p. 167; Lawrence, 'Private enterprise and public interests, p. 50.
[286] Lawrence, 'Private enterprise and public interests', p. 46.
[287] Ibid., pp. 47–57.

manhood'.[288] Popular prints like Hogarth's *Harlot's Progress* delighted Londoners with its strongly moralising tone, the telltale symptoms and signs of venereal disease easily recognisable in the prints. As the prostitute Moll lies sweating by the fire, two quack doctors squabbling in the background, venereal disease is ever visible as the disastrous, but deserved, consequence of her immoral life.

The city was responding to the perceived threat of venereal pollution in a multitude of ways. Wealthy philanthropists inaugurated the voluntary hospital movement from the early eighteenth century, hoping to restore London's ailing health, both physical and moral. Orthodox medical practitioners were formulating new theories about venereal disease within London, and unlicensed practitioners were selling their own cures to London's poxed. What is consistently apparent is the shared need of all these groups to advertise their presence in London's medical marketplace. With their self-promotion though also came a concomitant advertisement of the rampant presence of venereal disease on the streets of the city, making it a 'secret' in euphemistic name only.

The next chapter turns away from the dirt and pollution of London's streets to the intellectual pontificating of London's orthodox medical community. As demonstrated in the present chapter that London's surgeons and physicians were not working in a socio-cultural vacuum. Surgeon John Hunter, who was famously expert on venereal disease, is a key figure in the upcoming chapter and one example of how medical thought was deeply embedded within the society discussed above. Hunter displayed copies of Hogarth's *Harlot's Progress* in the receiving parlour of the house in Leicester Square, which also held his vast museum of anatomical and pathological preparations, models and drawings,

[288] Stephens, *Anatomy as Spectacle*, p. 53.

creating a visual continuity between London society's attitude to the disease and the medical representations of it kept in his collection, and published in his books.[289] An exploration of his, and others, orthodox medical work on venereal disease will elucidate further the purpose of these various visual and material representations in the creation, and further contestation, of conceptions of venereal disease.

[289] Simon David John Chaplin, 'John Hunter and the 'museum oeconomy', 1750 – 1800', (unpublished doctoral thesis, University of London, 2009), pp. 190–191.

2

Seeing and Representing Venereal Disease in Medical Discourse

> The various and discordant opinions which have been adopted and disseminated by different medical writers, concerning the efficacy of several articles of the materia medica, in the venereal disease, have proved the occasion of much confusion in reasoning and of no less instability in practice.[290]

Writing in 1800, surgeon to the London Lock Hospital John Pearson (1758–1826) relayed his frustrations that, despite the high levels of theoretical posturing devoted to venereal disease, it still had no certain method of cure. The problem as Pearson saw it, were the troublesome and protean symptoms that manifested in the course of venereal disease. 'The venereal virus, when introduced into the system, often gives rise to morbid appearances which do not in any proper sense partake of the nature of the remote cause', he went on to explain, adding that 'even symptoms originally venereal may lose that character, by the proper use of Mercury, while, to the eye of a common observer, they seem not to have undergone any favourable alteration.'[291] During the hundred years prior to Pearson's publication, ways of conceptualising infectious disease had undergone profound change. An increasing disavowal of a humoural body elicited a reformulation of disease, discussed in the previous chapter of this thesis. Foucault

[290] John Pearson, *Observations on the effects of various articles of the materia medica in the cure of lues venereal: illustrated with cases. By John Pearson* (London, 1800), p. i.
[291] Ibid., p. xlix.

theorised a shift in disease paradigms from one which posited disease as an invisible, intangible imbalance of the four humours, to one which saw distinct disease entities grounded physically in the body's own depths.[292]

It was the practice of clinical observation that was key to this shift. Though observation of patients' symptoms had been a means of diagnosing disease for many centuries, it was the eighteenth century when observation became, what Lorraine Daston refers to as an 'epistemic category'.[293] Which is to say that this is the period in which the practices of observation became formalized as primary components of new systems of medical inquiry. For the study of disease, this initiated a reconceptualisation of the meaning of symptoms. In the humoural body, disease was understood through considerations of signs and symptoms. Symptoms were those that were experienced by the patient, whilst signs were only recognisable to the learned medic who was diagnosing that patient, serving as ordering systems to make sense of the patient's symptoms.[294] For example, a rash on the skin was a symptom of a disease disrupting the body, it was felt by the patient and visible to the practitioner diagnosing them; a sign on the other hand was not knowingly experienced by the patient but was recognised by the practitioner as suggestive of the presence of disease, this could take the form of an unusual smell to the urine of patients or an elevated pulse. It was the eighteenth century and the development of pathological anatomy when the distance between signs, symptoms and diseases broke down; the practice of the pathological anatomy physically linked the symptoms of disease on the external live body with the pathological changes of structure in the morbid body, giving

[292] Michel Foucault, *The Birth of the Clinic*.
[293] Daston defines this as 'an object of reflection that had found its way into philosophical lexica and methodological treatises'. Daston, 'The Empire of Observation, 1600–1800', p. 81.
[294] Stein, *Negotiating the French Pox*, pp. 35–36.

disease a physical identity within the body.[295] The symptom therefore emerged as the central 'working object', in Daston's words, of enquiry into disease.[296]

The late eighteenth century was also the period in which medicine was making a new use of visual representations to depict pathological appearances of conditions such as venereal disease. However it would be rash to assume that because the visible symptom had become a central object of disease theory that this led unproblematically to a reliance on visual representation of those symptoms. The visual representation of disease was complicated by various different understandings of symptoms and how they related to disease. This chapter looks at two important analytic systems of disease in the eighteenth and nineteenth centuries, nosology and pathology, exploring how each system conceptualised the symptom and how they then chose to depict it. Nosological thought, what Foucault has termed 'classificatory medicine', was based on taxonomic orderings of disease by their visible symptoms and nothing more, as symptoms represented 'the immanent logic of morbid forms'.[297] Pathological analysis, which arose out of the classificatory gaze, took into account more than just the symptom. It compared the external symptom in the living body with the changes of structure of the internal, morbid body, and postulated on the causes and actions of the disease that happened in the time between these two appearances. The symptom then, had different importance to each system. These considerations are further complicated by venereal disease whose symptoms, as Pearson noted, were so liable to variety and transformation.

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[295] Michael Mahon, *Foucault's Nietzschean Genealogy: Truth, Power, and the Subject* (New York: State University of New York Press, 1992), pp. 49–50.
[296] 'Working objects' were examples of objects of study that were chosen to limit the 'too plentiful and too various natural objects' in a field of inquiry. Daston and Galison, *Objectivity*, p. 19.
[297] Foucault, *Birth of the Clinic*, p. 2.

Here, we are dealing predominantly with images in medical atlases. Though this chapter is ostensibly devoted to the theories expounded in these atlases, it is important to keep in mind that ideas were not free-floating, and they circulated around London's medical marketplace in the material production of the atlas. As well as disseminating theories of venereal disease for the pure good of medical knowledge, these productions were elaborate forms of demonstrating a practitioner's expertise and elite status. Daston alongside historian of science Peter Galison have shown that atlases represent disciplinary attempts to standardise working objects.[298] In the case of pathology, the notion of standardisation becomes more complex. Representing a disease as only one image requires identifying the meaningful moment of a dynamic, organic phenomenon that might differ from person to person, and moment to moment. In this case, as Daston and Galison note, the pathological atlas was the first to utilise the 'characteristic' appearance: an actual example from nature that could stand for a multiplicity, rather than an imagined or composite image that represented the perfect example of a phenomenon.[299] The problem of locating a characteristic appearance to represent though was complicated by the different emphasis placed on the visible symptom in both nosological and pathological thought, and further complicated by venereal disease, which seemed to defy all attempts to restrict its multiform identity to only one moment in its course. I argue that it is not enough to label images of venereal disease as 'characteristic', as this does not address what exactly they were considered characteristic *of*. By looking at the multiple definitions and understandings of venereal disease during this period alongside the

[298] Daston and Galison, *Objectivity*, p. 22.
[299] Ibid., p. 82.

ways in which they were visually represented this chapter seeks to problematise Daston and Galison's notion of the 'characteristic'.

This chapter looks at the development of nosology and pathology in the eighteenth century, exploring in detail the status of symptoms in each field, before moving on to investigate how the earliest images of venereal disease demonstrated beliefs over what was considered a suitable way to depict the disease. I argue here that it was not enough for the visible symptom to become a central object of enquiry into the nature of disease, but that representational traditions in medicine also had to evolve in order to grant the images themselves legitimacy as definitive of venereal disease. Within this chapter I look at the different intellectual and aesthetic strategies that practitioners of pathology and dermatology, a new medical field emerging in the early nineteenth century, employed to represent venereal disease.

The Meaning of Symptoms

To explain the emergence of pathology as a coherent system of knowledge, historians have made much of the importance of observation, in particular clinical observation as made possible by the increasing number of hospitals appearing during the eighteenth century. It was not that medical practitioners had rediscovered observation as an investigative tool, but that, as Foucault explained 'the relation between the visible and invisible – which is necessary to all concrete knowledge – changed its structure, revealing through gaze and language what had previously been below and beyond their domain.'[300] The most obvious subject of this new gaze was the symptom, which was to become the central working object

[300] Foucault, *Birth of the Clinic*, p. xiii.

of two important analytic systems emerging in the eighteenth century; nosology and pathology.

Nosologies of disease emerged in the mid eighteenth century, arising from the taxonomic drive of natural philosophers such as Carolus Linnaeus (1707–1778). Based on observation of symptoms, the nosologists of the eighteenth century attempted to group diseases into orders based on their symptomatic similarities with other diseases rather than any invisible, abstract 'essence' or cause.[301] Crucially, the analogies between diseases expounded in disease classification systems were not considered artificially imposed categories that merely grouped like with like, nosology was thought to reveal a natural order of disease.[302] British nosologists often equated this to what esteemed English physician Thomas Sydenham (1624–1689) had alluded to as a 'natural history of disease'.[303] One of the earliest nosological works on disease was published in the mid eighteenth century by French physician François Boissier de Sauvages de la Croix (1706–1767), and it would not be long before British practitioners began to formulate their own.

Celebrated Scottish physician William Cullen published his classificatory system as *Synopsis Nosologie Methodicae* in 1769.[304] Cullen paid the most attention to species, as he considered this to be the only natural category, believing Sauvages and Linnaeus had been too negligent with the orders and classes of their taxonomies, attempting to force too many species into too few

[301] Charles T. Wolfe, 'Empiricist Heresies in Early Modern Medical Thought', in Charles T. Wolfe and Ofer Gal (eds), *The Body as Object and Instrument of Knowledge: Embodied Empiricism in Early Modern Science* (Dortrecht: Springer, 2010), p. 339.
[302] Foucault, *Birth of the Clinic,* p. 7.
[303] Lawrence I. Conrad, Michael Neve, Roy Porter, Vivian Nutton, Andrew Wear, *The Western Medical Tradition* (Cambridge: Cambridge University Press, 1995), p. 409.
[304] W. F. Bynum, *Science and the Practice of Medicine in the Nineteenth Century* (Cambridge: Cambridge University Press, 1994), p. 15.

groups. '[N]ature has made nothing but species', he wrote, whereas 'the structure of genera is an effort of the human mind, which, till the species are well known and understood, must be salacious and uncertain'.[305] He was a firm proponent of the belief that nosology uncovered the true order of diseases through essential analogies with other diseases, and that this ordering of diseases based on symptoms alone would lead to the most effective therapies. However, this was not as simple as uncritically recording every symptom patients displayed. Cullen recognised that symptoms could potentially confuse as easily as they could clarify, lamenting that many diseases had very different causes but were 'so similar in external appearance and symptoms, as to be with the greatest difficulty distinguished from one another'.[306] It was minute attention to the appearance of symptoms that would eventually solve this problem. Rather than postulate on any fundamental and invisible essence to disease, redolent of a humoural view, Cullen's preoccupation was discerning the characteristic symptoms of each disease, rather than blindly recording every blotch and blemish present. He wrote of those who practiced pure observation that

> [t]hey detail symptoms that seldom attend the disease, or are not necessarily connected with it, and many that are adventitious and accidental; while at the same time they entirely neglect to distinguish between those that are unusual and accidental, and those that are common and inseparable. Thus, in order to render the history of a disease as complete as possible, they embarrass it, by omitting to specify those circumstances that then distinguish it from every other.[307]

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[305] Cullen, William, *Nosology, or, a systematic arrangement of Disease by Classes, Orders, Genera, and Species, With the Distinguishing Characters of Each and Outlines of the Systems of Sauvages, Linnaeus, Vogel, Sagar, and Macbride. Translated from the Latin of William Cullen, M. D. Late Professor of the Practice of Physic in the University of Edinburgh*. (Edinburgh: Printed by C. Stewart and Co. for William Creech; and sold, in London, by Messr. Robinsons, T. Kay, and F. Cox., 1800), p. vii.
[306] Ibid., p. i.
[307] Ibid., p. iv.

Instead of a fastidious devotion to every symptomatic appearance of a disease, Cullen advocated a more discerning medical eye. It was 'pathonomics' that practitioners needed, he said, to recognise 'those few symptoms which are so peculiar to each disease, that by them alone it may instantly and certainly be distinguished from every other.'[308]

Not all symptoms were considered equally important for Cullen. Symptoms could be classed as primary, what he termed 'idiopathic', which were the fundamental characteristic of the disease, and 'sympathetic', which manifested in the body but were not characteristic, or indicative of the disease itself, but were instead attributable to idiosyncrasies of the patient's individual constitution.[309] Cullen sought to build his nosology on 'idiopathic', rather than 'sympathetic' signifiers of disease. 'I have considered those symptoms as affording the chief characteristic marks, which are the never failing attendants of the disease' he wrote, adding that '[b]ut as many diseases, during their progress, assume various forms, the character of such is to be sought from in the course of the successive appearances and symptoms.'[310] For Cullen, characteristic symptoms were those that always appeared in every case of the given disease at some point during its course.

Classificatory medicine then held that the symptom was the only knowable component of disease. So where did venereal disease, largely considered incredibly protean in its symptoms, fit in? In his classificatory scheme, Cullen broke down diseases into four classes, 'Pyrexiae', 'Neurosis', 'Cachexiae' and

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[308] Ibid., p. v.
[309] Margaret DeLacy, 'Nosology, Mortality, and Disease Theory in the Eighteenth Century', *Journal of Medical History and the Allied Sciences*, 54:1 (April 1999), p. 283.
[310] Cullen, *Nosology,* p. xvii.

'Locales'.[311] Cullen's third class, Cachexiae, was divided into three orders, 'Marcores', 'Inteumescentiae' and 'Impetigines' with Cullen placing what he termed syphilis in with the third order. He defined the disease as a '[d]epraved habit, producing preternatural affections of the skin, or external parts of the body.' [312] Demonstrating what he considered to be the characteristic symptoms, Cullen described syphilis as '[c]ontagious; ulcers of the tonsils appear after impure venery and disease of the genitals; clustered pimples appear on the skin, chiefly at the margin of the hair, going off in crusts or scabby ulcers; pains in the bones, and protuberances of some parts of them.'[313] This is demonstrative of Cullen's nosological view of disease, a 'natural history' of the most commonly occurring symptoms.

What Cullen and his fellow nosologists were not interested in was postulating on anything beyond the morphology of disease. Cullen frequently questioned earlier definitions of disease itself, such as that advocated by Boerhaave who defined disease as 'that condition of the body whereby it is rendered unfit to exercise the actions proper to it exactly according to the rules or standards of health.'[314] The problem with this definition for Cullen was that it defined disease as a cause, an action in the body that threw up symptoms. For Cullen, there was nothing knowable but the symptom. However it inevitably proved difficult to discern characteristic symptoms of a disease without having some *a priori* conception of what the disease was. This paradox was especially evident when discussing what symptoms were to be considered idiopathic and therefore characteristic of the disease. Cullen could give no hard and fast rule on

[311] Ibid., pp. 23, 97, 136 and 154.
[312] Ibid., p. 136–149.
[313] Ibid., p. 150.
[314] Glasgow University Department of Special Collections, MS Cullen 346, Cullen's Lectures on Pathology, 1773–4, p. 7.

how to discern these characteristic symptoms, and when questioned as to how many symptoms should be considered as definitive he answered somewhat evasively that 'as almost every disease is known only by the concurrence of many symptoms, such of these as afford sufficient marks, and no more, are to be taken.'[315] He elucidated this a little further in a lecture course in which he broke down symptoms into classes, stating that 'in every disease, the most consistently concurring symptoms are the *symptomata morbi*, and these are to be distinguished from the *symptomata causae*, which may proceed accidentally from the same remote cause.'[316] Here we see that, though the symptom was the crucial working object of nosology, it was difficult to completely overlook a consideration of causes. Cullen's *symptomata morbi*, were to be considered as the true characteristics of a disease as they were the fundamental hallmarks of disease rather than the *symptomata causae*, which were merely the results of whatever external phenomenon caused the disease, rather than of the disease itself.

Cullen explained the idea of remote and proximate causes of disease using the analogy of canon fire causing a splinter to strike the head of a man and kill him. The proximate, or immediate, cause of death was the splinter hitting the head, while all other actions, the canon being fired, the canon ball hitting the wood frame that splintered, were to be considered 'remote' and therefore not directly responsible for the death.[317] There was frequent disagreement between practitioners as to how far a discussion of causes should be part of the nosological definition of disease as opposed to a purely symptom-based identification. Surgeon Allen Thomson (1809–1884), lecturing in 1836 was still dealing with

[315] Cullen, *Nosology,* p. xix.
[316] GU, MS Cullen 346, Cullen's Lectures on Pathology, 1773–4, p. 32.
[317] Ibid., p. 22.

such debates, with one of his own lectures covering the subject and expounding the reasons for his preference for symptoms alone, as he argued that '[t]he object of the nosologist in defining diseases, [is] to ascertain and mark the more constant and uniform symptoms of each disease.'[318]

Cullen was a celebrated, and by most accounts brilliant, medical mind. During his career, he taught in both Glasgow and Edinburgh, was appointed as Professor of Chemistry and Medicine at Edinburgh University from 1755, lecturing on a diverse range of subjects, from materia medica to physiology. However, nosology became a contentious subject in British medicine with a multitude of taxonomies competing alongside each other and absolutely no consensus. Notably, Cullen's own student John Brown (1735–1788) developed his own disease taxonomy that differed significantly to Cullen's.[319] Nosology evidently did not have the wide appeal that Cullen would have liked. Pathology, however, was gaining cultural traction. Whilst Cullen's definition of disease ignored any consideration of causes, pathology embraced them alongside symptoms to produce what its practitioners considered was a more fulsome understanding of the nature of disease. Pathology sought the causes, actions, and end results, as well as the symptomatic appearances of disease, and in doing so reformulated disease, not as an intangible essence, but as possessing a corporeal identity within the very flesh of the body. Pathology displaced the sovereignty of the symptom as the only way to know disease.

Following Foucault's *Birth of the Clinic*, the traditional historiography of pathology has focused on the work of Giovanni Battista Morgagni (1682–1771)

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[318] Glasgow University Department of Special Collections, Allen Thomson Medical Papers, MS GEN 1476/B/280, Synopsis of Lectures on General Pathology, to be delivered in the University of Edinburgh, during the session MDCCCXXXVI-VII, 1836, p. 10.
[319] Conrad, *The Western Medical Tradition*, p. 409.

and Marie François Xavier Bichat (1771–1802).[320] Morgagni's *De Sedibus et causis morborum per anatomem* was published in 1761 and is largely considered the first work of pathological anatomy, going beyond consideration of symptoms alone and linking the appearances of the morbid flesh seen in dissection with the pre-mortem actions and manifestations of specific diseases and giving each disease a physical 'seat' within the body, locating them in specific organs. Though highly influential, Morgagni's work was not without its problems and certain diseases he could not claim to truly locate in one organ alone. Venereal disease is one such example and he related over twenty-four cases that each placed the locus of the disease in a different organ.[321] Forty years later French army surgeon Bichat undertook his own investigations into pathological anatomy and published this work as *Traité sur les membranes* in 1800.[322] Bichat's work also saw disease as localized in specific areas of the body, but instead of organs, Bichat understood each disease to have its specific seat in one of twenty-one different types of bodily tissue.[323]

Both Morgagni and Bichat's systems sought to close the gap between the living and dead symptoms to not only grant disease a corporeal locus in the material of the body, but to uncover its invisible actions and causes. An essay by William Thomson (1802–1852), a physician and Fellow of both the Royal College of Physicians and of Surgeons in Edinburgh, written in the 1830s, laid out the 'common objects' of pathology;

[320] See Maulitz, *Morbid Appearances*.
[321] Richard C. Sha, *Perverse Romanticism: Aesthetics and Sexuality in Britain, 1750–1832* (Baltimore: The Johns Hopkins University Press, 2009), p. 56.
[322] Foucault, *Birth of the Clinic,* p.155.
[323] Sha, *Perverse Romanticism*, p. 57.

> These are, *first*, the morbid phenomena or symptoms by which we become aware that derangements have actually occurred in the economy; *second*, the morbific agents, by which derangments [*sic*] of the economy are liable to be produced; *third*, the more immediate seats of each of the derangments to which the economy is liable, and the peculiar nature of each of these derangements and, *forth*, the morbid alterations discoverable in the dead body, in those who, during life, had exhibited derangements in the performance of their functions.[324]

Pathologists concerned themselves then first with 'symptoms', just as nosologists had, but also took three other facets of diseases into account. 'Morbific agents', sometimes referred to as the 'remote causes' of disease, were external phenomena that were likely to bring about disease, for instance cold weather provoking pneumonia. The third category of 'immediate seats', sometimes termed 'proximate causes', were those changes in the structure or function of the body brought about by the external morbific agents, which in turn resulted in the final category 'organic lesions', which were the disease written into the morbid tissue of the body.[325] Pathology sought to link the external symptoms of disease with internal structural changes seen in the morbid body taking into account the causal relations between the two, and thus to reveal the action of disease.

Picturing Pathology

Though Morgagni and Bichat have dominated the history of pathology, historian Othmar Keel has advocated paying more attention to the British developments in

[324] Glasgow University Department of Special Collections, Allen Thomson Medical Papers, MS GEN 1476/B/284, General View of The Proximate Causes of Diseases, Organic and Dynamic, *c*.1842.
[325] The pathological study of specific diseases using these four access points was referred to as 'special pathology', as opposed to 'general pathology', which instead was concerned with using these four objects to study all possible changes in structure common to a specific organ or tissue. GU, MS GEN 1476/B/284, General View of The Proximate Causes of Diseases, Organic and Dynamic, *c*.1842.

pathology in the eighteenth century.[326] One of the figures Keel singles out is physician Matthew Baillie. In 1793, Baillie published *Morbid Anatomy of some of the most important parts of the Human Body*, one of the first learned works on pathology in Britain, following this over the next years with a series of fasciculi titled *A Series of Engravings to Illustrate the Morbid Anatomy*, completed in 1803. This atlas was intended to show the appearances of pathological changes of structure that Baillie thought, beyond any textual description, were 'more distinctly impressed upon the mind by figures of them being exhibited to the eye.'[327] Included in Baillie's *Series* is one image displaying the effects of venereal disease on the bones of the skull (fig 2.1). Baillie's book was highly praised. His obituary in *The Gentleman's Magazine* said of *Morbid Anatomy* that 'perhaps there is no book published of late years which has had so much influence upon the study of medicine, which has contributed so much to correct unfounded speculations upon the nature of disease, to excite a spirit of observation, and to lead the attention of the student to fact and experience.'[328] It is interesting to note that though it was nosological investigation that focused only and exclusively on what could be seen – the symptom – it was not the nosologists who first began to illustrate their systems but rather pathologists such as Baillie, who posited the symptom as only one common object of their work amongst other invisible and intangible objects such as actions and causes.

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[326] Othmar Keel, 'Was Anatomical and Tissue Pathology a Product of the Paris Clinical School or Not?' in Caroline Hannaway and Ann La Berge (eds), *Constructing Paris Medicine* (Amsterdam: Rodopi, 1995), p. 117.
[327] Matthew Baillie, *A Series of Engravings Accompanied with Explanations, which are intended to illustrate the Morbid Anatomy of some of the most important parts of the Human Body: Divided into Ten Fasciculi, by Matthew Baillie, M. D. F. R. S. L. and E. And fellow of the Royal College of Physicians* (Printed by W. Bulmer and C. for J. Johnson, St. Paul's Churchyard; and C. and W. Nicol, Pall-Mall: London, 1803), p. 5.
[328] 'Obituary: Matthew Baillie, M.D. F.R.S. L.&E.', *The Gentleman's Magazine,* October 1823, pp. 377–379.

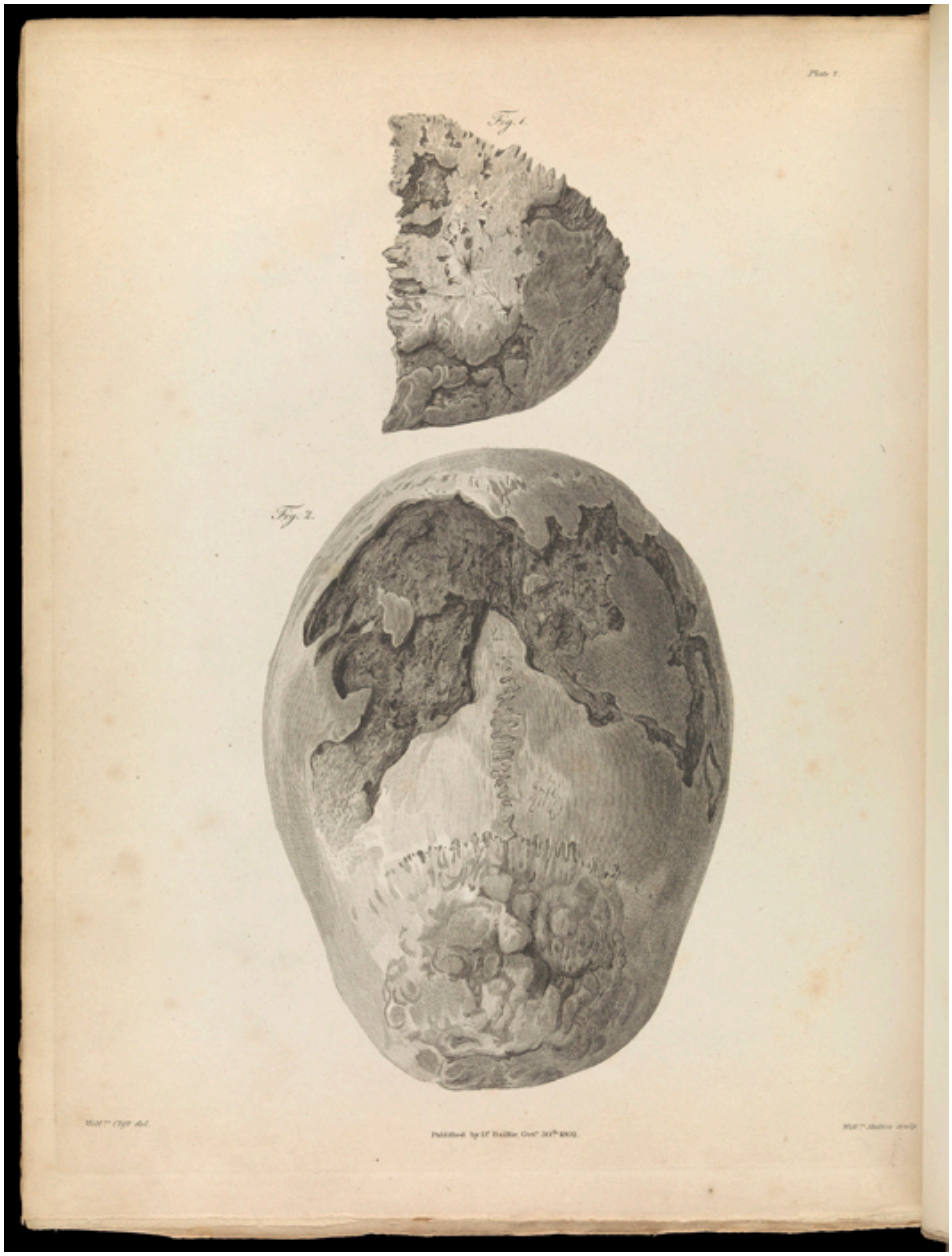

Figure 2.1. Effects of venereal disease on the bones of the cranium. Drawn by William Clift, engraved by William Skelton, in Matthew Baillie, *A Series of Engravings, Accompanied with Explanations, which are Intended to Illustrate the Morbid Anatomy of Some of the Most Important Parts of the Human Body* (London, 1803). Image courtesy of the Wellcome Library, London.

Baillie took great pains to explain and support his use of images, keen to demonstrate that they were not an indiscriminate set illustrating every case he saw, but defining features of the diseases in question. He sought to convince the

reader that these were appearances that could *only* be explained using a visual, rather than textual form, admitting that

> [i]t does not seem to be useful to represent by engravings every diseased change of structure to which the internal and more important parts of the body are subject. Some are of so little consequence as not to be worth representing; others can be so clearly understood from description, as not to require being illustrated by engraving; and other still may be of such a nature as not to be capable of being adequately represented by this kind of art.[329]

Baillie's images were careful and considered examples of those pathological changes that he deemed best suited a visual description. However, the extended consideration and textual support he gave for them highlights that the use of images within pathology was not, at this stage, universally and uncritically accepted. Though the visible external symptoms and internal lesions themselves had become important working objects of medical knowledge, this did not automatically grant legitimacy to their display in visual form, a problem exemplified by John Douglas's negative reaction to William Cheselden's images that opened this thesis. In the early years of the nineteenth century the pathological image was in its infancy and practitioners like Baillie had to employ a variety of strategies to negotiate legitimacy for them.

The very format of the atlas itself was an important factor in instituting this legitimacy. By the eighteenth century these lavish tomes were a well-established format for the transmission of learned knowledge between elite communities of medical practitioners in the medical marketplace. Thanks to advances in print technology making the inclusion of images cheaper, more and

[329] Baillie, *A Series of Engravings,* pp. 4–5.

more medical writers were beginning to co-opt the use of illustrations to raise the perceived intellectual status of their books to that of the atlas. In 1780 a medical practitioner called John Grubb published *A New Treatise on the Venereal Disease*, essentially an extended advertisement for a panacea which he called 'Friars Drops' with the forward to the book reproducing in full the patent granted to Grubb in 1777 for the invention of the drops, which were said to be perfect for curing all venereal afflictions.[330] Grubb too included, 'annexed for the use of the Curious in General, an Anatomical Discourse on the Parts of Generation' accompanied with three 'curious drawings of Anatomy' to draw attention to the parts of the body that could be afflicted by venereal disease. These basic diagrams, showing the anatomical parts of the body in perfect health, are an intriguing inclusion in a work primarily devised to peddle pills. Grubb was not affiliated with either the College of Physicians or Company of Surgeons, and nowhere in the book is a recognised medical qualification mentioned. It is therefore likely that Grubb's treatise was designed to mimic the format of elite, learned works, using the images to grant intellectual legitimacy to a book that was essentially an extended advertisement.

It was the image of healthy anatomy that was crucial in this endeavour. The depictions of the body in the medical atlases of the sixteenth and seventeenth centuries were overwhelmingly those of health, beauty and vitality. Anatomy atlases of this period often posed bodies within classical landscapes, with the flayed figures becoming active participants in revealing to the viewer the nuances

[330] Robert Grubb, *A new treatise on the venereal disease; or, every person afflicted with the disorder their own physician. To which is annexed for the use of the Curious in General, an anatomical discourse on the parts of generation in Male and Female. Also are added. Three curious drawings of anatomy, of the Genital Parts of both Sexes, Engraved by the most ingenious Artists; with an Explication to each Plate. By R. Grubb, patentee of the friars drops*. (London: printed for the author and sold by him, at his House No. 3, Old Bailey, and may be had of all booksellers and news carriers in town and country, *c*.1780), pp. 1–7.

of their own interior bodies. These atlases were the first to use a 'naturalistic' representational style, which depicted the body and the world as it was seen, however, historian Pamela H. Smith has warned that 'naturalistic representation emerges equally out of a desire to deceive'.[331] A naturalistic style was invoked to persuade the viewer that this was a representation of reality observed, which was often not the case in these atlases. Perhaps the most famous example of this trope is from Andreas Vesalius' 1543 anatomy atlas *De humani corporis fabrica libri septem*, a work whose perceived rejection of the ancient authority of Galen and commitment to experience and observation instead is generally considered foundational to the development of anatomy by historians such as Andrea Carlino and Andrew Cunningham (fig. 2.2).[332] Furthermore, not only did these illustrations reproduce the positions of the living, the artists creating them took pains to create images of a standard anatomy that was idealised rather than natural. The images were rarely, if ever, representations of one specific human cadaver, but instead presented an imagined composite, a perfectly proportioned human which historian Sachiko Kusukawa notes 'could never have been encountered as such in nature'.[333] Early medical practitioners wishing to display the pathological appearance of certain diseases then had to find a way to negotiate legitimacy for displaying, not only a dead body, but a unique example taken from one specimen only.

[331] Pamela H. Smith, *The Body of the Artisan: Art and Experience in the Scientific Revolution* (Chicago and London: The University of Chicago Press, 2004), p. 8.
[332] Andrea Carlino, *Books of the Body: Anatomical Ritual and Renaissance Learning*, trans. John Tedeschi and Anne C. Tedeschi (Chicago and London: University of Chicago Press, 1999), p. 39; Cunningham, *The Anatomist Anatomis'd*, p. 18.
[333] Sachiko Kusukawa, 'The Uses of Pictures in the Formation of Learned Knowledge: The cases of Leonhard Fuchs and Andreas Vesalius' in Sachiko Kusukawa and Ian Maclean (eds), *Transmitting Knowledge: Words, Images, and Instruments in Early Modern Europe* (Oxford: Oxford University Press, 2006), p. 91.

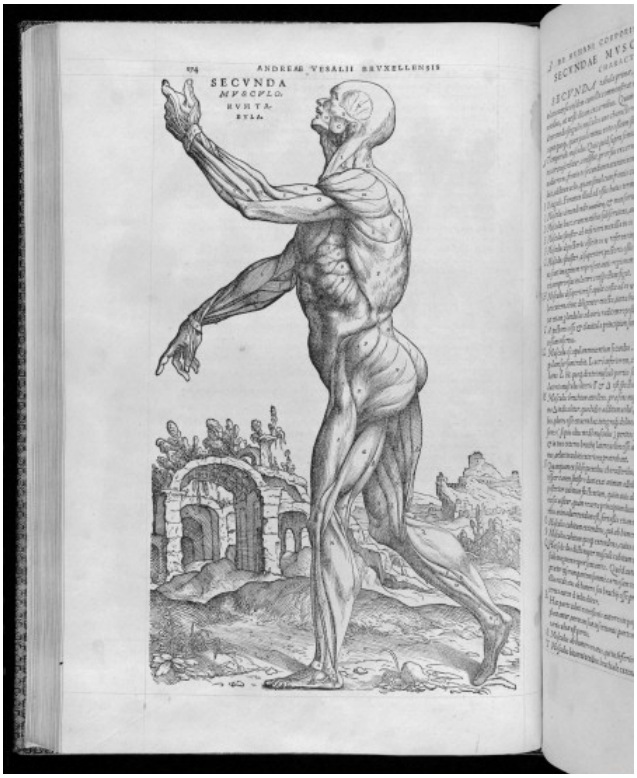

Figure 2.2. Second muscle man. Woodcut in Andreas Vesalius, *De Humani corporis fabrica libri septem* (book II, Basel, 1543), p. 174. Image courtesy of the Wellcome Library, London.

It was the late seventeenth century when the anatomists producing these atlases began to grapple with the display of dead flesh. Instead of the animated corpses gambolling across country idylls seen in atlases such as the *Fabrica*, authors such as Govard Bidloo (1649–1713) were orchestrating the creation of images that depicted the real materials of anatomy; dead flesh, the dissecting table and the instruments of anatomy (fig. 2.3). The images in Bidloo's 1690 *Ontleding des menschelyken lichaams* are stunning in their detail and technical execution, possessive of the necessary aesthetic quality required by the atlas, yet they focused on death rather than life.[334] Indeed, his images inspired a new style of anatomical illustration that took pains to show the reality of the dissection, but

[334] Benjamin Rifkin, Michael J. Ackerman and Judy Folkenberg, *Human Anatomy: Depicting the Body from the Renaissance to Today* (London: Thames & Hudson, 2006), p. 132.

only so far as to still be aesthetically pleasing. There is no blood for example in any of Bidloo's plates, and this is still ostensibly a disease-free anatomy.

Figure 2.3. Dissection of the human arm. Engraving in Govard Bidloo, *Anatomia Humani Corporis* (Amsterdam, 1685), tabula 67. Image courtesy of the Wellcome Library, London.

These images inspired a similar approach in Scottish physician, and uncle to Matthew Baillie, William Hunter, who in 1774 published one of the first atlases of obstetrics in Britain, *Anatomia uteri humani gravidi*. Hunter shared the sentiment expressed by his nephew with regard to his extensive use of images, arguing that including engravings 'conveys clearer ideas of most natural objects than words can express'.[335] In his atlas Hunter adhered to a strict empiricism in his images, using representations of cases as he saw them in the dissection room,

[335] Roberta McGrath, *Seeing her Sex: Medical Archives and the Female Body* (Manchester and New York: Manchester University Press, 2002), p. 79.

which he attributed to his inspiration by Bidloo.[336] The images are stark in their naturalism. The bodies are sectioned roughly down to the parts under consideration, appearing to have been almost brutally hacked up, and now looking, as Roberta McGrath has written, like 'so much dead meat' (fig. 2.4).[337] It was not only the appearance of the dead flesh that Hunter and his artists reproduced faithfully, but also the fidelity to each individual specimen's appearance, nothing was idealised, standardised or altered in the images, which reproduced every extraneous hair, wrinkle and blemish of the subject.[338] Historian Lyle Massey argues that this juxtaposition of 'pathological' images illustrating a 'normative account of gestation' effectively medicalised understandings of pregnancy and childbirth, ensuring that the subject was, from then on, seen as a concern of elite medical men, rather than midwives.[339] Crucially here though, this strategy demonstrated Hunter's belief that these 'pathological' images could speak for normative events; that the singular appearance could elucidate the general. This would be an important creed if images of disease were to gain epistemological legitimacy.

[336] Lyle Massey, 'Pregnancy and Pathology: Picturing Childbirth in Eighteenth-Century Obstetric Atlases', *The Art Bulletin*, Vol. 87, No. 1 (Mar., 2005), p. 80.
[337] McGrath, *Seeing her Sex*, p. 82.
[338] Martin Kemp, 'True to Their Natures: Sir Joshua Reynolds and Dr William Hunter at the Royal Academy of Arts', *Notes and Records of the Royal Society of London*, 46:1 (Jan., 1992), p. 80.
[339] Massey, 'Pregnancy and Pathology', p. 74.

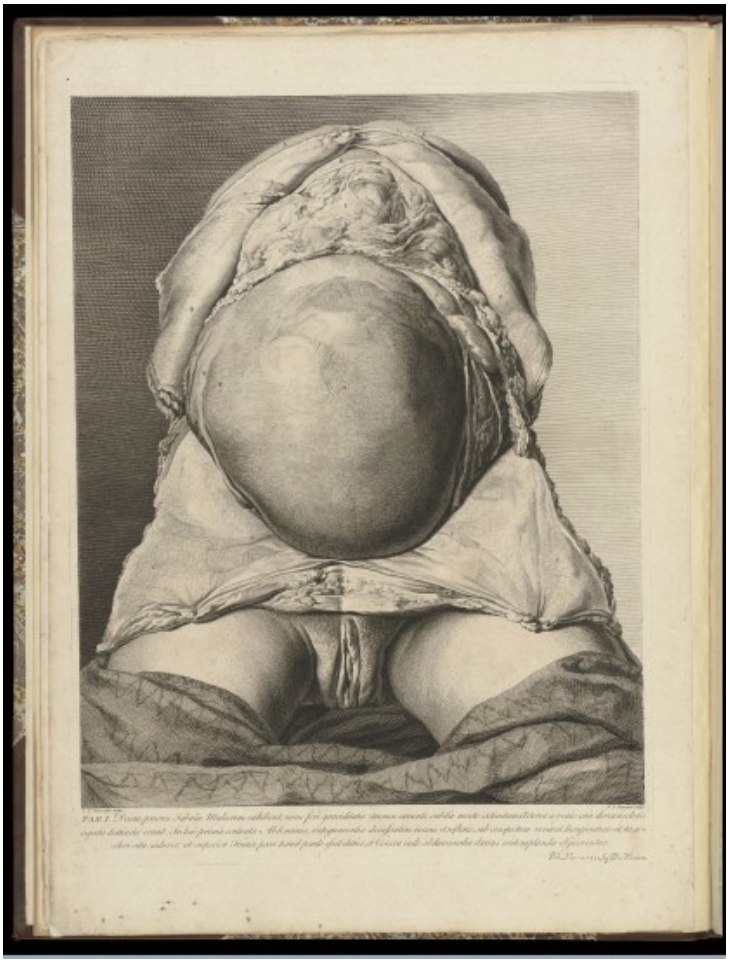

Figure 2.4. Dissection of the gravid uterus. Engraving in William Hunter, *The Anatomy of the Human Gravid Uterus Exhibited in Figures* (London, 1774), plate I. Image courtesy of the Wellcome Library, London.

Baillie's 1803 *Series of Engravings* was the intellectual product of all these changing approaches. It was not enough that the lesions depicted had come to be legitimate working objects of pathology; the representational traditions detailed above had to have developed alongside in order for the pathological image itself to be granted legitimacy. The format of the atlas granted his pathological images a material affinity with the long-established and respected field of anatomy. His images demonstrated a fidelity to the exact appearance of the specimen in question and yet, like Hunter's, they were still able to claim authority about a wider class of symptoms. The images themselves, whilst they depict the ravages of disease, are visually pleasing, without the attendant blood

and mess of the dissecting room. In a similar vein to Bidloo's somewhat idealised naturalism, Baillie's was an aesthetic pathology; but what did they communicate about venereal disease?

While preparing his atlas of morbid anatomy, Baillie lamented that those few pathological images he had seen did not adequately represent the most important changes of structure brought on by disease. 'The greater number of engravings upon this subject which I have seen, represent rather the general external appearance of morbid parts, than the real changes which are produced by disease' he wrote in his introduction.[340] Pathology did not just take into account the external symptom; in fact, this was probably the least representative part of the disease because it was prone to be so changeable, as well as often being less obvious in an autopsy. In *Morbid Anatomy*, Baillie wrote that parts of the vagina were liable to symptoms of venereal disease but '[t]hese diseases, although they are very often the subject of solicitude during life, yet are seldom examined after death, and therefore we shall omit them here altogether.'[341] Whilst in the later atlas, Baillie chose to depict the fragments of skulls that showed 'the effects which the venereal disease commonly produces upon the bones of the cranium'.[342] This was obviously what he considered as the 'real change' to the body's structure brought on by venereal disease. However he never claimed that this image was a representative definition of venereal disease in its totality; Baillie wasn't seeking to define it by choosing and displaying one characteristic symptom. Instead he

[340] Baillie, *A Series of Engravings,* p. 4.
[341] Matthew Baillie, *The Morbid anatomy of some of the most important parts of the human body. By Matthew Baillie, M. D. F. R. S. Fellow of the Royal College of Physicians, And Physician to St. George's Hospital.* (London: Printed for J. Johnson, St. Paul's Churchyard; and G. Nicol, Pall-Mall, 1797), p. 421.
[342] Baillie, *A Series of Engravings*, p. 221.

was portraying a common pathological change of osseous structure that only happened to be caused by venereal disease.

It was not just the grand atlases of general pathology that were beginning to use images though, and we can learn more about how venereal disease was conceptualised by exploring visual representations of it in works dedicated to that disease alone. William Hunter's brother, John Hunter was one of those who believed visual representation had a place within discussions of venereal disease, publishing *A Treatise on the Venereal Disease* in 1786, and including a series of illustrations. Hunter's treatise presents us with an excellent example of the difficulties inherent in attempting to visually represent venereal disease specifically, rather than one pathological change of structure in the body, in the early years of pathological inquiry. By assessing Hunter's theories on the disease alongside the type of images he used, we gain a fuller understanding of the complexity of visualising this particular disease.

In 1748 the twenty-year old John Hunter arrived in London where he began teaching anatomy alongside his elder brother. A skilled dissector, John soon looked to qualify as a surgeon, studying at several hospitals including the Chelsea Army Hospital under William Cheselden.[343] Following this, Hunter became a renowned surgeon and anatomist, amassing a collection of anatomical and pathological preparations in a museum at his house in Leicester Square. Though the established history of pathology in this period has focused on the work of Morgagni and Bichat, historian Russell Maulitz argues that the success of pathology in the nineteenth century 'essentially represented the practical

[343] Jacob W. Gruber, 'Hunter, John (1728–1793)', *Oxford Dictionary of National Biography,* (Oxford: Oxford University Press, 2004) [Consulted at http://www.oxforddnb.com/view/article/14220, (9 March 2010)].

implementation and the theoretical maturation of some well-established eighteenth-century pathological concepts', many of these being explored by British medical practitioners such as Hunter.[344] He was undoubtedly a key figure in the development of pathological inquiry and practice, indeed in an 1869 English translation of Morgagni's *De Sedibus* the translator, physician Benjamin Alexander, dedicated the book to Hunter, asserting that he had the honour 'in this country at least, to have stripped anatomical science of its mystery and disguise… The science has, by your means become more universally diffus'd, and more clearly understood'.[345]

Hunter's theories on venereal disease were to influence medical discussion of the disease in Britain until well into the nineteenth century. His was a pathological conception, knowledge of the causes and actions of disease were to be discerned through observing its symptomatic effects on the living body and linking them to the post-mortem structural change. 'We know nothing of the poison itself' he wrote 'but only its effects on the human body.'[346] Hunter was clear on his methods of describing disease. Like Cullen, he favoured certain symptoms over others as more revelatory of the disease, and, again like Cullen, Hunter considered those symptoms that appeared most frequently to be of greatest importance, especially in venereal disease. 'In describing diseases which like the venereal disease admit of a great variety of symptoms, we should keep a middle line, first giving the most common symptoms of the disease in each form, then the varieties which most commonly occur, and last of all the most uncommon',

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[344] Russell C. Maulitz, 'The Pathological Tradition' in W. F. Bynum and Roy Porter (eds) *Companion Encyclopaedia of the History of Medicine Vol. 1* (London and New York: Routledge, 1993), p. 176. See also Maulitz, *Morbid Appearances*, p. 3, and Keel 'Was Anatomical and Tissue Pathology a Product of the Paris Clinical School or Not?', p. 117.
[345] Morgagni, *On the Seats and Causes of Diseases Investigated by Anatomy,* 'dedication'.
[346] Hunter, *A Treatise on the Venereal Disease,* p. 11.

indeed, Hunter realised that venereal disease threw up such a range of symptoms that 'it will be impossible to take notice of every possible variety'.[347]

Like most of his contemporaries, Hunter divided the disease into local and constitutional stages, with the first symptoms appearing locally such as the chancre, before the disease moved inwards, infected the constitution, which he referred to as *lues venerea*, which in turn could produce secondary local symptoms such as ulcers of the throat and mouth, buboes in the groin, and pain in the bones. Hunter was curious as to the action of the poison between first infection and the development of primary symptoms, and then the actions between the primary, local symptoms, and the constitutional form of disease. This necessitated a consideration of time within the disease's progression, a consideration integral to pathological thinking about disease. Fellow surgeon, and notorious critic of Hunter, Jesse Foot also made mention of a specific time frame in which these symptoms operated. 'Every disease hath its characteristick [*sic*] marks, in the beginning, the middle, and the end. It would be contrary to the laws of nature to look for incipient symptoms at the end of disease.'[348] It was these characteristic marks that were the clues for Hunter, Foot and others to ponder on the action of the disease.

Logically for Hunter, the next question was by what means the poison moved inside the body from these first irritations, to affect the whole constitution. This line of pathological inquiry, into the very actions of the poison in the body, often necessitated more than just an observation of symptoms coupled with a comparison with internal lesions after death, and many practitioners turned to experimentation to help explicate their theories. Hunter explained the inward

[347] Ibid., p. 28.
[348] Foot, *Observations upon the New Opinions of John Hunter,* p. 91.

movement of disease as an action not of the poison itself, but of the body's lymphatic, or absorbent system, a relatively new discovery in the eighteenth century.[349] The first reference to the absorbent vessels, referred to as the lacteals, of the lymphatic system was made in 1622 by Italian physician Caspar Asellieus who located the minute vessels in a live dog he was dissecting, when the animal died however, the vessels immediately disappeared.[350] As Asellieus was 'not rash enough to open a living man' in order to investigate whether these absorbing vessels were present in humans, knowledge and understanding of the lymphatics did not come to the fore until the mid eighteenth century, as developments in microscopy and the pathological anatomy allowed practitioners access to the smaller structures of the body.[351] John Hunter himself performed several experiments to ascertain the purpose of the vessels, injecting fluids into the 'canals of various living animals' only to find these fluids wound up not in the blood, where he expected them, but in the lacteals.[352] Thus he posited that it was the absorbing action of the lymphatic system that drew the venereal poison into the body from its first application to the exterior body.

For Hunter, the process of absorption of the disease into the body highlighted a crucial prognostic relationship between the external and constitutional symptoms of the disease, with the external, local effects having an important role to play in charting the progress of the disease in the constitution. It was the absorbent system that drew the disease into the body, yet it was also the

[349] Cunningham, *The Anatomist Anatomis'd*, p. 421.
[350] John Sheldon, *The History of the Absorbent System, Part the First, Containing the Chylography or Description of the Human Lacteal Vessels, with the Different Methods of Discovering, Injecting and Preparing them and the Instruments used for these Purposes Illustrated by Figures, By John Sheldon, Surgeon F. R. S. Professor of Anatomy in the Royal Academy of Arts, and Lecturer of Anatomy, Physiology and Surgery*. (London: Printed for the Author, and may be had in his House in Great Queen-Street, Lincoln's Inn-Fields, 1784), pp. 21–22.
[351] Ibid., p. 22. See also Cunningham, *The Anatomist Anatomis'd*, p. 241.
[352] Hunter, *A Treatise on the Venereal Disease,* p. iv.

action of that system that produced secondary external symptoms, what Hunter termed 'intermediate complaints' such as ulcers, rashes and buboes that were thrown up locally by an infected constitution attempting to dispel the irritating poison.[353] As Hunter wrote '[b]etween the first and second kind, or the local and constitutional, certain intermediate complaints take place in the progress of absorption; these are inflammations and suppurations forming what are called buboes, in which the matter is of the same nature with that of the original disease.'[354] Unsurprisingly, it was Jesse Foot who took issue with this particular theory arguing that '[t]o look for local complaints, which produced the constitutional disease, again to be reproduced out of the constitutional disease, would be absurd indeed, unless disease were like a circle, where every part was a continuation; or unless a man was to die of the lues venerea, and to rise again with a gonorrhoea!'[355] Foot in fact developed his own particular theory of venereal disease published as his *New Discovered Fact of a Relative Nature in the Venereal Poison* in 1790, in which he stated that 'the venereal fluid produced through infection imparted by another subject, will be harmless to the subject who secrets it'.[356] After numerous experiments, Foot had discovered that if the pus from a primary symptom such as a chancre were applied to another part of the same patient's body, it would not produce any symptoms, meaning a person then could not be infected twice by the same poison. Foot claimed that this countered Hunter's assertion that the chancre caused the constitutional disease, which likewise caused more external symptoms.

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[353] Ibid., p. 254.
[354] Ibid., p. 23.
[355] Foot, *Observations upon the New Opinions of John Hunter,* p. 91.
[356] Jesse Foot, *New Discovered Fact of a Relative Nature in the Venereal Poison. By Jesse Foot, Surgeon*. (London: Printed for T. Becket, Pall-Mall, 1790), p. 6.

Hunter's *Treatise* was not just a textual discussion of the symptoms, actions and nature of venereal diseases; it also included several images that seem, at first, to be at odds with his discussion of the nature of the disease. There are seven plates in all, six showing various conditions affecting the penis and bladder, mostly involving stricture in the urethra, and one displaying a selection of surgical instruments. Like the earlier examples of images by his brother William as well as Govard Bidloo, Hunter used images of specific specimens drawn to capture all of their detail, both symptomatic and accidental, even showing the presence of the tools of dissection. In one figure, showing 'the bladder and penis of a person who died of a mortification of the bladder in consequence of a stricture and stone in the urethra', we can clearly see the cannula that was passed along the urethra during treatment (fig. 2.5). The image too does not shy away from showing the pathological changes in the part, showing the stricture itself, just below the stone, as well as labelling the parts of the bladder which had been subject to pathological change, resulting in 'its coats a little thickened, and its inner surface fasciculated'.[357]

[357] Hunter, *Treatise on the Venereal Disease*, plate iv.

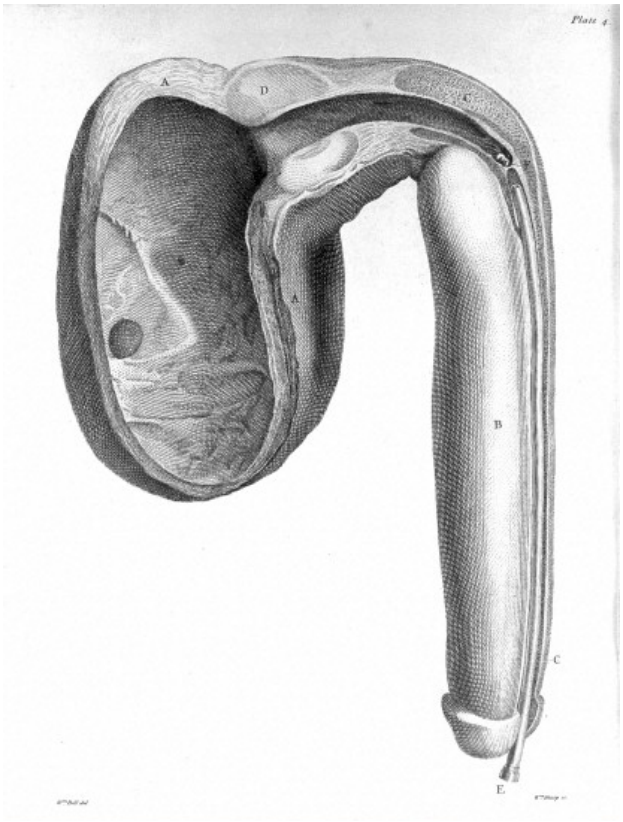

Figure 2.5. Penis showing the cannula in the urethra. Engraving from John Hunter, *A Treatise on the Venereal Disease* (London, 1786), plate iv. Image courtesy of the Wellcome Library, London.

What confuses the modern viewer of Hunter's images is that they appear not to show any of the actual symptoms of venereal disease; rather they refer to the third part of Hunter's treatise, which dealt with diseases arising as a consequence of venereal inflammation. Whilst we know that Hunter collected many pathological preparations that displayed both the cutaneous and internal symptoms of venereal disease, he chose instead to include plates showing images of these ancillary afflictions such as stricture.[358] Hunter does not discuss the plates at any length within the text and they appear at the end of the book, almost as an afterthought. However, when we consider the nature of the topic, the lack of representation of any of the uniquely venereal symptoms makes more sense. Pathology was not crucially focused on the symptoms alone and it was only one

[358] Quétel, *A History of Syphilis*, p. 81.

part of a set of observational and experimental practices utilised to discern an action or cause of disease. This necessarily complicated the idea that any characteristic symptom, even if one could be discerned for venereal disease, could define the whole disease. In pathological thought, a symptom alone said very little.

Depicting Dermatology

As Matthew Baillie was producing his pathological atlas in the early years of the nineteenth century, another burgeoning discipline was getting to grips with the use of images to lend itself professional credibility; dermatology. Literary theorist and philosopher Mikhail Bakhtin has written that it was the eighteenth century that saw a shift in understandings of the body from one governed by openness, and volatility, to a 'bourgeois' body, individuated and limited by its tangible boundary, the skin.[359] The skin was a phenomenon, which, largely thanks to pathological developments, especially the histopathology of those like Bichat, had by the late eighteenth century gained an identity as an organ in its own right, rather than just a surface that contained the body's fluids, and had accordingly become susceptible to its own class of diseases.[360] Diseases of the skin intrigued several medical practitioners during the eighteenth century; London surgeon-turned-physician Daniel Turner (1667–1741) had published *De Morbid Cutaneis: A Treatise of Diseases Incident to the Skin* in 1714, and Viennese surgeon Joseph

[359] M. I. Bakhtin, *Rabelais and his World*, trans. Hélène Iswolsky (Bloomington: Indiana University Press, 1984). See also Mechthild Fend, 'Bodily and Pictorial Surfaces: Skin in French Art and Medicine 1790–1860', *Art History*, 28 (2005), p. 312; Gail Kern Paster, *The Body Embarrassed: Drama and the disciplines of shame in early modern England* (Cornell University Press, 1993), p. 2; Séverine Pilloud and Micheline Louis-Courvoisier, 'The Intimate Experience of the Body in the Eighteenth Century: Between Interiority and Exteriority', *Medical History*, 47 (2003), p. 467.

[360] Steven Connor, *The Book of Skin* (London: Reaktion Books Ltd., 2004), pp. 24–35.

Plenck (1732–1807) advanced a rudimentary nosological system for cutaneous disease in 1776 as *Doctrina de morbid cutaneis*. Yet although these investigations led to a more prominent discussion of skin diseases by the end of the century, these debates remained nebulous and unstructured. It was to be physicians Robert Willan (1757–1812) and Thomas Bateman (1778–1821), both from Yorkshire but based in London, who made the first full systematic investigation into skin diseases.[361]

The emergence and growth of dermatology in the early nineteenth century inaugurated what Foucault has referred to as 'the paradoxical reactivation of classificatory thought' in the nineteenth century, with the first central figures of the discipline committed to the construction of nosological systems based on symptoms alone.[362] As a Quaker, Willan was barred from entering Oxford or Cambridge so took his medical degree at Edinburgh University where he was heavily influenced by the nosological system of Cullen.[363] Following this he moved to London in 1783 where he worked extensively at the Carey Street Dispensary, spending the next seven years treating a massive variety of skin complaints, during which time he began to formulate his nosology.[364] He divided skin disease into only eight orders, termed 'papulae', 'squamae', 'exanthemata', 'bullae', 'pustulae', 'vesiclae', 'tubercula' and 'maculae', relatively few in

[361] John Thorne Crissey, Lawrence Charles Parish and Karl Holubar, *Historical Atlas of Dermatology and Dermatologists* (New York: The Parthenon Publishing Group, 2002), pp. ix–x. Others have written against this, arguing that more attention should be paid to forerunners of Willan such as Plenck, see for example Karl Holubar, 'The Rise of Western Dermatology: The London, Paris, and Vienna Schools and Their Influence on the Development of the Dermatologic Alphabet', *International Journal of Dermatology*, 1:7 (September, 1989), pp. 471–474.
[362] Foucault, *Birth of the Clinic*, p. 161.
[363] Christopher C. Booth, 'Robert Willan MD FRS (1757–1812): Dermatologist of the Millenium', *Journal of the Royal Society of Medicine*, 92 (June, 1999), p. 313.
[364] Ibid., pp. 314–315. See also J. A. Savin, 'Dermatology in Edinburgh: The first 100 years', *British Medical Journal*, 289 (22–29 December, 1984), p. 1763,

relation to his forerunner Plenck, who had postulated fourteen.[365] Willan was obviously convinced of the importance of images to the burgeoning discussion of cutaneous diseases. There is evidence he was happy to diagnose diseases based on drawings of symptoms sent to him without needing to actually see the patient.[366] In *Cutaneous Diseases*, Willan included thirty-three plates, with the first being a visual 'definition' of sixteen commonly occurring cutaneous eruptions such as 'scurf', 'crusts', 'rashes' and 'tubercles' (fig. 2.6).[367] Writing a history of their discipline, dermatologists Lawrence Charles Parish and John Thorne Crissey have stated that this plate 'could well be considered the most important dermatologic illustration ever published'.[368] Crucially Willan considered these characteristic symptoms to be the most important appearances of disease, rather than any internal lesions.

[365] Robert Jackson, 'Historical outline of attempts of classify skin diseases', *Canadian Medical Association Journal*, 116 (21 May 1977), p. 1165. See also Thomas Bateman, *A Practical Synopsis of Cutaneous Diseases According to the Arrangement of Dr. Willan, Exhibiting a Concise View of the Diagnostic Symptoms and the Method of Treatment. By Thomas Bateman, M.D. F.L.S. Physician to the Public Dispensary, and to the Fever Institution. Second Edition.* (London: Printed for Longman, Hurst, Rees, Orme, and Brown, Paternoster-Row, 1813), p. xi–xii.
[366] Booth, 'Robert Willan', p. 816.
[367] Robert Willan, *On Cutaneous Diseases: Vol. 1: Containing ord. I. Papulae: ord. II Squamae: ord. III Exanthemata: ord. IV. Bullae* (London: Printed for J. Johnson, 1808), p. 12.
[368] Crissey et al., *Historical Atlas of Dermatology and Dermatologists*, p. xi.

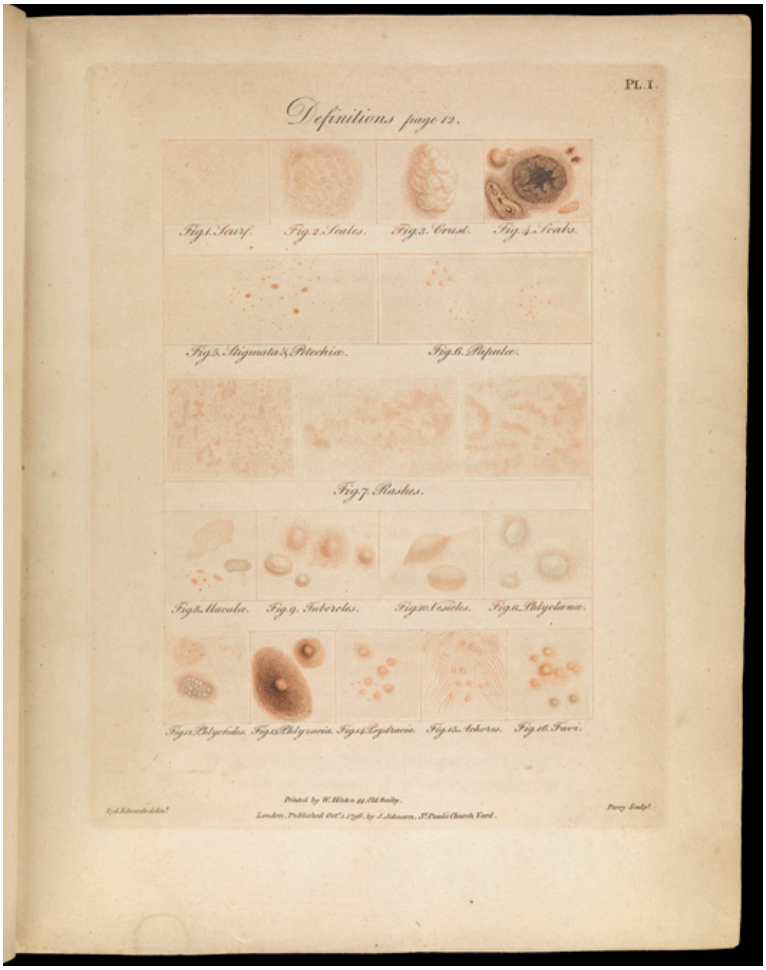

Figure 2.6. Definitions. Coloured engraving in Robert Willan, *On Cutaneous Diseases* (London, 1808). Image courtesy of the Wellcome Library, London.

Willan died in 1812 before he could complete the work on his second volume of cutaneous diseases, but the system proved so popular that Thomas Bateman, Willan's student and colleague at the Carey Street Dispensary, purchased the copyright to his mentor's writings, drawings and engravings in the hope of completing the publication of the system. In 1813, only a year after Willan's death, Bateman published *A Practical Synopsis of Cutaneous Diseases According to the Arrangement of Dr. Willan*, an octavo-sized volume intended as 'the completion of that original work' of Willan's, which covered not only the

four orders Willan had already published on, but also the remaining four.[369] As he was in something of a hurry to produce the *Synopsis*, Bateman did not incorporate the numerous images that his predecessor had, and included just one plate. Situated at the beginning of the volume it consists of eight small squares each demonstrating the key symptoms of one of the eight orders, intended to serve as a convenient diagnostic aid for dispensary and hospital physicians (fig. 2.7).[370] In composition, style and intention is it similar to the 'definitions' plate of Willan's.[371] However, whereas Willan's defined sixteen different forms of cutaneous eruption, Bateman chose to limit his images to the defining characteristic eruptions of each of the eight orders, stating that,

> I am fully aware, that it is very difficult to convey by words, used in an acceptation that is not familiar, distinct notions of many of the minute changes of appearance in the skin; and that one great deficiency, which Dr. Willan's larger work was calculated to supply, by means of the engravings which accompanied it, will be left unprovided for by this Synopsis. Perhaps, however, this defect will be partially obviated by the plate prefixed to this volume, in which I have endeavoured to convey an idea of the fundamental principles of the classification, as well as to designate the characters of some of the more remarkable genera of cutaneous disease.[372]

Without the need to take into account the whole history of the disease, from cause, to symptom, to action, to pathological changes, Willan and Bateman's only issue with visual representations was choosing which appearances could be deemed characteristic. Providing an overview of these 'fundamental principles' for a classification system that limited every possible cutaneous symptom to a mere

[369] Bateman, *A Practical Synopsis*, p. v.
[370] Booth, 'Robert Willan', p. 316.
[371] Willan, *On Cutaneous Disease*, p. 12.
[372] Bateman, *A Practical Synopsis,* p. xviii.

eight categories, necessitated an identification of the unifying characteristic of each set of symptoms, whether this was texture, colour or shape. So within each of the different squares we can discern a variety of distinct forms of cutaneous eruption, yet most are united by one characteristic quality.

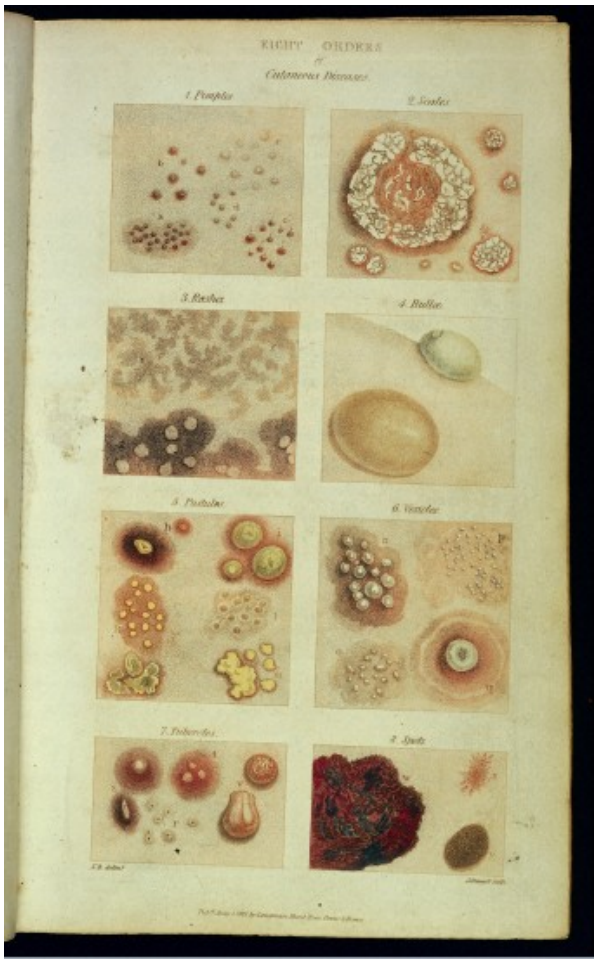

Figure 2.7. Eight orders of cutaneous diseases. Coloured lithograph in Thomas Bateman, *A Practical Synopsis of Cutaneous Diseases* (London, 1813). Image courtesy of the Wellcome Library, London.

Some squares demonstrate the symptom diachronically, such as the fourth, illustrating the order of *Bullae*, which 'shows the *bullæ* of Pompholyx diutinus, in different stages of their progress'.[373] Here, the two symptoms, though differing in size and colour, demonstrate a unity of shape and texture, with both taking the form of smoothly textured, rounded boils that sit upon the skin surface. By

[373] Bateman, *A Practical Synopsis*, 'Explanation of the Plate'.

contrast the third square, showing different forms of rashes, depicts two different coloured and patterned symptoms, but both are essentially flat stains on the skin rather than eruptions. Other squares instead depict a wider range of sub-forms of the key symptoms, such as the fifth square, *Pustules*, which shows the sub species *phlyzacia* as they typically appeared in 'Ecthyma vulgare', 'Scabies purulenta upon the hands', 'Impetigo', 'Porrigo scutulata, on the scalp', among others.[374] Here, each eruption, though differing in size and shape share a yellowish green colour surrounded by a pale pink or red coloured corona. It is more difficult to discern the unifying characteristic in the final square, 'spots'. Bateman's explanation states that this figure shows very different types of eruption that were still classed as Maculae.[375] In this case, the symptomatic varieties of Maculae defied the identification of a characteristic appearance, and so Bateman chose to focus on the inherent vagaries of the group. As the small book was intended as a pocket-sized companion for working practitioners to use as a diagnostic tool on hospital wards, the demonstration of the wide variety of symptoms defying a generic classificatory appearance seems practicable largely because in a clinical situation diseases often defied any so-called characteristic symptoms.

The lack of more detailed and clinically useful images in Bateman's publication perturbed many a reader, with one review stating that '[t]he *Synopsis* is now in every physician's library who pretends to any diagnostic skill; but accurate as the descriptions are, language is so inadequate to conveying a perfect idea of objects of sight, that every one, who has had frequent occasions of consulting the work, has had occasion to regret the want of plates'.[376] Bateman

[374] Ibid.
[375] Ibid.
[376] 'Review of *Delineations of the Cutaneous Diseases comprised in the classification of the late Dr Willan*', *Edinburgh Medical and Surgical Journal*, July 1815, p. 370.

himself was evidently frustrated with the lack of images as, in 1817, he published what came to be considered as the second and concluding part of Willan's initial 1808 publication, covering the remaining four orders; *pustules*, *vesicles*, *tubercles* and *maculae* in detail, which he titled *Delineations of Cutaneous Diseases*. Here Bateman attempted to make up for the perceived deficiency of the *Synopsis* by including many of Willan's original plates, as well as employing other practitioners and artists to create new illustrations. Like Willan, Bateman was a firm proponent of the value of visual representations to dermatology. Believing that this value lay in more than just accurately illustrating characteristic symptoms, he explicitly linked the process of classification with the work of visual representations. After readdressing the notion that cutaneous diseases were well suited to nosological systems such as Willan's, he pronounced that '[t]here is another circumstance, however, which renders the diseases of the skin equally capable of methodological classification with the other objects of natural history, namely, the facility of representing them by drawings.'[377] Certainly for Bateman, and indeed Willan, being able to visually represent a phenomenon made it much easier to classify.

Indeed, dermatology is a discipline that seems to have emerged dependant on such visual representations, evidenced by Willan and Bateman's early devotion. Because of the focus on symptoms as the basis of the discipline it may seem that it would be easier for dermatologists to discern appropriate appearances of disease to display, however this was clearly not an indiscriminate

[377] Thomas Bateman, *Delineations of Cutaneous Diseases: Exhibiting the Characteristic Appearances of the Principal Genera and Species Comprised in the Classification of the Late Dr. Willan; And Completing the Series of Engravings Begun by that Author. By Thomas Bateman, M.D., F.L.S. Librarian of the Medical and Chirurgical Society of London, Honorary Member of the Literary and Philosophical Society of New York, and Physician to the Public Dispensary, and to the London House of Recovery*. (London: Printed for Longman, Hurst, Rees, Orme, and Brown, Paternoster-Row, 1817), p. iv.

representation of every disease they came across, and in each book, conspicuous by its absence, is any depiction of the cutaneous manifestations of venereal disease. Here we come to the problem of the characteristic appearance; if the disease under question seems to defy such essential traits, how does one represent it visually? Bateman stated his difficulty outright, writing at the very end of *Synopsis* '[in] the course of this Synopsis, I have made only cursory allusions to a very important class of cutaneous eruptions, which are often the source of considerable embarrassment to the practitioner; I mean those which are the result of the venereal poison.'[378] The reason he gave for this omission was that

> these eruptions assume such a variety of forms, that they bid defiance to arrangement according to their external character; and, in fact, they posses no common or exclusive marks, by which their nature and origin are indicated. There is perhaps no order of cutaneous appearances, and scarcely any genus or species of the chronic eruptions, already described, which these secondary symptoms of Syphilis do not occasionally resemble.[379]

Whilst undeniably an important area of their study, venereal disease was to these early dermatologists an obstinate, protean disorder, which actually defied Willan's system and accordingly revealed little of its nature to the practitioner. As for Cullen in the preceding century, for Willan and Bateman the nosological system revealed the natural order of diseases, and any condition that did not fit within the system was to remain clouded in obscurity.

Bateman's only advice for the practitioner was that a 'practiced eye' could recognise the slight anomalies in frequently recurring cutaneous symptoms, such

[378] Bateman, *A Practical Synopsis,* p. 328.
[379] Ibid., p. 328.

as unusual colouring or size, which would indicate a venereal origin.[380] Following this, he reviewed all eight orders of symptoms and suggested in what ways they might vary from their typical characteristics in venereal cases. For example, if a patient was labouring under a syphilitic form of Lepra or Psoriasis, 'the patches are seldom so large as those of Lepra vulgaris, commonly not exceeding the size of a silver penny or of a sixpense [*sic*]; their base is of a darker red, or coppery hue, which, however, differs considerably in different instances'.[381] Bateman ended this section with a plea for caution, stating that consideration of the eruptions alone was not sufficient to diagnose a venereal case. 'The previous history of the patient, and especially as to the occurrence of the primary symptoms of Syphilis, the length of time that may have subsequently elapsed, &c. must then be taken into consideration, and the diagnosis determined from a careful and comprehensive view of all these circumstances.'[382] Even if nosologists claimed the symptom was the basis for defining diseases, venereal disease could not be diagnosed by attention to symptoms alone and a close attention to the temporal axis of the disease – the sequence in which these symptoms appeared – was considered necessary in clinical situations. Again in *Delineations*, Bateman reiterated the problem with visually representing venereal disease by drawing attention not only to the protean nature of the symptoms, but the confused theories of the disease itself. He wrote that 'the subject has been rather perplexed than elucidated by the most recent experiments; and it would be presumptuous, in the present state of our knowledge, to attempt to determine the character of the eruptions of true syphilis'.[383] It is understandable then that there are no

[380] Ibid., p. 329.
[381] Ibid., p.229–230; pp.330–331
[382] Ibid,, p. 334.
[383] Bateman, *Delineations of Cutaneous Diseases,* p. vi.

accompanying visual representations of these venereal eruptions in *On Cutaneous Disease*, the *Synopsis*, or *Delineations*.

Not all practitioners were as cautious as Willan and Bateman though and venereal, or syphilitic, diseases did make appearances in medical works of the early nineteenth century. However those works that did deploy such images of venereal disease could come under fire for not exercising enough caution in depicting this most protean of conditions, and falsely, or accidentally, claiming to represent a characteristic appearance. The first dermatological atlas published in France was *Descriptions des maladies de la peau* by Jean Louis Alibert (1768–1837) in 1806, a lavish work, imposing in both physical size and content. France was a key site for the nineteenth-century development of dermatology, thanks in a large part to Alibert's work at the Hôpital St Louis in Paris, where he worked as a physician from 1802.[384] Unlike Bateman, Alibert showed little caution in attempting to visually represent venereal disease and *Descriptions* included several plates showing images of patients with syphilitic symptoms, variously affecting the faces, limbs and genitals. Crucially, these images were not an exhaustive visual account of the range or type of symptoms venereal disease provoked, and after listing what was already a baffling array of syphilitic pustules, Alibert added that '[t]elles sont les variétés de la syphilide pustuleuse que j'ai eu occasion de rencontrer à l'hôpital Saint-Louis. Je ne doute pas qu'il n'y en ait un plus grand nombre, dont je m'abstiens de parler, parce qu'elles ne se sont point présentées dans le cours de mes observations.'[385] A confirmed devotee of clinical

[384] Wolfgang Weyers, *The Abuse of Man: An Illustrated History of Dubious Medical Experimentation* (New York: Ardor Scribendi, 2003), p. xiii.
[385] '[s]uch are the varieties of the syphilitic pustules which I had occasion to meet at the Hôpital Saint-Louis. I do not doubt that there is a greater number, of which I abstain from speaking, because they did not present in the course of my observations.' Jean-Louis-Marc Alibert, *Descriptions des Maladies de la Peau, Observées a L'Hopital Saint-Louis, Et Exposition Des*

observation, Alibert did not speculate on symptoms he had not personally witnessed.

Alibert's atlas reflected his idea of the character of the hospital. As historian of medicine Stephen Jacyna has noted, Alibert viewed the St Louis as a theatre in which the central spectacle was the various striking manifestations of cutaneous disease. In his own introduction to *Descriptions*, Alibert states that his intention with the atlas was 'to emphasize and to contrast more the characteristics of skin diseases, to fix their finest nuances, in a word, to strike the senses of my readers, and to reproduce vividly before them the various phenomena that have amazed my gaze.'[386] Though he used the word 'characteristics' it is clear that Alibert was uninterested in discerning the characteristic appearance of a specific class of disease as Bateman had done, but rather, his purpose was to demonstrate the variety of symptoms of 'skin disease' in general. That his aim was to 'strike the senses of my readers' is clear from his sumptuous images that are a world away from, for example, Bateman's introductory plate in the *Synopsis*. In one image, Alibert shows an individual patient, with symptoms specific to her unique case, in stark contrast to Bateman's abstracted patches of skin that demonstrate a multitude of definitive symptoms that would not have been seen together on the skin of one particular patient, but were instead designed to demonstrate the salient characteristics of each class of diseases (fig. 2.8). Alibert's patient is dressed, her hair arranged under an intricately patterned scarf, and there is almost a trace of a smile on her face. This is a theatrical presentation of the disease, emblematic of

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Meilleures Méthodes Suivres Pour Leur Traitement; Par J. L. Alibert, Médecin de L'Hopital St-Louis, Et Premier Médecin Ordinaire de Roi, Professeur A L'École de Médecine, Membre de L'Académie Royale de Paris, Etc. Deuxième Édition, Enriches D'Appendices. Tome Second. (Bruxelles: Auguste Wahlen, Imprimeur-Libraire, 1825), p. 242. My translation.

[386] Alibert quoted in L. S. Jacyna, 'Pious Pathology: J. L. Alibert's Iconography of Disease', in Caroline Hannaway and Ann la Berge (eds), *Constructing Paris Medicine* (Amsterdam/Atlanta, GA.: Rodopi, 1999), pp. 192–193.

the flamboyant character of a physician who once referred to a prostitute suffering from venereal disease as 'a priestess of Venus wounded by a perfidious dart of love'.[387]

Figure 2.8. Syphilide pustuleuse en grappe. Coloured engraving after G. Moreau Valvile, in Jean Louis-Marie Alibert, *Descriptions des Maladies de Peau* (Paris, 1833), plate 45. Image courtesy of the Wellcome Library, London.

In a review of Bateman's *Delineations*, one Scottish writer for the *Edinburgh Medical and Surgical Journal* praised the work, lamenting that there was little worth reading on the subject before Bateman, and denouncing Alibert by saying that his 'costly work… only proves how unfit he is for the task he has undertaken'.[388] Indeed, though *Descriptions* was read widely in Britain, many practitioners found that Alibert's nosological system of cutaneous diseases lacked

[387] Alibert quoted in Crissey et al., *Historical Atlas of Dermatology*, p. xii.
[388] 'Review: *Delineations of the Cutaneous Diseases comprised in the classification of the late Dr Willan*', p. 370.

the elegant simplicity and efficacy of Willan's, and in 1829 Laurant Biett a colleague of Alibert at the Hôpital St Louis abandoned his system in favour of Willan's.[389] In 1833 physician John Paget, attempted to provide a clarification of Alibert's system, concluding that his *Descriptions* was 'a series of splendid engravings, but deficient in arrangement and nomenclature', whereas, '[t]he system of Willan, from its apparent simplicity and certainty, was generally adopted throughout England, and extensively on the Continent; while the work of Alibert was confined to comparatively few.'[390] Likewise, Bateman himself denounced Alibert's system, arguing that 'with loud pretensions to superior skill, and much vaunting of the services which he has rendered this department of medicine, [Alibert] has, in fact, contributed nothing to the elucidation of the obscurity in which it is veiled', adding that '[t]he merit of his publication belongs principally to the artists, whom he has had the good fortune to employ'.[391]

Indeed an earlier review in the *Edinburgh Medical and Surgical Journal* chastised Alibert for his hubris in claiming that none before him had ever attempted such as project as the *Descriptions*, referring him several times to Willan for his dedication to nosology as well as his use of images. The same review though agreed with Paget's judgement and stated that many of the deficiencies of Alibert's system were made up for by his illustrations. However, although '[t]he richness and beauty' of the engravings was accepted, the journal was less certain of their medical utility.

> But we may safely question the taste and propriety of exhibiting together, the glowing tints of ruddy health and beauty with the disgusting representation of

[389] Conner, *The Book of Skin*, p. 24.
[390] John Paget, 'View of Baron Alibert's Classification of Diseases of the Skin', *Lancet*, 13 July 1833, p. 491.
[391] Bateman, *A Practical Synopsis,* pp. xii–xiii.

> scald heads, or the utility of so much finery and expense to furnish blocks for the representation of plica, of the hair convoluted and matted together into parcels or separate locks; as correct an idea of which might have been suggested to the reader, by simply referring him to a mop, or to the figure of the Mandarin on his china cup. In short, comparing these with the engravings in Willan, we remark, that if in splendor [*sic*] and general effect the French artist has excelled, the British artist has some advantage in the minute and accurate delineation of the characteristic shades of disease.[392]

Though Alibert's artistry was to be admired then, it was also to be treated with caution as it had the potential to undermine the veracity of the image. We can see this tension in the combination of 'ruddy health' and the 'disgusting' symptoms of disease played out in the image of the woman with syphilitic afflictions on her face. Though clusters of pinkish pustules dominate much of her nose and forehead, the complexion of her healthy skin is bright, her cheek is flushed and redolent of a neoclassical ideal of beauty that the reviewers of the *Edinburgh Medical and Surgical Journal* evidently found distasteful in this context.

The type of disease too is at issue in Alibert's images. The reviewers selected the example of the plate illustrating plica as an extraneous image that offered nothing more to the reader's understanding than a simple analogy with a mop would have. Jacyna explains the inclusion of the plica image, which shows a Polish beggar called Thomas Quart with his hair and beard matted into long spikes, by invoking Alibert's penchant for the unusual, with plica being a relatively rare condition in France, as well as a moralistic trend in Alibert's work

[392] 'Review: *Description des Maladies de la Peau, observées à l'hopital Saint Louis, et Exposition des meilleures methodes suivies pour leur traitement. Avec Figures colorées*. Par J. L. Alibert, Medicin de cet Hopital, et du Lycée Napoleon, Membre de la Société de l'Ecole et de celle de Medicine de Paris, de l'Academie Royale de Medicine de Madrid, de l'Academie Imperiale des Sciences, Belles Lettres et Arts du Turin, de College de Medicine de Stockholm, &c., &c. Folio. à Paris. 1806. 1ere et 2ed Livraison.', *Edinburgh Medical and Surgical Journal,* October 1807, pp. 449–450.

which saw him regard the disease as a punishment for what he saw as Quart's degenerate lifestyle.[393] Rather than being intended as a useful descriptive image of the disease for fellow medical practitioners, Alibert's inclusion of plica can therefore be considered more as an example of his perception of the hospital as a site of spectacle and theatre.

However the issue of the artistry of an image potentially detracting from its value as a depiction of disease is complicated when we return to Bateman's *Delineations*. Here, Bateman and his artists reproduced many of the stylistic flourishes that seemed to most annoy the reviewers of the *Edinburgh Medical and Surgical Journal*, for instance, the depiction of beauty amongst the ugliness of the disease. This is perhaps most obvious when plates from Willan's original work were reproduced. Bateman announced in the introduction to *Delineations* that, many in his profession had implored him to produce the second half of Willan's system, including images.[394] Bateman fully intended to comply with these requests, however he deemed some of the original illustrations inferior and hoped to improve upon them in his new publication.

One striking example of this improvement is that of *Psoriasis gyrata*, which he stated had been 're-engraved' in *Delineations*.[395] In the 1808 image from Willan's original work the image showed the back of a patient, who could be male or female, with a rash spreading in a worm-like pattern on their back, and indistinct circular patches of pale skin on the neck (fig. 2.9). There are no clothes or blankets visible and the patient is sitting up straight. Unquestionably, the image is about the symptom lacing its way across the back of a nondescript torso. When

[393] Jacyna, 'Pious Pathology: J. L. Alibert's Iconography of Disease', p. 198.
[394] Bateman, *Delineations of Cutaneous Diseases*, p. v.
[395] Ibid., p. v.

we compare this with the 're-engraved' image in Bateman's *Delineations*, the differences are striking. In Bateman's image we see the patient is almost certainly female, much more of the surrounding detail is shown, such as the left arm, cut off in the original but here resting loosely on a pillow (fig. 2.10). The woman is leaning more to the left than in the earlier image, almost reclining on the bed, and is draped in sheets in much the same way as many of Alibert's patients appeared. The soft folds of the drapery and the relaxed position of the patient here is evocative of contemporary neoclassical artistic conventions for portraying female nudes.[396] The symptoms are indeed clearer in the second image, with the eruptions on the back of the neck shown in full, yet many of the changes Bateman and his artists made to this engraving have little to do with further explicating the symptoms, and more to do with the overall aesthetics of the image. However, this is an unusual level of stylistic flourish in Bateman's work as the majority of the illustrations within do not show any extraneous detail beyond the symptom on the body part, usually an abstracted limb or patch of skin and occasionally a face. Each of Bateman's illustrations still essentially acted as an example of the characteristic symptoms of particular diseases, unlike most of Alibert's. What Bateman still did not depict of course, were the symptoms of venereal disease. Just as venereal disease itself seemed to defy neat nosological classification, the cutaneous symptoms of the disease seemed to both Bateman and Willan, to defy representation.

[396] Jacyna, 'Pious Pathology: J. L. Alibert's Iconography of Disease', p. 186.

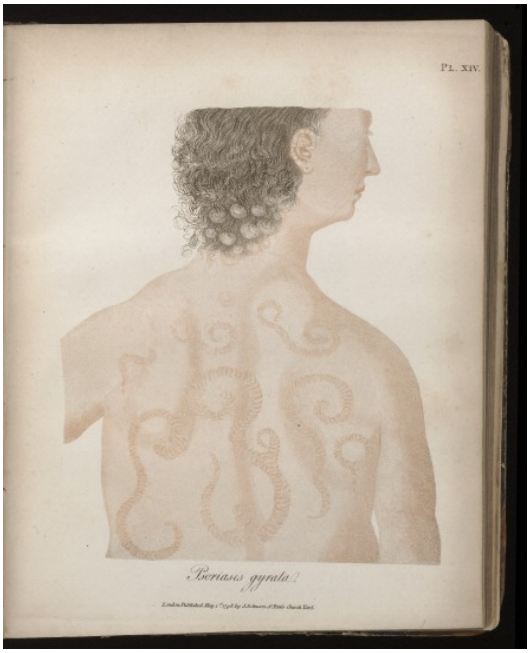

Figure 2.9. (left) Psoriasis gyrata on the back. Colour plate in Robert Willan, *On Cutaneous Diseases* (London, 1808), plate XIV. Image courtesy of the Wellcome Library, London.

Figure 2.10. (right) Psoriasis gyrata re-engraved. Colour plate in Thomas Bateman, *Delineations of Cutaneous Diseases* (London, 1849), plate XII. Image courtesy of the Wellcome Library, London.

Alibert though was not the only practitioner who considered it useful to visually represent the disease. One other practitioner was Irish surgeon Richard Carmichael (1779–1849) who in 1814 published *An Essay on Venereal Diseases*. Influenced by Willan and Bateman's nosologies of cutaneous diseases, Carmichael's treatise attempted to accurately systematize venereal disease itself into four distinct orders, using four plates to illustrate the characteristic symptoms of each of these groups. Carmichael was a highly esteemed surgeon, a member of the College of Surgeons of Ireland, employed at a number of institutions over the course of his career including St George's Hospital and Dispensary and later the Richmond Hospital, where he would go on to found the school of medicine known as the Carmichael school. He published widely on cancers, scrofula and venereal disease and was the first Irishman elected a corresponding member of the

French Academy of Medicine in 1835.[397] His long-running interest in venereal disease was first kindled in 1810 when he was appointed surgeon to the Dublin Lock Hospital and four years later he published his *Essay on Venereal Disease* based heavily on case studies he had encountered at the hospital.

Carmichael's system was predicated on his assertion that there were too many venereal diseases that practitioners conflated with syphilis which were not the result of a *true* syphilitic poison. This, he lamented, resulted in many patients being poisoned and made worse by the effects of being prescribed, and over-prescribed, mercury. According to Carmichael, mercury could only ever be effective in cases of venereal disease that were the result of the true syphilitic poison, which, judging by the complexity of his system, were relatively rare. This system depended on a rigorous and minute observation of symptoms, as the difference between what Carmichael deemed a syphilitic and a non-syphilitic chancre was often as subtle as an 'induration', a hardened edge, to the eruption. The system sought to distinguish syphilis from the many variations of venereal disease that were not brought on by the syphilitic poison. Instead of referring to all venereal diseases as 'pseudo-syphilitic' they were to be properly distinguished as specific forms of venereal disease distinct from those that arose because of the syphilitic poison. Carmichael's system divided venereal disease into four orders 'papular', 'pustular', 'phagedenic', and finally 'that disease which I have hitherto distinguished by the name of syphilis (but which has been extended by other writers to every description of venereal disease, although it is probable that every other was known in Europe before it) may with much greater advantage be

[397] J. B. Lyons, 'Carmichael, Richard (1779–1849)', *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004) [Consulted at http://www.oxforddnb.com/view/article/4707, (12 June 2011)].

denominated the *Scaly Venereal Disease*'.[398] He provided a table of symptoms characterising the appearances of each of the orders asserting that,

> a classification of venereal complaints, grounded on the character of the eruption, is not only the most natural, and most in accordance to the pathological arrangement of other eruptive diseases attended with fever, but it is also, in a practical point of view, the most useful that can be devised;- for the general tendency of the disease either with respect to mildness, severity or duration may be anticipated by the character of the eruption.[399]

Carmichael, like John Hunter, posited that the cutaneous manifestations of venereal disease were crucial in prognosticating the course that the constitutional disease would take.

Before going on to elucidate his four orders of venereal disease though, Carmichael devoted the first chapter of his treatise to considering 'those morbid poisons which stand in nearest relation to the syphilitic, and evidence of the existence of venereal diseases which do not arie [*sic*] from that poison'.[400] For Carmichael, the sheer variety of venereal symptoms meant that venereal disease could not possibly be considered as one condition. Instead he argued that there was a specific disease called syphilis that arose in Europe at the end of the fifteenth century, which began with a chancre followed by constitutional effects, and that could be cured by mercury. However there were also a whole host of other diseases, some venereal, some not, which practitioners often confused with

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[398] Richard Carmichael, *An Essay on Venereal Diseases, and the Uses and Abuses of Mercury in their Treatment. Illustrated by Drawings of the Different Forms of Venereal Eruptions. Second Edition. By Richard Carmichael, M.R.I.A. Vice-President of the Royal College of Surgeons in Ireland, and one of the Surgeons of the Richmond Surgical Hospital, Dublin. &c. &.c &c.* (London: Printed for Longman, Hurst, Rees, Orme, Brown, and Green, Paternoster-Row, 1825), p. 69.
[399] Ibid., pp. 363–364.
[400] Ibid., p. 1.

syphilis, inducing them to immediately prescribe mercury to deleterious effect in the patient. Amongst those he recognised as similar in appearance but not venereal were Yaws; Sivvins, a skin disease prevalent in Scotland; Radesyge, a similar complaint found in Norway, and Button Scurvy, a skin condition common amongst Dublin's poor.[401] To explain the occurrence of venereal diseases which were not the result of the syphilitic poison, Carmichael asserted that '[t]he organs of generation are subject to a variety of ulcers, destitute of the characteristics of chancre' as 'the very organization, secretions, and functions, of the genitals, dispose them to ulceration beyond all other parts of the body'.[402] Carmichael's identification of a multitude of local, cutaneous afflictions that were often misdiagnosed as syphilis was not unique; however most practitioners, when considering the specificity of venereal diseases, were concerned with differentiating between syphilis and gonorrhoea, discussed in chapter one of this thesis.

Carmichael complicated the idea of merely dividing venereal disease into these two by breaking it down into four distinct types of disease. Carmichael attributed each of these types to the action of four distinct poisons, whereas gonorrhoea he posited as a primary symptom of some of these poisons.[403] The fourth order, which Carmichael defined as the 'scaly venereal disease' was what he considered to be the only truly syphilitic form of venereal disease. Carmichael used both primary and secondary cutaneous symptoms to distinguish between the

[401] Ibid., pp. 2–16.
[402] Ibid., pp. 17–19.
[403] 'Review: *Part Second. An Essay on the Venereal Diseases, which have been confounded with Syphilis, and the Symptoms which exclusively arise from that Poison. Illustrated by Drawings of the Cutaneous Eruptions of true Syphilis, and the resembling Diseases*. By Richard Carmichael, M.R.I.A. President of the Royal College of Surgeons in Ireland, and one of the Surgeons of the Lock Hospital, Dublin. 4to. Pp. 116. Longman and Co. London, 1814.', *Edinburgh Medical and Surgical Journal*, July 1815, p. 373.

four states. The primary symptoms he noted were the chancre, 'or callous ulcer', and buboes, whereas the secondary symptoms were 'scaly blotches, presenting either the character of lepra, or psoriasis', ulcers on the tonsils, pains in the joints, skull and leg bones and nodes on the bones.[404] The scaly venereal disease was also the only order where mercury was prescribed for all symptoms. For the other three orders mercury was often explicitly contraindicated. 'Mercury unnecessary in any stage;' ran the therapeutic advice for certain secondary symptoms of papular venereal disease, adding that it would be 'highly injurious until the eruption desquamates, the fever is subdued, and the disorder is evidently on the wane'.[405]

Carmichael's strategy for visually representing his four classes differs considerably from Bateman's visual 'definitions' of his eight classes. Carmichael took both primary and secondary symptoms into consideration when visually representing, demonstrating his lack of concern for a temporal element to disease. A defining symptom for him could be at any stage. The plate accompanying the scaly order of venereal disease presents four figures showing a variety of secondary symptoms, delimited by Carmichael's system (fig. 2.11). The figure in the bottom left corner shows the back of the neck and shoulders of a patient labouring under the 'syphilitic lepra' which Carmichael described as 'spots' which 'form a firm elevation above the surrounding surface and the circumference of each spot is still more elevated than its centre'.[406] Carmichael also included in the figure 'a spot covered by a thick crust which has proceeded to ulceration' on the patient's shoulder. This figure represents two distinct stages of the same symptom visible on one identifiable patient, with the early development of the

[404] Carmichael, *An Essay on the Venereal Diseases*, p. 371.
[405] Ibid., p. 365.
[406] Ibid., pp. 364–365.

spots shown on the neck, and a later stage of the symptom on the shoulder. This shows the disease in situ, its real temporal manifestations on the body of the patient. Carmichael also deployed more abstracted images and on the same plate, to the far right is a single circular eruption, completely removed from any bodily context which Carmichael labelled, 'a single syphilitic blotch, of a medium size, on the same patient.' Indeed, all four of the figures included on the plate were from the same patient, with the symptom on the chest being labelled 'syphilitic psoriasis' and the symptom on the groin a 'copper-coloured blotch… partly degenerated into an ulcer'.[407] Indeed, while each image on the plate ostensibly demonstrates an important, though not characteristic, symptomatic moment, when taken together, the four figures represent a diachronic view of the secondary symptoms. We see them separated visually on the page but are told that they all manifested on the same patient, the different stages of the syphilitic lepra shown explicitly on the lower left figure. Thus no one symptom is deemed to be characteristic; instead, each is shown to be dynamic and developing.

[407] Ibid., pp. 364–365.

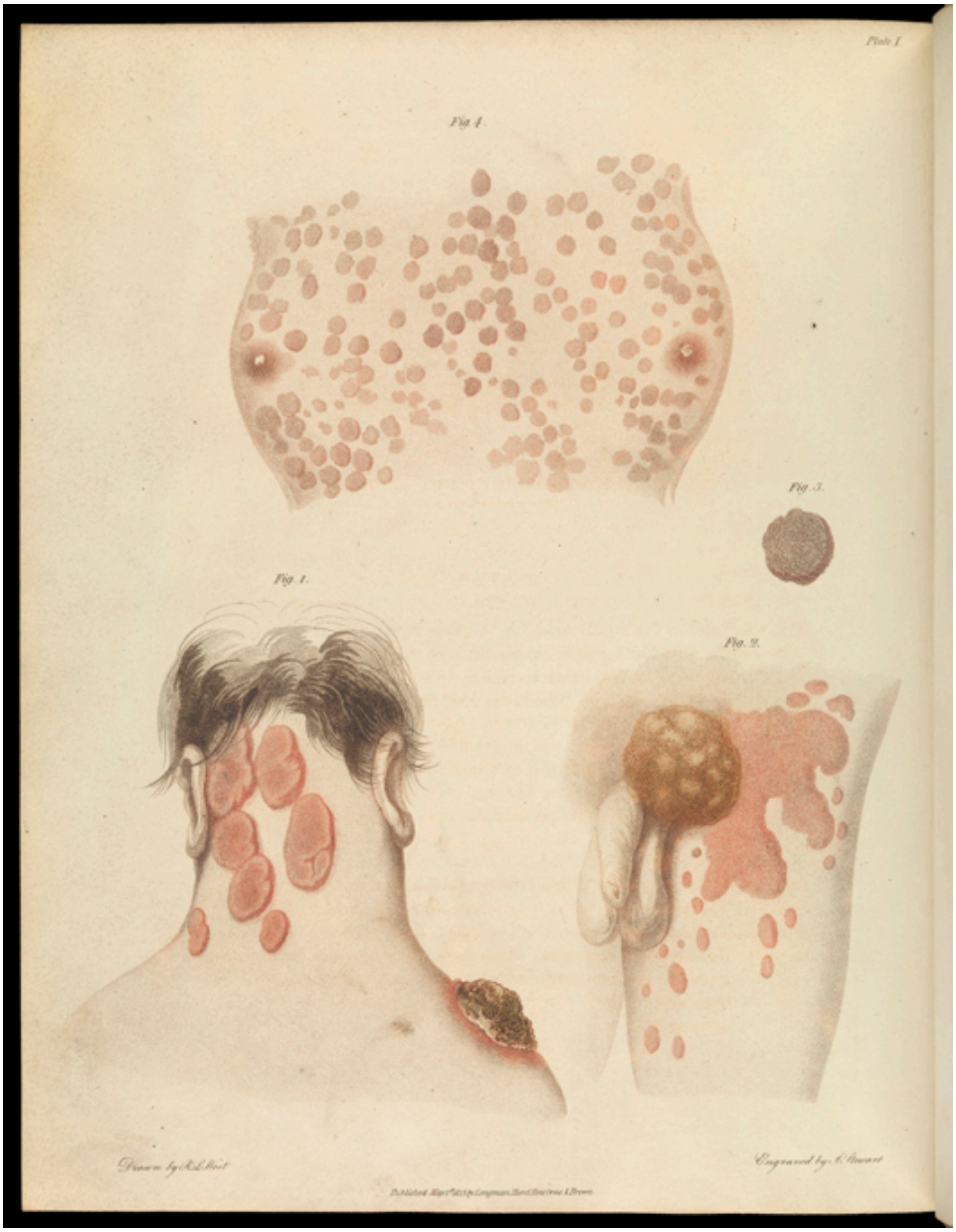

Figure 2.11. The Scaly order of venereal disease. Drawing by R. L. West, engraving by J. Stewart, in Richard Carmichael *An Essay on the Venereal Diseases* (London, 1814). Image courtesy of the Wellcome Library, London.

Carmichael's was a devoted and concerted effort to systematize venereal disease; to not to be overwhelmed by the sheer number and variety of symptoms but to embrace them, and use them to demystify the very disease they were considered to cloud. The medical press though did not react favourably to it, with several reviews accusing Carmichael of attempting to formulate a theory based on

insufficient clinical experience, and asserting that 'his doctrines will not stand the test of experience, but will prove at variance with more extended observation.'[408] The *Medico-Chirurgical Review* asserted that the four orders were based too heavily on primary eruptions alone, allowing Carmichael to ignore many of the numerous varieties of secondary venereal symptoms that had bewildered other practitioners wishing to accurately categorise venereal disease. The journal complained that 'he finds it easy to dispose of, in their appropriate places under the name of the eruption which belongs to their respective species, the numerous symptoms, both primary and constitutional, of venereal disease which are so various, as seemingly to bid defiance to any attempt at arrangement.'[409]

The images were a particular sticking point for many reviewers. The *Edinburgh Medical and Surgical Journal*, though accepting Carmichael's assertion that too many symptoms were diagnosed as syphilitic when they were not, was not impressed with the images he used to demonstrate this fact. On the plate demonstrating scaly venereal disease just discussed here, the journal complained that they could not look at these symptoms only,

> and assent to the statement, that no other eruptions than these require the full impregnation of mercury for their cure, or are the result of the true primary symptoms of syphilis; nor do the other three or four cutaneous appearances, which he has delineated, comprise a twentieth part of the various affections of the skin which are seen in the cachetic states, which follow primary ulcers in some part of the body, or arise where no such ulcers have been seen.[410]

[408] 'Review: *Part Second. An Essay on the Venereal Diseases*', p. 371.
[409] 'Mr Carmichael on the Venereal Disease', *The Medico-Chirurgical Review,* 1 October 1825 p. 443.
[410] 'Review: *Part Second. An Essay on the Venereal Diseases*', p. 371.

Recalling the words of a surgeon who had worked at the London Lock Hospital for thirty years and who had still professed an inability to attain a complete knowledge of the symptomatic forms of venereal disease, the reviewer went on to further disparage the supposed utility of the images, implying that they could be no replacement for experience in a hospital.[411] Carmichael addressed the negative press the first edition of his *Essay* had received in the 1825 edition, as he introduced the work by writing, '[t]he novelty of the views, as well as the numerous host of facts adduced, perplexed the profession at that time not a little; and were it not for the authenticity of the latter, the former, by their boldness and opposition to long established opinions, would have been totally disregarded.'[412] However the later edition did not fare much better than the first in the press with the *Lancet* professing to be unimpressed with the images. Not, however, with their quality, which they deemed to approach 'the excellences of Willan and Bateman', but instead in their number, bemoaning that 'it would not have been difficult for Mr. Carmichael to have enumerated half a dozen more, and then we should have had as many more plates to illustrate the varieties of patches on the body, which these ulcers would occasion.'[413] For the *Lancet* the images were potentially effective, but this potential was attenuated by their scarcity.

Conclusion

That the *Lancet* bemoaned the lack of images Carmichael provided demonstrates the extent to which the fortunes of the pathological image had changed. Images now had the potential to become useful, powerful even, within these new systems,

[411] 'Review: *Part Second. An Essay on the Venereal Diseases*', p. 371.
[412] Carmichael, *An Essay on the Venereal Diseases*, p. v.
[413] 'Review: Carmichael on the Venereal Disease', *Lancet*, 30 April 1825, p. 113.

however they had to negotiate the nuances of their disciplines. Visual representations were becoming the basis of new fields such as dermatology, evinced by Willan and Bateman's use of them, and pathology demonstrated by Matthew Baillie, and they would go on to play a central role in both disciplines. This was a new form of medical image, far removed from the display of health and vitality that the anatomical atlases of the early modern period had demonstrated. However to visually represent venereal disease successfully, practitioners had to negotiate not only the issues involved in portraying dead and diseased flesh, but also the theoretical foundations of their conceptions of disease. For early pathologists, such as Baillie, representing venereal disease itself in an image was impossible as the disease was a complex grouping of external symptoms, internal lesions, and invisible actions and causes. Instead, Baillie chose to focus on the changes of structure commonly found in the bones, which coincidently were common effects of venereal disease. For Carmichael, ostensibly a nosologist, the focus was the symptoms alone, regardless of what time they appeared on the body during the course of the disease. They were the basis for differentiating the various forms of venereal disease, so he considered their visual representations of great use to other practitioners.

These differing images then demonstrate the multitude of varying conceptualisations of venereal disease coexisting in early nineteenth-century medical discourse. Furthermore, the example of venereal disease demonstrates that visually representing disease successfully required a nuanced consideration of what symptoms could be representative that went far beyond Daston and Galison's simple 'characteristic' image.[414] The images discussed above

[414] Daston and Galison, *Objectivity*, p. 82.

demonstrate that venereal disease itself did not have one easily locatable and agreed upon characteristic. The characteristic symptom was not the only appearance used to represent disease in the medical sphere, and in order to explore the wealth of representational practices surrounding venereal disease it is necessary to go beyond the clean pages of the atlas, to examine the more workaday images produced within medical discourse. Therefore this thesis now moves on to the murky everyday world of the London Lock Hospital.

3

Medicine, Art and Venereal Disease at the London Lock

Figure 3.1. No. 113 Charles Crowther. Watercolour by J. Holt, 17 July 1849. RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

On Tuesday 17 July 1849 Charles Crowther sat naked from the waist up in the London Lock Hospital, an institution devoted to curing only those, like Crowther, who suffered from venereal disease. Behind him an artist rendered in watercolour paint the rash spreading across his back (fig. 3.1).[415] On Thursday Crowther once again found himself before the artist, head tilted back and open mouthed, focusing distractedly upon the ceiling (fig. 3.2). Crowther evidently did not recover well, and in May of the following year, he once again found himself in the hospital and before the artist. By this time, the effects of the disease had taken their toll. The small rash visible on his forehead in July 1849 had spread over his head leaving him almost bald, his scalp was covered in sores that also marked much of his face. This time, he did not sit for the painter, but lay back in his bed whilst the artist worked, staring into the distance almost serenely, in stark contrast to the very noticeable violence of his symptoms (fig. 3.3).

[415] The black patches across Crowther's back are likely a discolouration brought on by Holt's use of 'flake white', a lead based white pigment that, when used in watercolours, darkens when in sustained contact with hydrogen sulphide in the air. This discolouration is visible in a number of Holt's images, meaning the original colour was likely a pale flesh tone made from a mixture of white lead. See Gregory D. Smith, Alan Derbyshire and Robin J. H. Clark, 'In situ Spectroscopic Detection of Lead Sulphide on a Blackened Manuscript Illumination by Raman Microscopy', *Studies in Conservation*, 47:4 (2002), pp. 250.

Figure 3.2. No. 113 Charles Crowther. Watercolour by J. Holt, 19 July 1849. RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

Figure 3.3. No 38 Charles Crowther. Watercolour by J. Holt, 7 May 1850. RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

It is likely that Charles Crowther eventually recovered and was discharged. The annual report of the hospital for the year 1850 recorded that there was only one death in house, 'from an accidental cause, which no human skill could have anticipated'.[416] Furthermore it is unlikely he would have been allowed to linger so long in the hospital if he was suspected to be incurable. Whatever his eventual fate, the watercolour drawings of Crowther demonstrate a visual translation of venereal disease markedly different from those seen in the pathological atlases discussed in the previous chapter. The artist, known only as J. Holt, painted patients in the Lock between July 1849 and January 1851. Around a hundred of these survive, though from his numbering scheme it is likely that Holt

[416] Royal College of Surgeons, London Lock Hospital and Rescue Home, MS0022/4/1/2, Report of the Lock Hospital and Chapel, 1850, Centenary Report of the Lock Hospital and Asylum, 1846, p. 5.

completed many more. Most depict male genitalia afflicted in a variety of ways with venereal symptoms, though there are around twenty paintings of patients' faces, such as Crowther's, that could appear almost portrait-like were it not for the very obvious marks of their disease. These images do not attempt to define venereal disease with one characteristic symptom, or even as a series of distinct stages as Richard Carmichael had. Instead they show individual patients with wildly variant symptoms, and, here and there, flashes of humanity and personality, the hints of clothing reminding the viewer that the patient is present as well as the disease. Holt's images invite us to question the changing conception of and approach to venereal disease as it moved through different spaces in London, both intellectual and physical.

The previous chapter discussed the emergence and development of systems such as nosology and pathology that were based on the clinical observation made possible by the move of medicine into the hospital. It was here that the signs and progress of disease could be monitored in life and correlated with internal bodily changes after death, essentially resituating disease within and throughout the fabric of the body. Though this Foucauldian narrative has often been based around the French situation and the post-1794 reorganisation of Paris medicine, eighteenth-century London was arguably witnessing this recognisable shift, with a large number of voluntary hospitals appearing in the capital at this time.[417] Where the London hospitals diverged significantly from the French model though was their funding model. After 1794, the new French Republic took over control of the hospitals, resulting in a centralized system of medical care that

[417] Foucault, *The Birth of the Clinic*, and Erwin Ackerknecht, *Medicine at the Paris Hospital 1794–1848* (Baltimore: Johns Hopkins Press, 1967). See also Ann La Berge and Caroline Hannaway, 'Paris Medicine: Perspectives Past and Present', in Caroline Hannaway and Ann La Berge (eds), *Constructing Paris Medicine* (Amsterdam: Rodopi, 1998), pp. 1–69.

could support much larger hospitals than charities could.[418] By contrast, the British voluntary hospitals, with the exception of the endowed St Bartholomew's and St Thomas's, were charities, dependent on wealthy donors and entirely integrated in the commercial realities of the medical marketplace. A hospital appointment was not only an opportunity for medical practitioners to gain access to a large variety of cases upon which to formulate their theories, but also a way of demonstrating their status and advertising their private practice or publications in the wider market.

A further corollary of the voluntary hospital structure is that with no centralised control there was no one regulated way to either diagnose or treat venereal disease. Historian J. N. Hays has suggested that as medical thought came to conceptualise diseases as distinct entities in the eighteenth century, a notion that they would benefit from separate sites of care and cure emerged.[419] This is possible, though it posits the hospital as a body with a unified theoretical conception of disease; in its everyday reality however, the theories of disease created and circulating within voluntary hospitals like the Lock were the theories of the individual medical staff, mostly surgeons, who worked the wards, and who were as liable to disagreement as any practitioner working from his own practice. However, the hospital situation necessitated a greater degree of co-operation between surgeons, physicians, nurses and governors, at the very least on the basic consideration of admitting patients, with all having to agree that a patient was suffering from venereal disease.[420] On a purely superficial level Holt's images can tell us much about the type of symptoms commonly seen at the hospital. One

[418] Ackernecht, *Medicine at the Paris Hospital*, p. 17.
[419] J. N. Hays, *The Burdens of Disease: Epidemics and Human Response in Western History*, (2nd edn, Piscataway: Rutgers, 2009), p. 118.
[420] Claudia Stein has written of the process of negotiating such consensus between medical staff in hospitals in early modern Augsburg. Stein, *Negotiating the French Pox*, p. 107.

common symptom depicted was the bubo. First presenting as swellings around the groin, they were liable to suppuration if left untreated. Evidently many patients did not seek treatment until the bubo burst as these were commonly recurring symptoms in Holt's drawings, presenting as long open sores extending from the groin, near the penis, across the top of the thigh. A particularly characteristic one is the case of Charles Penrose who Holt first painted on 26 April 1850 (fig. 3.4). By 1 August of the same year, Penrose was painted again this time with some change in the condition of the bubo (fig. 3.5).

Figure 3.4. (left) No. 36 Charles Penrose. Watercolour by J. Holt, 26 April 1850. RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

Figure 3.5. (right) No. 36 Charles Penrose. Watercolour by J. Holt, 1 August 1850. RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

This chapter though is not about how patients negotiated admission to the Lock, nor the treatment or cure of patients once they were inside; it is about the value of the hospital in the theoretical conceptualisation of venereal disease.[421] Indeed it is impossible to narrow down the commonly occurring symptoms that would secure a patient's admission, and if there *was* an accepted majority opinion

[421] For a history of the Lock Hospital see Williams, *The London Lock*, and for the treatment of patients see Kevin Siena, *Venereal Disease, Hospitals and the Urban Poor*.

on what venereal disease looked like, it was arguably only an agreement that it manifested in a staggering variety of symptoms. In 1799, Surgeon Henry Clutterbuck (1767–1856) wrote that given the attention lavished upon venereal disease, it was alarming that the disease was still 'so unsettled in its doctrine, and with the series and order of its symptoms, so ill described, as we find to be the case'.[422] As demonstrated in the previous chapter, there was little consensus over any characteristic symptoms of venereal disease in the atlases of medical practitioners, and the hospital was no different. I argue that the assemblage of patients labouring under such a wide range of symptoms was the defining virtue of the hospital to medical practitioners, especially those who sought to lecture and publish on venereal disease. The hospital contained the mundane everyday symptoms like buboes, as well as the explicit, the unusual, and the idiosyncratic, and it was here that this diversity could be condensed into theory. I argue that Holt's drawings were a vital part of this work in the hospital, both as recording technology for practitioners to keep track of symptoms, and for tools with which to think about venereal disease. To demonstrate their roles, this chapter looks at the writings, practices and teachings of three key individuals working at the Lock during the first half of the nineteenth century; surgeons John Pearson, Samuel Armstrong Lane and Henry Lee (1817–1898), focusing on how they formulated this multiplicity of appearances into theoretical frameworks, and the roles images played in this process.

[422] Henry Clutterbuck, *Remarks on some of the Opinions of the Late Mr. John Hunter respecting the Venereal Disease; in a letter to Joseph Adams, M. D. Physician at Madeira, Author of an Essay on Morbid Poisons. By Henry Clutterbuck, Surgeon.* (London: Printed for T. Boosey, Old Broad-Street, Royal Exchange, 1799), p. 2.

The Hospital

As introduced in the first chapter of this thesis, the Lock Hospital was founded in 1746 by surgeon William Bromfeild, in response to the growing number of London's poor afflicted by venereal disease who could not afford the consultations of licensed practitioners, the nostrums of the unlicensed, or the entry fee to any of the general hospitals.[423] One further factor in the founding of the hospital was the general optimism of medical practitioners who believed that, despite its many manifestations and horrifying consequences, venereal disease was eminently curable.[424] Aside from the admirable offer of free treatment to the city's venereal citizens, and the promise of moral reform of prostitutes in the Asylum, the Lock Hospital was particularly keen to justify its own existence by referencing this relative ease of cure. An annual report from 1796 stated that, '[t]he malady, to the cure of which the Lock-Hospital is appropriated, peculiarly requires medical assistance; and if it be neglected, or improperly treated, it must terminate fatally, by the most dreadful progress of lingering sufferings; which at the same time, it is more generally curable than most other diseases.'[425]

The emphasis on curable patients was common to all the voluntary hospitals of the eighteenth century. It was this century when the hospital ethos began to expound cure over an older focus on care, meaning most hospitals would not take patients with chronic conditions, or the mad.[426] The voluntary hospitals, because of their reliance on charity, wanted to prove their efficacy in returning the

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[423] Siena, *Venereal Disease, Hospitals and the Urban Poor*, p. 222.
[424] Williams, *The London Lock,* p. 2.
[425] Jabez Fisher, *An Account of the Nature and Intention of the Lock-Hospital, Near Hyde Park Corner. The Proceedings of the Governors and the Improvements Lately Adopted. With an Abstract of its Income and Expenditure: And the State of its Finances at Lady Day 1796. To Which is added an Account of the Lock Asylum for the Reception of Penitent Female Patients when discharged cured from the Hospital, also a list of Governors of, and Subscribers to, both Charities. By Order of the Annual General Court, held May 5th 1796*. (London, 1796), p. 3.
[426] Rivett, *The Development of the London Hospital System,* p. 24.

poor to health, and were desperate not to be seen as almshouses. Patients who were suspected to be incurable were either sent to workhouses if fit enough, or redirected to one of the few institutions intended for incurables such as one ward at Guy's Hospital.[427] Though much was made of its potential atrocious effects on the body, the eighteenth-century medical community was generally optimistic about the curable nature of venereal disease, largely thanks to its specific – mercury – and so the Lock hospital was eager to demonstrate this fact.[428] The hospital began accepting patients on Saturday 31 January 1747 with an initial thirty beds and indeed, the records reflect an impressive success rate. The first report of the hospital released in 1749 announced that during its first two years, 695 patients had been admitted, out of which 644 were discharged cured, and thirty-one remained in house.[429] The fate of the remaining twenty is not recorded; they either died in house or were discharged early as a punishment for bad behaviour. The records reflect a perhaps surprisingly low mortality rate, potentially due to the hospital's vehement adherence to admitting only those who could be cured.

Patients were only admitted to the hospital at the Thursday weekly board meetings. Like London's other voluntary hospitals, the Lock only accepted patients if they were recommended by a hospital governor, though there is evidence to suggest that patients were accepted without the requisite recommendations if the patient's parish paid the hospital two guineas.[430]

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[427] Croxson, 'The price of Charity to the Middlesex Hospital', p. 29.
[428] Williams, *The London Lock,* p. 2.
[429] Royal College of Surgeons, London Lock Hospital and Rescue Home, MS0022/6/7, A Short History of the London Lock Hospital and Rescue Home 1746 – 1906. Female Hospital and Home – Harrow Road W. Male Hospital and Out-Patient Department, 91 Dean Street Soho, W. – Compiled from records of the Hospital, Minute Books of the Board of Governors from its foundation, p. 4.
[430] Williams, *The London Lock,* p. 26.

Governor's recommendations took the form of written orders addressed to the board, reading 'I desire you will admit into your Hospital the Bearer ____ of the Parish of ____ if h__ Case entitles h__ to the Charity'.[431] The basis of this 'entitlement' is ambiguous. Potentially it refers to the severity of the individual case though far more likely, according to Kevin Siena, is that this refers to the economic situation of the nominee, whether they were 'sufficiently impoverished'.[432] A further consideration as to whether they could be considered a proper object of charity was whether they were curable, as there was no dispensation in the Lock's charity to cover incurables.[433] If satisfactorily entitled, admission orders had to be countersigned by a nurse to prove that they had never been in the hospital before. Refusing readmission was cited in most of the advertising literature of the Lock as a means of dissuading people who had already suffered the disease from returning to their licentious behaviour. This was likely based on similar policies for venereal patients at the pre-existing hospitals such as St Bartholomew's who would readmit all but venereal patients.[434]

However, there is evidence within the administrative records of the hospital that this rule was not always adhered to, with medical staff contravening official policy if they considered it likely that a patient would go on to suffer later manifestations of venereal disease. Whilst working on the women's ward, John Pearson, surgeon to the hospital from 1782 until 1818, recorded the case of a young woman named Martha Rayner admitted in July of 1798 with gonorrhoea and bubo. Martha was discharged in September of the same year convalescent yet

[431] *Centenary Report of the Lock Hospital & Asylum*, p. 19.
[432] Siena, *Venereal Disease, Hospitals and the Urban Poor,* pp. 228–229.
[433] Croxson, 'The price of charity to the Middlesex Hospital', p. 29.
[434] Siena, *Venereal Disease, Hospitals and the Urban Poor,* p. 21.

later in Pearson's notes she appeared again as a 'returned patient'.[435] As well as individual surgeons bending the law, the Lock also occasionally treated people as outpatients, rather than admitting them to the house, though this practice would not become so frequent until the mid-nineteenth century when the hospital moved site.[436] In a published account of a case under his care in 1800 Pearson recollected that after healing a patient's ulcer, Pearson discharged him, but not before giving him instructions to return. 'I knew that this patient was not perfectly cured of the Lues Venerea, I ordered him to return to the hospital, on the first appearance of any suspicious symptoms'; this he did about a month later.[437] Whether Pearson had contravened the bylaws of the hospital and readmitted him or treated him as an outpatient is unclear, however it is likely that the medical staff had a great deal of leeway when it came to circumventing the governors of the hospital. Though governors were elected each week to visit the hospital in order to ensure both the patients and staff were behaving themselves, they often ignored this duty. Reformer John Howard (*c*.1726–1790) complained in a report on the state of London's hospitals that '[g]overnors visits are often perfunctory and overlook bad state of house and mistakes of staff'.[438]

The physical building itself was also increasingly subject to change because of the medical concerns of the staff, rather than those of the governors. Upon joining the Lock in 1782 surgeon John Pearson noted that although patients labouring under infectious fevers were supposed to be denied admission to the

[435] Royal College of Surgeons, London Lock Hospital and Rescue Home, MS0022/6/1, Records of Mr Pearson, 28 July 1798–6 April 1799.
[436] Williams, *The London Lock*, p. 70.
[437] Pearson, *Observations on the effects of various articles of the materia medica,* pp. 36–37.
[438] Howard, *An Account of the Present State of the Prisons, Houses of Correction and Hospitals,* p. 36.

house, fever was rife upon the wards.[439] In 1795 he suggested the creation of four new specialist wards and three years later the hospital underwent the necessary major building works.[440] These four new wards were set out for those with infectious conditions, those 'labouring under extensive mortification', and those convalescent but not yet well enough to leave the hospital, as Pearson thought that these groups 'not only need a purer air for themselves but also contaminate the wards, and endanger the lives of other patients'.[441] This was not the first time the hospital had reorganised wards. In 1759 the Lock entered into an agreement with the Foundling Hospital whose governors paid for a special ward and nurse to attend to the children they sent to the Lock.[442] The 1798 new wards though mark more than separation of cases by gender or age as was previously the only distinguishing criteria. The four smaller wards represent the first reorganisation of the hospital space based on medical criteria, the belief that those with fevers, other infectious diseases or the convalescent needed different spaces in which to get treatment. This goes against the assertions of many historians writing about venereal disease who argue that segregating venereal patients in separate wards in many hospitals was due to cultural attitudes about the immorality of the afflicted, rather than contemporary medical theories influencing hospital space.[443] This would become more apparent in the nineteenth century as theories about the space

[439] Samuel Wright, 'A Course of Lectures on Clinical Medicine', *The Medical Times, A Journal of English and Foreign Medicine and Miscellany of Medical Affairs*, 20 February–9 October 1847, p. 169.
[440] RCS, MS0022/6/7, An Account of the Lock Hospital taken from the minute books, p. 43.
[441] Fisher, *An Account of the Nature and Intention of the Lock-Hospital, Near Hyde Park Corner*, p. 8.
[442] RCS, MS0022/6/7, A Short History of the London Lock Hospital and Rescue Home 1746 – 1906. Female Hospital and Home – Harrow Road W. Male Hospital and Out-Patient Department, 91 Dean Street Soho, W. – Compiled from records of the Hospital, Minute Books of the Board of Governors from its foundation, p. 7.
[443] For example, Kevin Siena writes 'while contemporary ethics (medical or otherwise) never prevented hospitals from treating the pox, cultural attitudes coloured the form of hospital care at every step.' Siena, *Venereal Disease, Hospitals and the Urban Poor,* p. 12.

of the hospital as being profoundly unhealthy began to emerge. 'Hospitalism' was the term used to refer to the conditions and complications that could result in a patient who had lingered too long in house.[444] Thus we begin to see how the understanding of venereal disease as a multitudinous entity shaped the form of the hospital just as the hospital environment shaped the understanding of disease.

The Artist

The hospital also determined the mode of enquiry into venereal disease. Many of the publications that medical staff produced were not the grand, theoretical ponderings on the deepest nature of venereal disease that elite surgeons such as John Hunter produced. They were much more likely to be series of case studies, such as Pearson's *Observations on the Effects of Various Articles of the Materia Medica in the Cure of Lues Venerea*, published in 1807 and based on his therapeutic practices at the Lock, or published lectures such as surgeon Henry Lee's 1854 *Pathological and Surgical Observations: Including a Short Course of Lectures Delivered at the Lock Hospital*.[445] Alongside clinical observation and pathological anatomy, the provision of large numbers of case studies that could be reworked into statistics, was a vital factor in the rise of hospital medicine.[446] The focus in the hospital was on the multiform appearances of the various venereal conditions seen. For this reason, Holt's drawings presented a perfect medium to represent and record the clinical realities of the Lock's patients. Though there is no mention of Holt anywhere in the hospital records apart from his drawings, I

[444] Rivett, *The Development of the London Hospital System,* p. 39.
[445] Pearson, *Observations on the effects of various articles of the materia medica*; Henry Lee, *Pathological and Surgical Observations: Including a Short Course of Lectures Delivered at the Lock Hospital, and an Essay on the Surgical Treatment of Haemorrhoidal Tumours* (London: John Churchill, 1854).
[446] Ackernecht, *Medicine at the Paris Hospital*, p. 15.

argue that by analysing the institutional structures of the hospital, how it was run and the place of medical practitioners, we can deduce his purpose in the hospital, and thus reveal more about the roles of the images.

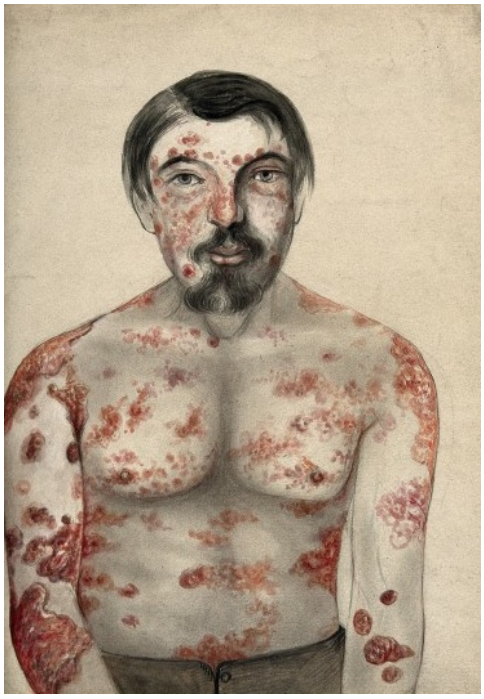
In the nineteenth century the practice of artists entering hospitals to create images of patients' conditions was not unusual. These images had a variety of purposes depending on institutional practices and individual predilections. Surgeons and physicians often used them when instructing their pupils, they filled the museums often attached to hospitals, and they were sometimes even displayed in hospitals to impress visitors.[447] Such images sometimes formed part of patient records such as those by artist Christopher D'Alton (*fl*.1847–1871) working at the Royal Free Hospital in the mid nineteenth century, his images often accompanied by scribbled medical notes. One such painting, which shows the upper body of man suffering from psoriasis and syphilis, has patient notes written on the reverse, reading '[h]istory of primaries (primary syphilis) rather obscure; eruption on arms and shoulders simple psoriasis – the face and chest decidedly copper coloured and syphilitic' (fig. 3.6).[448] D'Alton was likely an experienced medical artist; not only did he create many paintings at the Royal Free Hospital, he is also mentioned as being connected to the Medical Society of London where he was referred to as 'our able artist'.[449]

St Bartholomew's Hospital employed artist William Alfred Delamotte (1806–1872) in the mid nineteenth century to create pictures of patients that

[447] Sander Gilman describes the tale of medical missionary Peter Parker visiting Guy's hospital where a selection of patient images were on display to the visitor, though the extent of this practice in other hospitals in unclear. Sander L. Gilman, 'Lam Qua and the Development of a Westernized Medical Iconography in China', *Medical History*, 30 (1986), p. 65.
[448] 'Pencil and watercolour drawing illustrating lesions on the face, torso and arms of a man suffering from psoriasis and possibly syphilis', watercolour, Christopher D'Alton, 1866. Wellcome Library, London.
[449] John D. Hill, *A Analysis of One Hundred and Forty Cases of Organic Stricture of the Urethra: of which one hundred and twenty cases were submitted to Holt's operation, and twenty to perineal section…* (London: Churchill, 1871), p. 34.

would form the basis of the Pathology Illustration Collection for the hospital's museum in 1844.[450] As well as living patients, Delamotte also drew morbid appearances, and preparations made at the hospital (fig. 3.7). Delamotte was so convinced of the good work of St Bartholomew's that he wrote and illustrated a history of the hospital in which he hoped to show 'by many interesting records, anecdotes, and illustrations, the beneficial influence of a system prolific beyond all others in the grandeur of its institutions'.[451] The employment of an artist to the hospital's museum was evidently deemed important, and in the late nineteenth century one of St Bartholomew's staff physicians, Leonard Portal Mark (1855–1930), would fill this role, even giving a presidential address to the West London Medico-Chirurgical Society on the subject of 'Art and Medicine' in 1906.[452] Little is known of most of these medical artists, particularly in relation to how they came into contact with the hospitals who employed them. In her study of the creation of Gray's Anatomy, historian Ruth Richardson describes how the artist, Dr Henry Vandyke Carter (1831–1897), often used to advertise his artistic services in the *Lancet*, as well as gaining commissions from fellow medical men at his own hospital.[453] There is, however, no trace of how Holt came into contact with the Lock Hospital.

[450] St Bartholomew's Hospital, Pathology Museum of St Bartholomew's Hospital, GB 0405 MU/14, Pathological Illustration Collection, 1819–1950.
[451] William Alfred Delamotte, *An Historical Sketch of the Priory and Royal Hospital of St. Bartholomew: Illustrated by W. A. Delamotte* (London: Published by Hugh Cunningham, 193 Strand, 1844), p. viii.
[452] Warrington Haward, 'The Aspects of Diseases', *Lancet*, 16 July 1910, p. 161.
[453] Richardson, *The Making of Mr Gray's Anatomy*, p. 52.



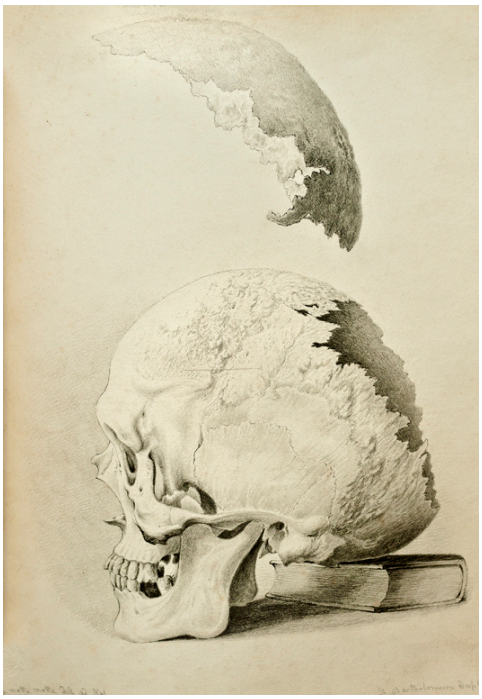


Figure 3.6. (left) Lesions on the face, torso and arms of a man suffering from psoriasis and possibly syphilis. Pencil and watercolour drawing by Christopher D'Alton at the Royal Free Hospital, 1866. Image courtesy of the Wellcome Library, London.

Figure 3.7. (right) Appearance of the Cranium. Pencil drawing by W. A. Delamotte, at St Bartholomew's Hospital, 1841. Reproduced by kind permission of the Royal College of Physicians of Edinburgh.

With the exception of his two years practicing in the Lock, Holt is completely untraceable. Around a hundred of his drawings survive, though in all probability he created more. The records of the Lock Hospital, including Holt's drawings, are held by the Royal College of Surgeons, who list the drawings under 'Patient Records'. The fact that the collection remains with the hospital records, and that each includes both the patient's name and their attending surgeon indeed suggests that the images were commissioned and utilised by the hospital itself. However, the administrative and financial records of the institution suggest otherwise, purely through omission. At the board meeting the week previous to Holt's first arrival the governors were preoccupied with struggles with the building committee, their financial shortfalls, appointing a new trustee, settling

sundry bills and choosing between competing butchers for a new meat supplier.[454] At the following week's meeting held on Thursday 19 July, whilst Holt was busy on the ward completing his second painting of Charles Crowther, the board was appointing a new house surgeon and again settling some minor bills.[455] The 19 July also saw the quarterly court of the hospital sit, where four new governors were elected and the hospital's financial auditors went through the accounts, but still no mention of Holt.[456]

This administrative silence is maintained in the minutes of the weekly boards as well as the quarterly, annual and special courts for the entire period of Holt's work in the hospital from July 1849 to January of 1851 and indicates that, as all official hospital business had to be discussed at the board meetings, the artist was not an employee of the hospital. Hospital rules and orders stated that at least three governors had to meet every Thursday at midday for this board to take care of the business of the hospital. Those expected to attend the weekly boards alongside the governors were the secretary, subscription collectors and key medical staff of the hospital. The meetings covered 'all matters relating to house keeping, repairs and the disposal of the current cash for the payment of wages, salaries and tradesmen's bills', and were also the place for the admission and discharge of patients.[457] Officers of the hospital; the surgeons, physicians, house

[454] Royal College of Surgeons, London Lock Hospital and Rescue Home, MS0022/1/1/24, Minute book, 2 October 1845–14 October 1852, 'Minutes from Thursday 12 July 1849', pp. 335–337.
[455] RCS, MS0022/1/1/24, Minute book, 2 October 1845–14 October 1852, 'Minutes from Thursday 19 July 1849', p. 339.
[456] Royal College of Surgeons, London Lock Hospital and Rescue Home, MS0022/1/3/6, General and special court book, 26 October 1848–21 January 1897, 'Minutes from Quarterly Court held Thursday 19 July 1849', p. 6.
[457] RCS, MS0022/6/7, Rules and Orders made at a general court of governors of the Lock Hospital Held 28 November 1754 and confirmed with additions and alterations by the general court held 28 April 1814.

pupils, secretary and matron were elected at quarterly courts held throughout the year, whilst nurses, the porter and servants could be appointed at weekly boards.[458]

All that remains of Holt then are the drawings he made. Based on a visual analysis, it is probable that Holt was a trained artist, rather than an artistically gifted physician like Portal Mark. Holt does not appear on any student list for the Royal Academy of Arts, so if this is the case it is likely that he was trained in drawing at one of the many small private art schools appearing around London in the early eighteenth century.[459] These frequently taught life drawing in much the same way as medical students were taught anatomy, through witnessing dissections, and schools kept large collections of medical atlases for students to consult.[460] Holt's drawings share many of the contemporary conventions of both portrait painting and anatomical drawing. A particularly striking example of this is the only full-figure painting in the Holt collection, which depicts patient Francis Sherwood standing in the traditional contraposto position utilised by artists for centuries (fig. 3.8). This is markedly similar to the standard position depicted in life drawing manuals such as French physician Julien Fau's, translated into English in 1849, which aimed to emphasize the utility of anatomy to artists. 'Artists may rest assured that Science never presumed to govern or regulate the Fine Arts', reassured Fau, 'its efforts are confined to the offering them, in a friendly way, some knowledge likely to be useful to them'.[461] One of Fau's plates

[458] RCS, MS0022/6/7, An Account of the Lock Hospital taken from the minute books, p. 13.
[459] Cunningham, *The Anatomist Anatomis'd*, p. 269.
[460] Darlington, 'The Royal Academy of Arts and its Anatomical Teachings', p. 208.
[461] Julien Fau, *The Anatomy of the External Forms of Man; Intended for the use of Artists, Painters and Sculptors By Doctor J. Fau Edited with Additions By Robert Knox, M. D., Lecturer on Anatomy, and Corresponding Member of the National Academy of Medicine of France With an Atlas of Twenty-eight Plates, Quarto* (London: Hippolyte Bailliere, Publisher and Foreign Bookseller, 219, Regent Street, Paris, 1849), p. xv.

shows a standing figure in the contraposto position that closely echoes Holt's positioning of Francis Sherwood (fig. 3.9).

Figure 3.8. No. 92 Francis Sherwood. Watercolour by J. Holt, 1849. RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

Figure 3.9. Standing male figure and skeleton. Coloured lithograph in Julien Fau, *The Anatomy of the External Forms of Man: Intended for the Use of Artists, Painters and Sculptors* (Paris, 1849). Image courtesy of the Wellcome Library, London.

There is other information in the images that might hint at the relationship between Holt and the Lock Hospital. As well as Holt's signature and the date, most of the paintings have the name of the patient, a number and the consulting surgeon noted on them. The earliest dated image that Holt painted was that of Charles Crowther on 17 July 1849, and until October of that year he seemed to have worked exclusively alongside surgeon Samuel Armstrong Lane. As the only mention of J. Holt within the official Hospital records are the signatures on each of the hundred or so watercolours, it is perhaps more likely that the artist had little to do with the hospital itself, and that his tenure there was instead linked with a particular member of the medical staff, most likely Lane. Generally, the governors of London's voluntary hospitals were not concerned with the actual day-to-day

practice of medicine. The bureaucracy of the hospital dealt mostly with feeding patients, paying staff and contractors, and admitting or discharging patients, rather than medical practice. The medical staff of the hospital was therefore effectively free from any central control and would almost certainly have had the freedom to bring in an artist to record some specific cases that interested them.[462]

Aside from the fact that Lane is noted as the surgeon for seventy-eight out of the 108 images that record the attendant surgeon's name, there are other indications that he, not the hospital, was Holt's employer. The minutes for the weekly board held on 19 September 1850 recorded that, '[o]n the application of Sam[ue]l Lane Esq. Leave was given to admit Tho[ma]s Jones as a Private Patient on payment of the usual fee'.[463] This was likely the only private patient admitted to the hospital that year as the Quarterly Court held on 16 January 1851 noted in the financial records only one 'fee from Private Patient'.[464] Two days after Thomas Jones was admitted to the hospital, Holt painted his arm showing a large open sore just above his elbow (fig. 3.10). Evidently Jones got what he paid for and made a good recovery with Holt adding another painting of Jones's arm to the original sheet just over a month later on 23 October, showing the sore almost healed. The fact that Holt created two images of a private patient admitted by Lane suggests a closer relationship between the artist and the surgeon than Holt enjoyed with the administrative workings of the hospital. Furthermore, the time at which Holt was operating in the Lock Hospital was one of enormous financial pressure for the hospital administrators, as the hospital had just relocated to a

[462] Bynum, 'Physicians, hospitals and career structures in eighteenth-century London', p. 118.
[463] RCS, MS0022/1/1/24, Minute book, 2 October 1845–14 October 1852, 'Minutes from the Thursday 19 September, 1850', p. 426.
[464] RCS, MS0022/1/3/6, General and special court book, 26 October 1848–21 January 1897, 'Minutes from the Quarterly Court held Thursday 16 January, 1851', p. 18.

purpose built site in Westbourne Green.[465] Though the move was completed by 1849, the hospital was far from being out of debt and would therefore probably be unwilling to use precious resources to aid the relatively well off surgeons.

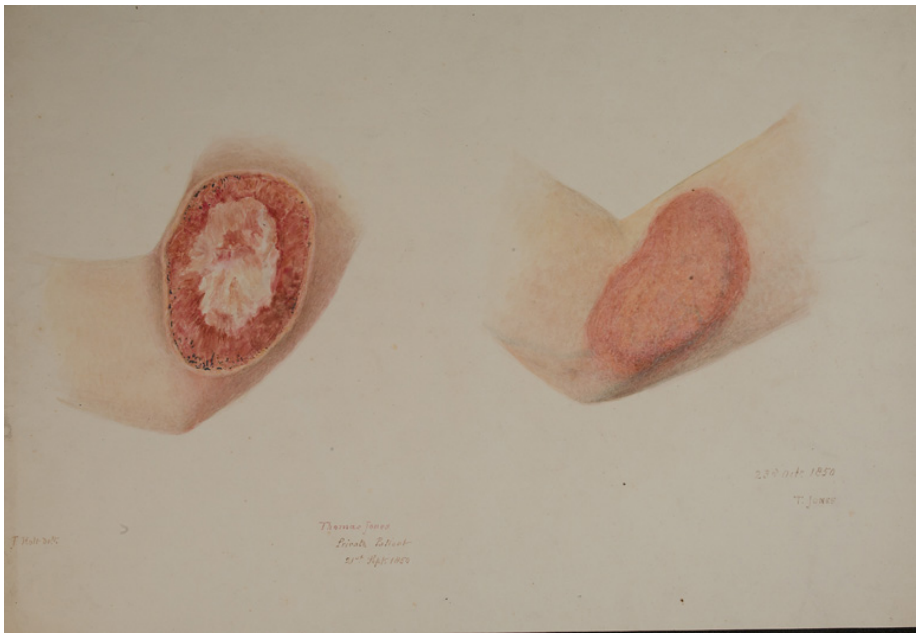


Figure 3.10. Thomas Jones. Watercolour by J. Holt, 21 September (left) and 23 October 1850 (right). RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

Samuel Lane seems a likely candidate for embracing the use of images in his work. He was trained largely at William Hunter's Great Windmill Street School of Anatomy, an institution that both reaped and extolled the benefits of the collection of visual material amassed by both Hunter brothers.[466] He also spent time at St George's Hospital as a pupil, and spent a year as a house pupil at the Lock Hospital from 1 June 1826.[467] A celebrated surgeon, in 1830 Lane established himself in the private teaching market from his house at 1 Grosvenor Place, close to St George's Hospital and the original site of the Lock Hospital.

[465] Williams, *The London Lock*, p. 70.
[466] RCS, MS0022/6/7, An Account of the Lock Hospital taken from the minute books, 'Biographical notes'.
[467] Ibid.

When, in 1827, Lane initially petitioned St George's to allow him to establish the school within the hospital, he was denied on the grounds that it would upset the patients of the house.[468] However once established next door, the hospital board had no qualms about attaching the St George's name to it. Later in life Lane was to play a large part in the establishment of St Mary's Hospital to which, according to an obituary in the *British Medical Journal*, he bequeathed 'his valuable museum and collections'.[469] Like Hunter's school at Great Windmill Street, and other private schools, it was likely that Lane managed to amass his own collection of preparations, specimens and images for use at the school. It is then possible that Lane commissioned the images to stock this personal museum, as the Lock Hospital itself did not have one.

To better gauge the supposed virtues of the images in the understandings of venereal disease in the hospital, we must look closely at what is being depicted, and what is not. What is at first interesting in the case of images drawn by Holt, who exclusively depicts venereal symptoms manifest on the skin, is the ostensible lack of drawings that show the development of such symptoms. This is a trope recognisable in other contemporary visual representations of skin conditions such as those showing the development of smallpox and cowpox inoculation sites drawn by George Kirtland and published in 1802, which chart the development of the local symptoms from day to day (fig. 3.11).[470] There are exceptions in Holt's collection, with several images devoted to depicting the progression of common localised symptoms such as the chancre or bubo seen in the pictures of Charles Penrose (figs. 3.4 and 3.5), though the practice of depicting the progression of

[468] Williams, *The London Lock,* p. 65.
[469] 'Obituary: Samuel Armstrong Lane F.R.C.S., Consulting Surgeon to St. Mary's Hospital.', *British Medical Journal,* August 1892, p. 391.
[470] George Kirtland, *30 Plates of the Small Pox and Cow Pox Drawn from Nature… by Capt. Gold R. A. Published and engraved by G. K* (London: J. Johnson, Kirtland, 1802).

symptoms does not seem to have been regularly implemented in every such case. There are several images that depict the same patient but are not so explicit in showing the development of any one symptom over time, such as the three images of Charles Crowther (figs. 3.1, 3.2 and 3.3). True, all show the same patient, yet in each, different affected areas of Crowther's body are shown, first the rash on the back, secondly his open mouth, and the third showing the disease marking his head and face. The lack of explicitly sequential images as standard practice devoted to venereal disease in the Lock collection, suggests that the purpose of many of the images was not to indicate the development of the disease, but instead to highlight a specific feature that would aid the medical practitioner's knowledge of the patient or demonstrate a relevant feature of the disease to a medical student.

Figure 3.11. Two plates, the 12th day of the small pox and cow pox. Coloured engraving in George Kirkland, *30 Plates of the small pox and cow pox* (London, 1802). Image courtesy of the Wellcome Library, London.

Arguably, especially in the second and third images of Crowther, Holt shows us more of the patient than the disease, taking care to include his clothes and the small detail of the blue stripes on Crowther's pillow (fig. 3.3). Whilst these details could be considered as medically extraneous, it could also suggest

that images of individual patients were of value. Sander Gilman has argued that the depiction of a recognisable individual as 'the bearer of a specific pathology', was an iconographic trope that reflected the medical idea 'that only single cases could be validly examined and could serve as the basis of any general medical nosology'.[471] This is especially interesting when compared with the practices of another artist employed by a hospital, this time the also elusive A. Johnson at Bethlam Asylum. Around the same time as Holt was employed at the Lock, Johnson was at Bethlam to make a series of images of patients as a source for physician Alexander Morison's (1779–1866) planned work on mental diseases. The majority of Johnson's images depict the patient 'before and after' cure, despite the fact that the mad patients do not show any outward pathology beyond a frown (figs. 3.12 and 3.13). This was redolent of a physiognomic trend in psychiatry that saw an individual's specific pathology in their facial expressions.[472] In Johnson's images though, it was also the grooming and clothing of the individual patients that demonstrated their mental state, with recovered patient's well dressed and clean. Likewise Holt's inclusion of details such as clothing and hairstyles indicates the desire for images that were more than abstracted patches of skin displaying pertinent symptoms. The personality of the patient was important, to localise the disease as a recognisable case study within the hospital.

[471] Gilman, 'Lam Qua and the Development of a Westernized Medical Iconography in China', p. 63.
[472] Sander L. Gilman, *Seeing the Insane* (Lincoln and London: University of Nebraska Press, 1996), p. 92.

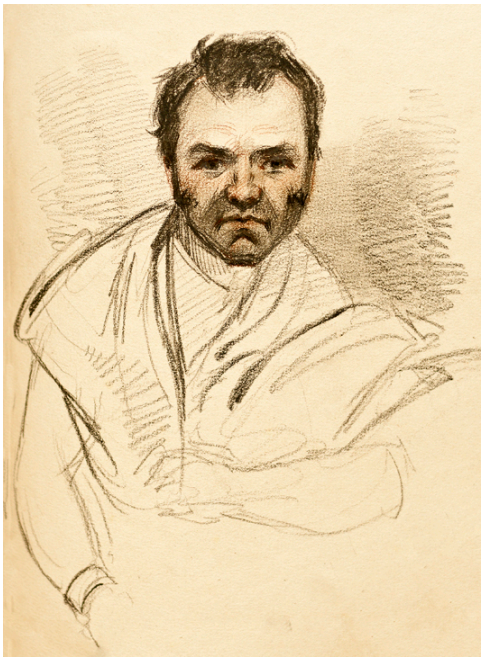


Figure 3.12 (left). J.W. suffering from Mania and very violent. Coloured pencil sketch by A. Johnson for Sir Alexander Morison, *c*.1779–1866. Reproduced by kind permission of the Royal College of Physicians of Edinburgh.

Figure 3.13 (right). J.W. recovered, remains well for one or more years. Coloured pencil sketch by A. Johnson for Sir Alexander Morison, *c*.1779–1866. Reproduced by kind permission of the Royal College of Physicians of Edinburgh.

Holt's predilection for rendering details such as blankets or clothing could also be further proof that he was not a medical practitioner, but a lay artist. In contrast to the depiction of a codified neoclassical beauty, the depiction of recognisably individual patients is suggestive of a shift in aesthetic practice to a more romantic representational style.[473] Romanticism turned away from models of beauty that the neoclassicists had promoted, and towards a commitment to the individual as it appeared in nature.[474] This trend is obvious in Holt's depictions of female patients. Throughout the history of the Lock there was generally an even split between male and female patients.[475] The hospital governors however, eager

[473] Jacyna, 'Pious Pathology', p. 186.
[474] Martin Kemp, *The Oxford History of Western Art* (Oxford: Oxford University Press, 2000), p. 304.
[475] Williams, *The London Lock,* p. 68.

to attract subscribers, emphasized the plight of the women in the advertising literature, either portraying them as wives done wrong by devilish husbands, or as poor prostitutes who could be morally reformed at the Asylum for the good health of their own souls, as well as the city of London.[476] The centenary report of the Lock bemoaned, in typically histrionic style that,

> [w]omen of irreproachable character become victims to the profligacy of their husbands; nay, infants derive the malady from their parents and nurses; while the vices of such relatives commonly so impoverish their families as to preclude them from relief, except by charity; and it may be affirmed with truth, that of the number of females received within the walls of the Hospital, very many of them have not been, strictly speaking, the vicious and abandoned, but the young, the uninstructed, and the destitute.[477]

The gender dynamics within the hospital present an uncertain facet of care. Siena has noted the importance of gender within the walls of the hospital, noting that in spite of the presence of female staff in the form of nurses and matrons, the majority of hospital staff, from administrative to medical were male, and in order to access care, 'poor women had to expose themselves before a male medical gaze, like it or not'.[478] The medical staff at the Lock certainly did not seem to show any deference to any perceived notions of female modesty in their writings. In 1854 Lee based three lectures around the case studies of three female patients in the hospital, delivering these only after he had allowed his students to see the patients themselves first hand.[479] Pearson, also used cases from the women's ward to illustrate his own lectures in 1811.

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[476] Siena, *Venereal Disease, Hospitals and the Urban Poor,* p. 192.
[477] *Centenary Report of the Lock Hospital & Asylum*, p. 5.
[478] Siena, *Venereal Disease, Hospitals and the Urban Poor,* p. 14.
[479] Lee, *Pathological and Surgical Observations*.

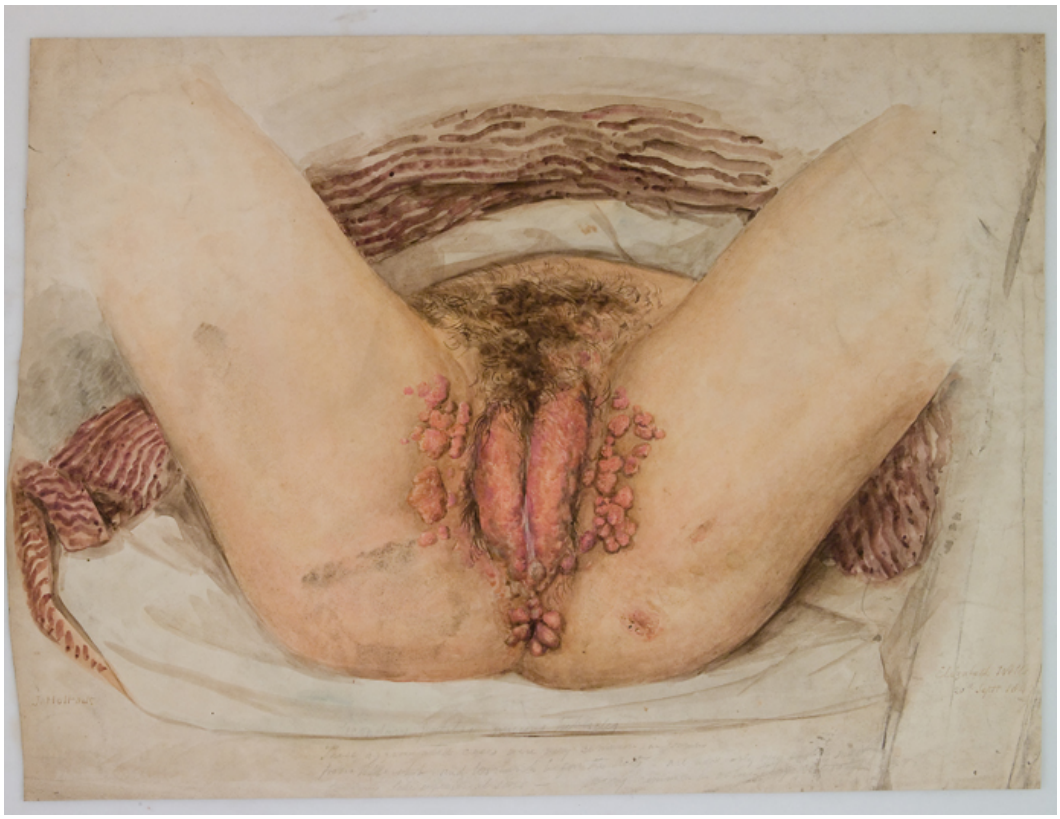

Figure 3.14. Elizabeth Wells. Watercolour by J. Holt, 20 September 1849. RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

However there are far fewer female patients depicted in Holt's images than male, and significantly fewer that depict female genitalia, with only three images showing female genitalia and forty-one representing male. One of the most graphic images is that of patient Elizabeth Wells, which Holt completed on 20 September 1849 (fig. 3.14). The first thing noticeable in this image is the shocking violence of the woman's symptoms. Legs apart she reveals massive swelling and clusters of sores covering her genitals. The close focus on the groin almost extracts the presence of the patient in the drawing, and it begins to look almost like an image of the abstracted symptoms shown in the dermatology atlases of Robert Willan and Thomas Bateman discussed in the previous chapter. It is in fact a standard visual trope in the representation of female genitalia within

medicine. We can see the same viewpoints, for instance, in the obstetrical atlas of William Hunter (fig. 3.15).

Figure 3.15. The Child in the womb. In William Hunter, *The Anatomy of the Human Gravid Uterus* (London, 1774). Image courtesy of the Wellcome Library, London.

Despite the conventional composition of the image, what also becomes apparent in Holt's image of Elizabeth Wells is the presence of the striped blanket, concealing her upper body from view; an intricately detailed concession to modesty. Mostly these details were added in the pictures that show the face of patients, the bonnets and jacket reminding the viewer that there is an individual person in the images, rather than just another set of symptoms. However in Elizabeth Well's image, with no face there to remind the viewer of the patient, the detail of the blanket almost rescues the image from becoming the 'dead meat' of other medical views of female genitalia such as Hunter's.[480] D'Alton, likely a more experienced medical artist, painted many more images of female genitalia at

[480] McGrath, *Seeing her Sex*, p. 82.

the Royal Free Hospital, depicting the same view in all its clinical glory, with no bedding or patterns to distract from the symptoms themselves (fig. 3.16). Even the skin tone is interesting, in Holt's image, the thighs of Elizabeth Wells look an almost healthy colour, with no spreading symptoms, whereas in D'Alton's we see ulcers spreading down her legs as well as covering her vagina.

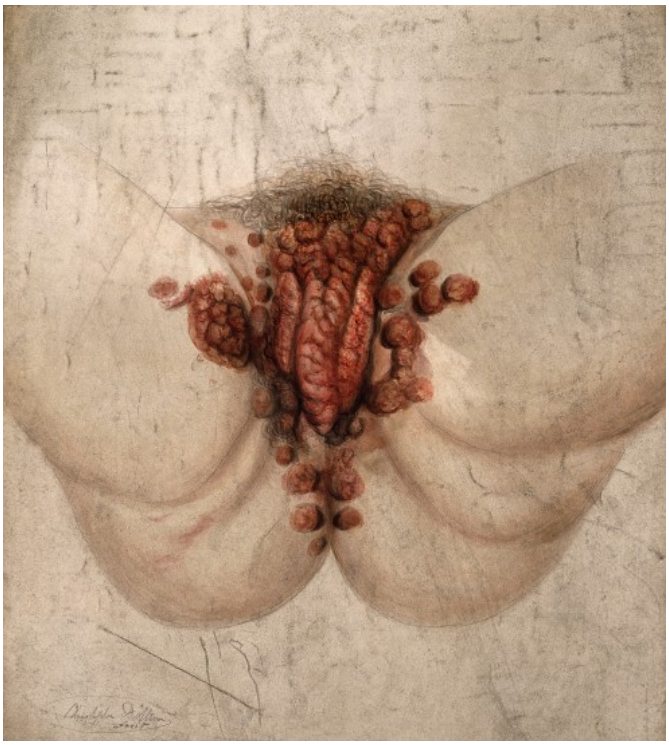

Figure 3.16. Female genitalia showing severely diseased tissue spreading to the thighs and anus. Watercolour by Christopher D'Alton at the Royal Free Hospital, 1857. Image courtesy of the Wellcome Library, London.

It is important to note here that Holt does not take the same care for his male subjects. The numerous images of male genitalia are usually shown in isolation, completely abstracted from the body of the patient and the environment of the hospital. Indeed, Holt generally takes more care over the images of female patients, especially to make sure that the details of their femininity were rendered closely and carefully. In an image of patient Emma Daly, although Holt is ostensibly showing the cluster of small pink sores on the back of her neck, he takes the time to depict the complexity of her hairstyle, infusing the patient's

gender into what might otherwise be an androgynous patch of skin afflicted by venereal sores (fig. 3.17).

Figure 3.17. Emma Daly. Watercolour by J. Holt, 23 August 1850. RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

Another intriguing element in Holt's paintings is the expressions of the patients. Charles Bell (1774–1842) was a surgeon who was fascinated with the alliances between medicine and art. In 1806 he published *Essays on the Anatomy of Expression in Painting*, which was intended to 'mark the traits of emotion, and compare them with the anatomical structure' to aid artists in the accurate depiction of the facial expression.[481] One subject of Bell's *Essays* was the face in

[481] Charles Bell, *Essays on the Anatomy of Expression in Painting By Charles Bell* (London: Printed for Longman, Hurst, Rees, and Orme, Paternoster-Row, 1806), p. 1.

pain, and in one plate he depicted the pain 'of one sick, and in some degree subdued by continual suffering' (fig. 3.18).[482]

Figure 3.18. (left) Pain of the sick. Engraving in Charles Bell, *Essays on the Anatomy of Expression in Painting* (London, 1806), p. 116. Image courtesy of the Wellcome Library, London.

Figure 3.19. (right) Soldier with missing arm, lying on his side. Watercolour by Charles Bell, 11 August 1815. Image courtesy of the Wellcome Library, London.

Bell's exemplar of the sick man in his *Essays* was echoed in his own paintings of soldiers wounded at Waterloo, where he was working as a surgeon (fig. 3.19). In Bell's images, the suffering of the patients is evident, understandable given the severity of some of their wounds. Bell's images are relentlessly realistic depictions of the individual patients' sufferings. After his death, the paintings were displayed at the Royal College of Surgeons where the *Lancet* called them 'bold and powerful water-colour sketches of the most serious and painfully instructive injuries'.[483] Holt's subjects by contrast, show little to no emotion. Though they are not suffering from the acute wounds that Bell's patients were, their symptoms are often incredibly dramatic, causing deep fissures in the flesh and disfiguring the face (fig. 3.20). The serene countenances of the Lock patients

[482] Ibid., p. 117.
[483] 'Sir Chas. Bell's "Waterloo Sketches"', *Lancet*, 24 February 1866, pp. 213–214.

then is much more demonstrative of a classical, unanimated composition of subject, evocative of a distinctly neoclassic artistic style.[484]

Figure 3.20. Unnamed Lock Hospital Patient. Watercolour by J. Holt, undated, *c*.1849–51. RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

The Surgeons

If, as I suspect, Holt was a non-medical artist employed by Samuel Lane to create the drawings, we might gain more insight into their creation and meaning by studying the surgeon's work. Lane was well placed both to commission and utilise the images, being highly active in the medical school he established and which was consequently annexed to St George's Hospital. Lane himself lectured at St George's as well as at the Lock Hospital, and was part of an established tradition of hospital teaching that had developed over the eighteenth century thanks to the

[484] Bell, *Essays on the Anatomy of Expression in Painting*, p. 6.

emerging voluntary hospitals. In the 1840s, Samuel Lane began a course of highly anticipated lectures on syphilis that were published in the *Lancet*.[485] Here this chapter turns to a close examination of Lane's lectures in order to explore his theorising on venereal disease that arose out of his exposure to such a wide range of symptoms depicted for him by Holt.

Lane's lectures utilise the abstracted and philosophical language of the published treatises on pathology examined in chapter two yet also include details that demonstrate his expert knowledge of the individuality and variability of the disease. In one lecture Lane gave a very general description of syphilis, designed to educate his audience on the general principles of the disease.

> Syphilis is one of the contagious animal poisons transferable by inoculation, capable of reproducing itself like small-pox or cow-pox, followed, as in these diseases, after a certain interval, by a primary effect at the point of insertion of the poison, and at a subsequent period by secondary or constitutional symptoms, which in syphilis affect the skin, the throat, the eye, the nose, the palate, the fibrous and osseous tissues.[486]

This description is clearly a world away from the individual cases depicted in Holt's paintings, most of which display very different manifestations from patient to patient. However, Lane was a deft educator and from an initial discussion of fixed principles, used his lecture series to demonstrate that in a clinical situation, practitioners must learn that general principles rarely apply. In a later lecture on the primary appearances of syphilis he emphasized that how the primary symptoms manifest themselves depended on the state of the patient's constitution,

[485] 'Obituary: Samuel Armstrong Lane', p. 390–391.
[486] Samuel Lane, 'A Course of Lectures on Syphilis: Lecture XI', *Lancet*, 28 May 1842, p. 294.

their general habits, and on any treatment already given, and that crucially, first appearances were rarely the same in any two patients.

> The practical inference I wish you to draw from these remarks is, that a mere pimple, an excoriation, a vesicle, a pustule, a minute ulcer, one covered with a scab or not, a superficial ulcer, a raised ulcer, a deep one, one with or without induration; a spreading ulcer, phagedenic or sloughing; a stationary one, a cicatrising ulcer; ulcers varying in form, in colour, size, or number, may contain, or have contained, the syphilitic virus, and, consequently, may be followed by the secondary or constitutional disease.[487]

Lane asserted that by paying attention to the multitude, medical practitioners could discern more accurate characteristic types to aid diagnosis. Through a close examination of the seemingly endless forms primary symptoms took, Lane postulated four stages through which the primary effects progressed. The first he called the 'pustular, or stage of origin', the second, generally occurring after about six days he termed 'the ulcerative stage', which could last from a few days to several months. Thirdly there was 'the stage of granulation', which saw new tissue forming over the wound, followed finally with that of 'cicatrisation', the healing stage.[488] Following on from this, Lane proceeded to give minutely detailed descriptions of the visual appearances of these developments, remarking for example that the first stage was marked by a small red spot at the site of infection, after a few days 'this redness has extended, and some interstitial deposition has taken place, producing the appearance of a pimple surrounded by a red areola.'[489] Lane supposed that, when used alongside a patient's history, this detailed system

[487] Samuel Lane, 'A Course of Lectures on Syphilis: Lecture XIV', *Lancet*, Saturday 30 July 1842, p. 594.
[488] Ibid., p. 594.
[489] Ibid., p. 594.

would allow the practitioner to pinpoint the time of infection and better gauge how far the disease could have worked its way into the constitution.[490]

The minutely detailed descriptions of the four stages of primary symptoms that Lane gave note the size, colour and texture of symptoms as they progress. In the same way, Holt's images visually collected this type of information in order for the practitioner to organize them into useful systems. Indeed, we might consider Holt's images as tools used by Lane to formulate these diagnostic models. In the summer of 1850 a patient named Edward Denney was admitted to the hospital and placed under the care of Lane (fig. 3.21). Holt was summarily called in and first painted Denney's symptom, a large open sore on the foreskin on 29 June. On the 16 July, Holt returned to Denney and this time depicted the same site, much smaller than it had been the previous month. The following month on 21 August, Holt's final drawing showed the sore almost perfectly healed. Unlike the three images of Charles Crowther, which depicted the patient in three different positions, demonstrating three different symptomatic appearances, the drawings of Edward Denney are unusual in that they represent a regular visual tracking of the progress of the sore during his time under treatment at the Lock. It seems almost as a complete visualisation of Lane's stages of primary infection. The virtue of the image being that it temporally arrested this progression, allowing for a comparison across time. Whilst Denney was in the Lock for around three months, Lane could see the course of his disease simultaneously. All at once the images present a series of symptoms in stasis, as well as representing a dynamic progression from symptom to cure. Indeed, the pencilled notes to the left of the

[490] Ibid., p. 597.

page read ‘edward’s sore… case in [three] stages’, indicating that this was a particularly useful set of appearances for Lane’s theoretical work.

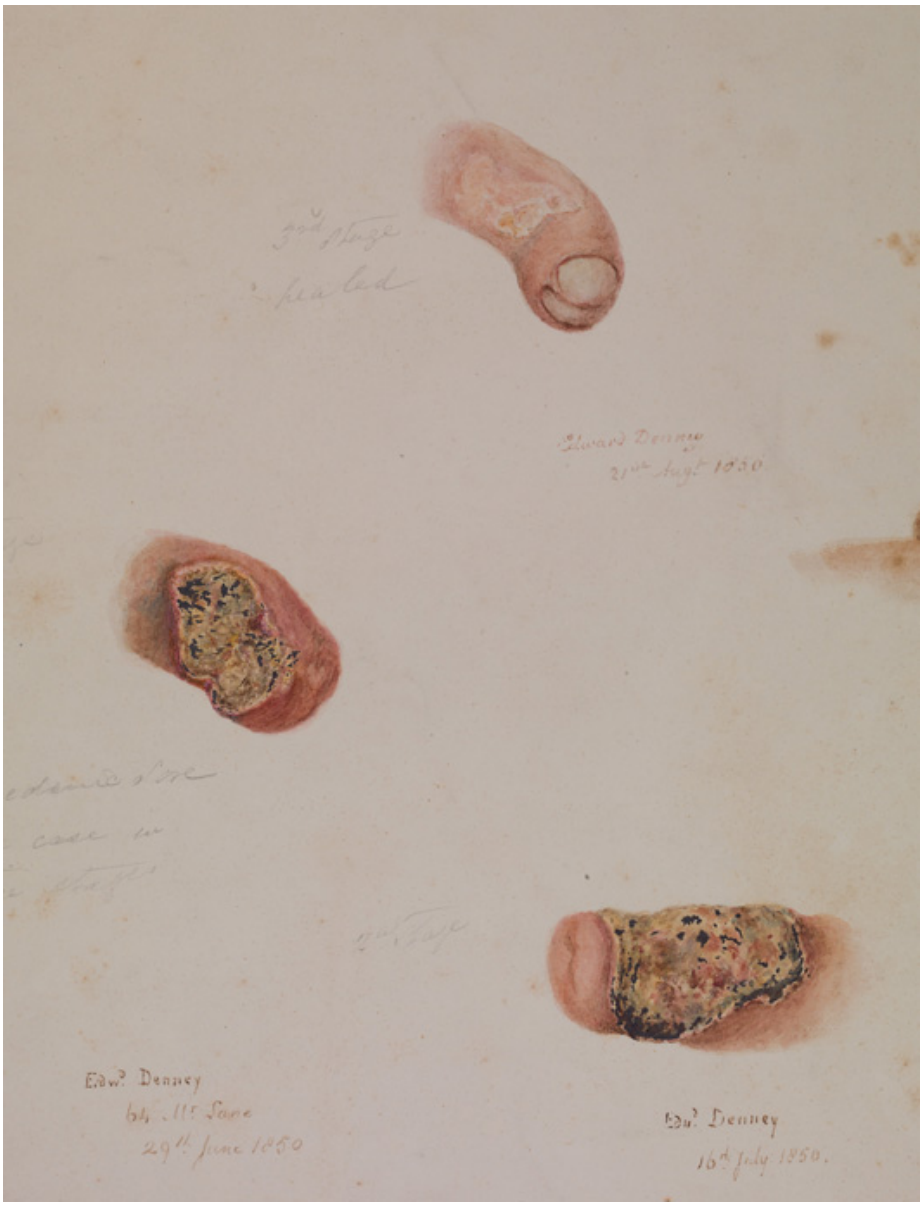

Figure 3.21. Edward Denney’s sore in three stages. Watercolour by J. Holt 29 June (middle), 16 July (bottom), and 21 August (top). RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

The use of individual cases to construct practical models was also a feature of John Pearson’s approach to venereal disease in the earlier part of the century. In 1811, Pearson began a course of lectures on venereal disease. Like Lane, Pearson was keen to point out the variations in manifestations of the disease from

patient to patient, first noting the variance in times between first connection with the disease and the appearance of symptoms, saying the usual incubation period was seven to ten days but allowing that the disease was capable of lying dormant for up to seven weeks.[491] Though deaths in house were supposed to be rare, Pearson suggests that his position at the Lock Hospital gave him access to the cadavers of patients. In Matthew Baillie's *Morbid Anatomy,* one of the examples of carious skulls depicted is credited as belonging to Pearson (fig. 2.1). Baillie noted that 'this engraving was taken from a preparation belonging to Mr. Pearson, who had the patient under his care in the Lock Hospital'.[492]

Pearson's lectures seem to be extensively comprised, not of formulated abstracts like Lane's, but of a series of graphically described case studies which his students took pains to transcribe in all their gory detail. When discussing the appearance of chancre in women, one note taker related that '[w]hen a woman has long neglected herself the ulcer will become so large & discharge a matter of offensive a nature that it is almost impossible for any one so much as inspect, the room in which she is cannot be cleaned for some days after.'[493] Pearson seems to take continued relish in describing the worst case scenarios, going on to describe the case of a woman whose clitoris became so large 'as to descend between the thighs', and that of a man who sliced off his own foreskin to alleviate a phymosis, a painful retraction of the foreskin.[494] Faced with such graphic descriptions, one cannot help but be put in mind of some of Holt's more disturbing images such as that of Elizabeth Wells. Indeed, one reason hospital teaching had become such an

[491] Royal College of Physicians of Edinburgh, Pearson, John [1758–1826], 1. Medical casebook, 1804–19, and lectures on lues venerea and gonorrhoea, 1812–12, London, 1804–1819.
[492] Baillie, *A Series of Engravings Accompanied with Explanations,* p. 212.
[493] RCPE, 1. Medical casebook, 1804–19, and lectures on lues venerea and gonorrhoea, 1812–12, London, 1804–1819.
[494] Ibid.

important facet of education for many medical students was that it gave them the opportunity to encounter more variety in the appearance of disease that they may not have seen on an apprenticeship.[495]

Pearson though did not just lecture on the subject and in 1800 published an extensive treatise investigating the successes of each of the supposed cures for venereal disease. His introduction was a weary denouncement of practitioners who continued to rely on the same hackneyed old cures.

> No men are so prone to indulge in fanciful speculations, as those that are without practice; for, having little occasion to bring their notions to the test of actual experience, they proceed boldly in forming splendid and attractive theories, without the least fear of those consequences, which would be apprehended by men of an established reputation, and long experience.[496]

Indeed Pearson's descriptions of the effects of various medicines suggest consistent observation of, and interaction with, his patients. As in his lectures, Pearson relied heavily on a series of case studies, though less graphic than described in his lectures, to demonstrate his opinions on various items of the *materia medica*.

The opportunities of having so many patients available with the same disease also allowed Pearson to experiment. Whilst discussing the benefits of *Cicuta* (hemlock) he recounted a time when two young women were admitted to the hospital 'both of them suffering from the secondary symptoms of the Lues Venerea; the most troublesome of which were, large painful, spreading

[495] John S. Haller, *A Profile in Alternative Medicine: The Eclectic Medical College of Cincinnati, 1845–1942* (Kent: The Kent State University Press, 1999), p. 4.
[496] Pearson, *Observations on the effects of various articles of the materia medica,* p. lii.

ulcerations, between, and under, the toes of each foot.'[497] The surgeon at first put both women on a course of mercury that healed all but the ulcers of the feet; hoping to alleviate the pain, Pearson prescribed opium to be administered every three to four hours, but still the women suffered. Pearson endeavoured to try the cicuta, but, unsure of its effects gave it only to one of the two women, whose pain receded and sores healed. Meanwhile, '[t]he other young woman continued taking Opium during a week after the first had begun with the Cicuta; but, when I observed the remarkable advantages which had been gained by giving this last medicine, I ordered this patient to take it in the same manner'.[498] Soon, both women were healed. From this, Pearson deduced that the initial course of mercury had rid the body of the venereal poison and the cicuta had healed the now non-venereal ulcers, concluding that although hemlock had no virtues as an anti-syphilitic, it could be used to great effect in treating the attendant symptoms.

Another surgeon eager to experiment in the hospital was Henry Lee, a man whose 'zeal for surgery and his fondness for operation made him in the judgement of some of those who followed his practice a little too active'.[499] Whilst most of Holt's pictures were of patients under the care of Lane or fellow surgeon Edward Cutler (1796–1873), one survives from 1 September 1849 where the surgeon is noted as Lee.[500] The patient was William Tyler and the image shows his penis with a small black sore just under the foreskin (fig. 3.22). Lee began his medical education at King's College in 1833 and entered St George's hospital as a pupil in

[497] Ibid., p. 64.
[498] Ibid., p. 65.
[499] 'Obituary: Henry Lee, Consulting Surgeon to St. George's Hospital', *British Medical Journal*, June 18, 1898, p. 1632.
[500] Cutler's practice remains difficult to recreate as he published nothing and left no notes. His obituary in the *Lancet* recorded that, '[h]e never lectured, never spoke at medical societies, never wrote on professional subjects, yet obtained a practice and an influence over such a number of people of importance as few of his *confrères* could boast of – an example showing that the vicious system of advertising medical works, resorted to by many, is not necessary for professional success.' 'Obituary: Edward Cutler', *Lancet,* 19 September 1874, p. 343.

1834. Four years later he spent a year as a house pupil at the Lock from August 1838. Zealous indeed, in 1848 Lee was appointed as assistant surgeon in the new hospital founded as part of King's College London, as well as accepting the same position at the Lock Hospital, where in 1851 he would rise to the position of surgeon.[501] Lee became renowned for his work first on the veins, and then on syphilis, upon which he became an authority publishing a number of papers and lecturing extensively at the Lock. A paper on calomel (mercurial) fumigation as a treatment for syphilis read before the Medical and Chirurgical Society in 1858 was hailed as marking 'a very real and a very important improvement in the practical treatment of these affections, and would be sufficient, if Mr. Lee had rendered no other service to surgery, to entitle him to grateful recollection as a benefactor to humanity'.[502]

[501] 'Obituary: Henry Lee, Consulting Surgeon to St. George's Hospital', pp. 1631–1632, and Royal College of Surgeons, London Lock Hospital and Rescue Home, MS0022/6/7, Staff Lists.
[502] 'Obituary: Henry Lee, Consulting Surgeon to St. George's Hospital', p. 1631.

Figure 3.22. No. 144 W[illia]m Tyler. Watercolour by J. Holt, 1 Sept 1849. RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

In 1849 though, Lee was only an assistant surgeon at the Lock, perhaps explaining why only one of Holt's remaining drawings notes him as the attending surgeon. It certainly seems from much of his work that he, like Lane, made frequent use of illustrations of specific cases rather than standard types. In an 1861 report in the *British Medical Journal* on varicocele, a swelling in the spermatic veins, Lee cited three patients upon whom he performed an innovative new operation at the Lock. In the third case a complication presented itself when the testes of the patient hung too low for the standard operation to be performed and Lee was forced to improvise using his own method and the advice of a fellow Lock surgeon. Successful, Lee noted that the wound from the operation healed

within three weeks and included a small illustration of the case that 'shows the varicocele permanently cured, and the testis maintained much in its natural position'.[503] Lee had a taste for using visual material in his practice and teaching, and even served as curator at St George's Hospital museum for a time before he became lecturer in physiology there in 1845.[504] Over the course of his life he managed to amass his own collection of specimens and models, donating 'sixteen models illustrating syphilitic affections of the male and female generative organs', and 'a syphilitic sore of the tongue' to St George's Hospital museum.[505]

After his appointment as surgeon in 1851, the board of governors of the Lock gave Lee permission to hold a course of lectures in the hospital. These were delivered in the boardroom of the hospital, which gave Lee the space to show particular patients currently in the hospital to the attendees. He used his lectures to discuss the different modes of constitutional infection after the initial first appearance of chancres and sores, using three patients to demonstrate these differences, stating that '[t]hese three cases, which we have just seen, are interesting, as presenting the common and well marked characters of three very different and distinct results of syphilitic contagion.'[506] His audience's appetite thus whetted from seeing the symptoms he was about to discuss in the flesh, Lee proceeded to use the three cases to argue that constitutional syphilis was liable to occur only if the initial appearance was an indurated chancre, a hardened sore producing no pus. If the sore was open, 'unindurated, inflamed and ragged', then the matter extruded by the sore would rid the body of the infecting syphilitic

[503] Henry Lee, 'Records of the Lock Hospital', *British Medical Journal,* 7 Dec 1861, p. 602.
[504] 'Obituary: Henry Lee, Consulting Surgeon to St. George's Hospital', p. 1631.
[505] John W. Ogle and Timothy Holmes, *Catalogue of the Pathological Museum of St. George's Hospital* (London: Printed by J. Wertheimer and Co., Circus Place, Finsbury Circus, 1866), pp. 795–796.
[506] Lee, *Pathological and Surgical Observations,* p. 151.

poison rather than absorbing it into the constitution.[507] Written in pencil on Holt's drawing of William Tyler's penis, in a different handwriting to Holt's, are the words 'hard sore well developed', suggesting that Lee asked Holt to capture this important symptom for him. This understanding is markedly similar to that of Richard Carmichael's, discussed in chapter two, who also claimed that only an indurated chancre would cause constitutional syphilis.[508]

Lee himself admitted that this theory was a controversial one and set about detailing minutely the specifics, as well as engaging in experimentation. This was an important facet of the development of pathology. Historian Alex Dracobly has written that, in the French case, the basis of nineteenth-century pathological investigation is thought to have been clinical examination, pathological anatomy and the compilation of statistics, meaning that historians have paid little attention to the prevalence of experimentation.[509] I would argue this is certainly also true in Britain. It was however, not enough to postulate on the invisible actions and causes of disease and practitioners often engaged in experimentation on patients to flesh out their theories.

Like Pearson, Lee was a devotee of experimentation, used not only to back up his theories, but also as day-to-day prognostic practice. In one instance he forecast a patient's prognosis based on an experiment he carried out on her. The woman, whom he referred to only as E.A. presented with an open sore that he treated with opium. As the sore began to heal, Lee transferred some of the matter emitted from it to the patient's thigh, much in the same way as contemporaries would when inoculating for smallpox. After a few days there was still no reaction,

[507] Ibid., p. 156.
[508] Carmichael, *An Essay on Venereal Diseases*, p. 113.
[509] Dracobly, 'Ethics and Experimentation on Human Subjects in Mid-Nineteenth-Century France', p. 334.

leading Lee to conclude that the original sore had rid itself of all syphilitic poison, meaning there was no chance that the body had absorbed any of the poison. Pleased with this result Lee proclaimed that '[i]n that case, there will be no necessity for any specific treatment'.[510] These experiments were similar to syphilization, a practice that emerged in the 1840s in France where practitioners inoculated people with pus from a syphilitic sore in the hope of protecting them against more serious forms of the disease.[511] The most infamous practitioner of syphilization was Dr Joseph Alexandre Auzias-Turenne (1812–1870), who inoculated patients at the Hôpital St Louis in 1859, eliciting outcry from the French medical press.[512] Lee however was not using inoculation to attempt to vaccinate patients, but rather as a diagnostic tool.

Holt's images did not just reflect the specific ideas of venereal disease conceived by Lane, Pearson and Lee, they were a vital element in creating them, being tools for practitioners such as Lane to form diagnostic theories, and were especially important in disseminating this specific view of disease. As referred to several times so far, the hospital became an important site for education during the eighteenth century, but it could not do this solely on its own merits. The site of the hospital naturally offered the opportunity for significant clinical observation, but hospital teachers also had to compete with the teaching opportunities that the private schools offered, such as museums. The main difference between hospital teaching and apprenticeships was in the type of instruction received, as a hospital pupil paid to be taught by experienced practitioners, whilst an apprentice worked

[510] Lee, *Pathological and Surgical Observations*, pp. 162–163.
[511] Joan Sherwood, 'Syphilization: Human Experimentation in the Search for a Syphilis Vaccine in the Nineteenth Century', *Journal of the History of Medicine and the Allied Sciences*, 54:3 (1999), p. 364.
[512] Dracobly, 'Ethics and Experimentation on Human Subjects in Mid-Nineteenth-Century France', pp. 332–366.

for his master and learned where he could.[513] Hospital teaching gave students the opportunity to go beyond the manuals and atlases of a discipline and to engage with disease as a clinical reality. Clinical lectures were considered vital as students were 'given the History of the Disease under which the Patient labours, the purpose proposed, for the administering, of this or that medicine, and their effects upon the Patient pointed out; lastly if the patients dies, the cause of his death is more evidently pointed out and shown to the Students, by the dissection of the morbid body.'[514]

Alongside the patients themselves, these lectures made use of an array of visual material such as clinical images. In 1800 medical writer James Lucas wrote a report on the education of surgeon-apothecaries, suggesting the growing usage of drawings within such lectures at this time, advocating that '[e]xplanations by drawings, or tables, as well as preparations, might be rendered permanently instructive to Pupils. The late Mr. Sue, Chirurgien Major a l'hopital de la Charité, an able Anatomist, Draughtsman, and Engraver, assured me, that his private pupils exceeded in proficiency, by being additionally thus instructed.'[515] Lucas seems to have been a keen exponent of the benefits of visual material in the education of medical pupils. After first noting the characteristics desirable in a potential apprentice, which included a good grasp of English and arithmetic, obedience, discipline, neat handwriting and good health, he added '[o]f amusements, the art of drawing claims a preference, as it would be found highly

[513] Gelfand, '"Invite the Philosopher, as well as the charitable"', p. 130.
[514] J. Lind, *Sketch for a Medical Education* (Windsor, 1800), pp. 4–5.
[515] James Lucas, *A Candid Inquiry into the Education, Qualifications, and Offices of a Surgeon-Apothcary; The several branches of the Profession being Distinctly treated on, And suitable methodological forms annexed; besides Various other topics connected with the principal Office are also subjoined; By Mr. James Lucas, Late a Surgeon of the Leeds Infirmary, from its institution; a Member of the Corporation of Surgeons, And a corresponding Member of the London Medical Society*. (Bath: Printed and sold by S. Hazard, 1800), p. 62.

estimable in assisting the study of anatomy, and botany; as well as contriving, or retaining the forms of pieces of mechanism, or preserving singular appearances.'[516]

It was not just the seven general hospitals – St Bartholomew's, St Thomas's, Guy's, Westminster, St George's, the London and the Middlesex – that attracted pupils. Students were always keen to attend the specialist institutions to further augment their education. The British Lying-in Hospital played a role in training midwives, John Howard's report noting that '[h]ere *female* pupils are instructed in the art of midwifery, and after residing four or [six] months, receive certificates of their ability to practice.'[517] House pupils at the Lock, in return for food, board and education at the hospital, were expected to prepare medicine, dress patients, record treatments in the medicine books for governors at every weekly board, keep a separate list for the apothecary, keep lists of patients to be discharged, and to behave well towards patients. They were forbidden to engage in private practice or to 'divulge any of the practices of the hospital either directly or indirectly'.[518]

Whilst teaching in hospitals remained on a private enterprise model throughout the eighteenth century, there were several calls for a more regulated approach to hospital teaching, most often through the establishment of special medical schools attached to hospitals, in part inspired by the runaway success of London's private medical schools established in the second half of the century. John Hunter himself sought to establish a school of medicine attached to St

[516] Ibid., pp. 2–9.
[517] Howard, *An Account of the Present State of the Prisons, Houses of Correction, and Hospitals in London*, p. 28.
[518] RCS, MS0022/6/7, Rules and Orders made at a general court of governors of the Lock Hospital Held 28 November 1754 and confirmed with additions and alterations by the general court held 28 April 1814.

George's Hospital during his tenure there but was defeated by a reluctant board of governors.[519] More successfully, in 1780 William Blizard (1744–1835) senior surgeon at the London Hospital, petitioned the governors there to allow him to start such a school. In a published address to the London's subscribers, Blizard bombastically proclaimed the need for medical schools attached to hospitals for the good health of the nation, though he was keen to also emphasize to the donors the good it would do for the charity, and their reputations. The senior surgeon promised that, '[i]f Public Lectures on the various branches of Medicine are delivered at the Hospital, its reputation will be raised, its fame extended, and it will become an object more generally noticed.'[520] Permission was grudgingly granted though with the proviso that Blizard was not to use patients in demonstrations, nor was the charity's main aim of curing patients to be diluted by the aim to educate medical students. By 1785 a new building had been constructed consisting of a lecture theatre, chemical laboratory, museum and dissecting room and the school was open for business.[521]

By the dawn of the nineteenth century, St Thomas's, St Bartholomew's and the London had established their own medical schools, and St George's had annexed the private school Samuel Lane had established next door to the hospital as its own. Lane was widely regarded as a good teacher, one obituary praising 'his clear power of exposition, his thorough anatomical knowledge, and his skill in applying that knowledge to practical surgical principles and details'.[522] His school must have had a museum from its inception as Lane had a large collection of specimens himself which he bequeathed to St Mary's upon his death, and the St

[519] Gelfand, '"Invite the Philosopher, as well as the charitable"', pp. 145–148.
[520] James Maddocks and William Blizard, *An Address to the Friends of the London Hospital and of Medical Learning* (London, 12 August 1783), p. 8.
[521] Clark-Kennedy, *The London,* pp. 165–167.
[522] 'Obituary: Samuel Armstrong Lane', p. 390.

George's Museum still housed an impressive collection well into the nineteenth century.[523] Indeed the possession of a museum was a prerequisite for a teaching establishment by the nineteenth century. Holt's drawings in this capacity become important in attracting students to study at the Lock, rather than at one of the other voluntary hospitals around London. The images then not only aided surgeons in theorising on venereal disease, they also helped them to engage students in a competitive medical market.

Conclusion

The Lock Hospital's position within London's medical marketplace dominated its approach to disease. The official advertising literature proclaimed loud and clear that venereal disease was, however terrible it appeared, fundamentally curable, projecting the idea of a disease that was under the control of medical theory. Within the hospital of course, it was a very different story. The medical practitioners who worked in house were not responsible to any central regulation that dictated diagnosis or treatment, and were free to approach the multitudinous disease in their own individual ways. This offered them the opportunity to observe and examine a cornucopia of symptoms alongside each other, using this experience to organize these disparate symptoms into working diagnostic models or theories. Within this intellectual environment, Holt's images do more than merely record patients' symptoms, they represent the ways in which practitioners thought about disease in the hospital. They depict the progression of symptoms in some patients, such as Edward Denney, allowing surgeon Lane to postulate on distinct stages of the disease. In others a portrait of the individual patient is

[523] Ibid., p. 391. See also Ogle and Holmes, *Catalogue of the Pathological Museum*.

presented, the hair, clothes and expressions captured, in a visual translation of the importance of the empiricism of the case study to hospital medicine (fig. 3.23).[524]

Figure 3.23. No. 150 Daniel Thomas. Watercolour by J. Holt, 2 October 1949. RCS, MS0022/6/3. Reproduced by kind permission of the Royal College of Surgeons of England.

Voluntary hospitals like the Lock though were about more than allowing practitioners the necessary space and materials to formulate theories, deliver lectures and prepare treatises. A hospital appointment brought a practitioner

[524] Gilman, 'Lam Qua and the Development of a Westernized Medical Iconography in China', p. 63.

enormous cultural capital in London's medical marketplace and competition over appointments was fierce. Before the two men came to work together at the Lock, both Samuel Lane and Edward Cutler sought a surgical position at St George's hospital, which Cutler eventually won, to Lane's dismay.[525] These placements enhanced the social status of practitioners, attracted students and built their reputations within London. Yet practitioners within these institutions still had to compete to attract students, and the collection of visual material, such as the watercolour drawings made by Holt, D'Alton, and others in London, was one strategy by which practitioners augmented their clinical teaching. Collections and museums attached to medical schools and hospitals were becoming the *sine qua non* of medical teaching in the nineteenth century, and were even attracting non-medical audiences. In the following chapter, I explore the world of the medical museum, going beyond the two dimensions of the drawing, to the material representations of venereal disease as preparations and models.

[525] 'Obituary: Samuel Armstrong Lane', p. 390.

4

Museums and Materials: Venereal Disease on Display

By the late eighteenth century, London had become a well-established centre for medical education. The voluntary hospital system discussed in the previous chapter offered myriad opportunities for students to gain clinical experience, in both the general hospitals and specialist institutions such as the Lock, and the capital was flush with celebrated practitioners offering courses or establishing their own schools. Medical teaching was not state regulated in Britain. Those wishing to become qualified practitioners had to take exams at the Company of Surgeons, Royal College of Physicians or Society of Apothecaries, but the corporations did not regulate the supply of teaching in the capital so private practitioners competed for students amongst themselves.[526] One important factor in attracting students was the possession of a museum containing a variety of visual representations in the form of preparations, drawings or models. These materials not only demonstrated the superior status of the school, they also enhanced the reputation of the individual who created or collected them.

Preparations were important objects within this pedagogical sphere, and those representing venereal disease were common in many of London's museums and schools. As disease came to be considered as resident within the flesh of the

[526] Bonner, *Becoming a Physician*, especially chapter 4, 'The Clinical Impulse and National Response', pp. 103–141. See also Lawrence, *Charitable Knowledge*, p. 77.

body, these pathological preparations became vital sources and representations of knowledge. In an advertisement for a course of lectures given by surgeon John Hunter on surgery and disease, the text noted that '[t]his Course of Lectures is illustrated by a collection of diseases, and of comparative Anatomy, which in point of curiosity, accuracy, and comprehension, is equal to any collection in the world.'[527] The phrasing, referring to Hunter's preparations as 'a collection of diseases' rather than representations of disease, demonstrates that these preparations were considered as more than merely display, they encapsulated the disease itself. This invested them with as many contested meanings and identities as venereal disease itself, and the first half of this chapter explores some of these meanings and roles. Focusing on the actual creation of pathological preparations gives us further insight into what was thought about the actual dead flesh that disease was now considered to be resident within. Owning preparations became an important marker of the elite medical practitioner, however the process of making them was equally important. The process of making preparations, by cutting, injecting and preserving, entailed a number of practical skills the surgeon needed, such as the manual dexterity necessary for the mechanics of surgery. Indeed, the very word 'preparation' seems to suggest a work in progress, therefore it is in their *becoming* as much as their *being* that they take on meaning and value.[528]

However, just as venereal disease was a contested phenomenon, so the preparations' ability to function as medical knowledge was never guaranteed, and voices of dissent claimed that other forms of material representation were better

[527] 'Schools of the Arts and Sciences. No II.', *European Magazine, and London Review*, October, 1872, p. 247. Also quoted in Chaplin, 'John Hunter and the "museum oeconomy", 1750–1800', p. 112.
[528] Daston, 'Speechless', p. 20.

suited to depicting venereal disease. In particular, wax models and moulages were posited as offering superior representational possibilities. Preparations and models were not merely confined to schools intended only for medical practitioners, and there were a whole host of other medical collections, either permanently resident in the city or travelling exhibitions that appeared in London sporadically throughout the eighteenth and nineteenth centuries. These medical museums were initially seen as beneficial for the public as it was there that medical men could educate the general populous about their own health, and thus guard them against the machinations of quacks. Yet it was often these very quacks who used the museums to attract prospective patients and persuade them that they were in dire need of whatever panacea the owners wished to sell. The movement of material representations of venereal disease between orthodox and illicit medical spaces further challenged and changed the meanings of these objects.

Seeking to investigate these multiple and shifting meanings, the second half of this chapter explores the various interpretations of the material and visual representations in these public medical exhibitions. This prompts a closer look at the cultural attitudes surrounding the fear of venereal disease, which reveals a coalescence of the representational strategies of orthodox and illicit practitioners. Much has been made in the historical literature on venereal disease of it being characterised by shame, secrecy and fear.[529] Yet within this literature there has been little discussion of any specific reasons for these reactions, with many historians unquestioningly assuming that the sexually transmitted aspect of the disease was cause enough for it to be surrounded by shame and embarrassment. However the fixation on certain reappearing representations of the disease in both

[529] For instance Merians (ed.), *The Secret Malady*.

the orthodox medical schools and illicit museums discussed in this chapter demonstrates a complexity to public anxieties about venereal disease that went beyond a moral panic about an ahistorical 'sexual shame'.[530] Contemporary visual discourse suggests that fear of the disease was due to a much more sophisticated public conception of its nature that reacted especially to the potentially destructive symptoms of venereal disease.

What makes a disease shameful is far more complex than its mode of transmission. Writing on nineteenth-century France, historian Jason Szabo has shown an interesting incongruity in how consumption was conceptualised in the nineteenth century. Whilst it was associated with working class prostitution, the symptoms it brought on made the sufferer appear as a sympathetic, tragic and romanticised character. Szabo writes that the early signs of consumption – 'mild weight loss, glossy whiteness, and rosy cheeks – were also marks of beauty', adding that this disease 'lent itself to emotionalism partly because it left some people's sense of dignity relatively intact'.[531] Venereal disease, also associated with prostitution, rarely elicited the same degree of cultural romanticisation as consumption. It seems that the shame and fear surrounding venereal disease was elicited by more than just embarrassment about the sexual mode of transmission, though I do not deny that this was a factor in nineteenth-century London. Furthermore, during the nineteenth century, more people died from consumption than venereal disease, which was conversely seen as eminently curable.[532] If this was not the fear of death, then perhaps it suggests a fear of what came before it, the pain and the very violent, very visible symptoms venereal disease provoked.

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[530] Hayden, *Pox*, p. xvii.
[531] Jason Szabo, *Incurable and Intolerable: Chronic Disease and Slow Death in Nineteenth-Century France* (Piscataway: Rutgers University Press, 2009), pp. 72–76.
[532] Nico J. D. Nagelkerke, *Courtesans and Consumption: How Sexually Transmitted Infections Drive Tuberculosis Epidemics* (Delft: Eburon Academic Publishers, 2012), p. 16.

This chapter argues that common cultural anxieties about venereal disease were visible in the representational strategies of both orthodox and illicit medical communities, as well in those of the non-medical public, demonstrative of the integration of medical discourse within public life.

Preparations in Medical Pedagogy

Material representations of disease, in the form of preparations, were in mass circulation between the medical practitioners of London in the early nineteenth century. Medical journals are full of references to various preparations and models being used in lecture courses, and becoming popular attractions at medical society meetings; for instance the minutes from one meeting of the London Medical Society recorded that the turnout was 'exceedingly large' as members were keen to 'see the specimens of Mr. Langstaff'.[533] In 1819 surgeon Thomas Watson wrote to esteemed surgeon Astley Paston Cooper (1768–1841) regarding a tumour he removed from a child which he considered might be interesting to preserve as a preparation, offering to send the offending article to Cooper.[534] That Cooper was a keen collector of such items is again indicated in a letter from another surgeon, Henry Harris, who wrote, '[t]he many recollections of your former kindnesses induce me to offer the inclosed [*sic*] Urinary Calculus for your acceptance.'[535] Preparations were an important means of arresting specific appearances of disease in order to get second opinions from other practitioners.[536] However, they also served ostensibly less intellectual and more commercial purposes, and were vital objects for education.

[533] 'London Medical Society', *Lancet*, 31 March 1827, p. 849.
[534] Royal College of Surgeons, Case note received by Sir Astley Cooper from colleagues and patients, MS0008/2/2, (7) Letters and notes on cases sent to Sir Astley Cooper, *c*.1813–1838.
[535] Ibid.
[536] Daston, 'The Empire of Observation', 105.

By the late eighteenth century, London was coming to prominence as a site of medical teaching, rivalling even Edinburgh which had long been considered a pre-eminent place for medical and surgical education over the century previous. At this time, students who had once considered Edinburgh as capable of providing a full medical education were becoming dissatisfied with the insufficient opportunities for clinical practice, and were augmenting their instruction with courses in London's many hospitals.[537] Before the emergence of London's universities from the 1820s onwards, the city was almost saturated with private schools and courses in anatomy, pathology, obstetrics, chemistry, medical practice, and various lectures on specific diseases.[538] The elite surgeon-anatomists who ran the most famous schools kept extensive collections of visual material such as preparations, models and drawings intended both for the education of pupils as well as the edification of their peers. Some of these collections have survived, most famously John Hunter's, kept as a museum at his house in Leicester Square until his death in 1793 when it was transferred to the Company of Surgeons where parts of the collection still remain as a public museum. Hunter's brother William also had an extensive collection that he bequeathed to the University of Glasgow. Fellow well-renowned London surgeons Joshua Brookes and Astley Cooper also had large museums, though most of these have not survived, as the collections were sold on, many of them incorporated into the Hunterian collection in the nineteenth century.

John Hunter was an obsessive when it came to creating and hording preparations and models. Not merely confining his collection to Leicester Square,

[537] Christopher Lawrence, 'Ornate Physicians and Learned Artisans: Edinburgh medical men, 1726–1776', in W. F. Bynum and Roy Porter (eds), *William Hunter and the Eighteenth-century Medical World* (Cambridge: Cambridge University Press, 1985), p. 168.
[538] Porter, 'Medical Lecturing in Georgian London', p. 94.

he frequently retired to his house at Earls Court, then a couple of miles outside of London's boundaries, to create and experiment away from the hustle of London life. The house looked unassuming from the exterior however,

> there were caves and dens of earth, in which wild beasts were kept and from which they sometimes escaped; and coppers in which the skeleton of a giant could, if need arose, be quickly freed of its flesh. Other strange animals roamed around the park, and a stuffed crocodile hung, like a presiding saint, over the front door. Within were carried out all sorts of investigations… There no doubt many of the preparations were made, if not mounted, which found their way into the Museum at Leicester-square.[539]

This museum was visited by other elite medical practitioners, used as a site for lectures and society meetings as well as being opened to medical students. The house not only contained his museum, but also a large parlour for 'weekly meetings of his medical friends and a theatre for his lectures'.[540] The museum was opened to 'noblemen and gentlemen' in May, and to scientists in October.[541] As he had worked extensively on venereal disease it is perhaps not surprising that Hunter's collection contained numerous preparations of venereal symptoms. Within his grand museum were several examples of preparations that preserved both osseous and cutaneous symptoms of the disease, including '[p]art of a Penis of a man who died clap'd'.[542] Perhaps the most common class of preparations displaying the effects of venereal disease in Hunter's collection though were those of the bones demonstrating caries or lesions resulting from venereal disease. One

[539] Rickman J. Godlee, 'The Hunterian Oration; Delivered before the Royal College of Surgeons of England on Feb. 14th, 1913, By Sir Rickman J. Godlee, Bart., M.S.Lond., F.R.C.S. Eng., Hon. M.D. Dub., President of the College, Etc.', *Lancet*, 22 February 1913, p. 507.
[540] Ibid., p. 507.
[541] Richard D. Altick, *The Shows of London* (Cambridge and London: The Belknap Press of Harvard University Press, 1978), p. 28.
[542] Royal College of Surgeons, Hunter, John (1728–1793), MS0189/2, (10) Original manuscript catalogue of the Hunterian Museum by John Hunter. Mid to late eighteenth century.

of the images of syphilitic skulls included in Matthew Baillie's 1803 atlas of pathology, discussed in chapter two, was drawn from a preparation in Hunter's museum (fig. 2.1).[543]

By the time Hunter died the entire collection comprised 13,632 preparations and models, and was bought by the government for the Company of Surgeons, which would become the Royal College of Surgeons seven years later.[544] After Hunter's death the responsibility for running the museum passed to William Clift (1775–1849) who had previously worked for Hunter, and for his nephew Matthew Baillie, producing the original drawings for Baillie's 1803 atlas. Clift was so devoted to his duties at the Hunterian that one editorial in the *Lancet*, many years after his death, described him as a 'pathetically faithful servant'.[545] In his expansion of the museum's holdings however, Clift seemed rather more zealous than pathetic, and he continued to build up the collection, purchasing specimens and accepting donations from fellow London medical men. In July of 1807, Clift accepted a collection of bones from William Long (1747–1818), a surgeon at St Bartholomew's Hospital, which had previously belonged to William Cheselden, and had formed the basis for his atlas of bones *Osteographia*.[546] When Joshua Brookes auctioned off his museum in 1828, Clift was present along with other well-known anatomists eager to augment their own collections.[547] Over the course of his tenure as curator, Clift oversaw the acquisition of not only parts of Brookes's collection, but also the collections of esteemed figures including Cooper, William Blizard, John Heaviside (1748–1828), Robert Liston (1794–

[543] Baillie, *A Series of Engravings*, p. 6.
[544] Altick, *The Shows of London,* p. 28.
[545] 'The Original Hunterian Museum', *Lancet*, 22 February 1913, p. 550.
[546] Royal College of Surgeons, Notes and transcriptions of publications and lectures, MS007/1/6/2 (13), Folio manuscript volume with notes by William Clift, 1829.
[547] Samuel J. M. M. Alberti, 'Objects and the Museum', *Isis*, 94:4 (December 2005), p. 546.

1847), George Langstaff (*c*.1780–1846), John Flint South (1797–1882) and John Howship (1781–1841).[548]

Hunter's museum is testament to the place of preparations within the medical marketplace of the late eighteenth century. They were valuable not only for their use in teaching, but also for the prestige they brought to Hunter himself, who was an avid creator of preparations and was said to have surpassing skill at the process. Even in the early twentieth century his preparations were still being celebrated for their clarity of purpose. Rickman Godlee (1849–1925), president of the Royal College of Surgeons in 1913, wrote that they 'illustrate in a striking way the particular object for which they have been preserved – that is, the physiological or pathological process, not the mere isolated anatomical fact'.[549] To further expand his impressive collection, Hunter did not just limit his museum to preparations and also collected a variety of complimentary visual representations such as models, drawings and paintings of patients similar to those created in the Lock hospital discussed in the previous chapter, including, '[a] portrait of a young man, a native of Oxford who having had his lower lip destroyed by a venereal ulcer, had a new lip formed out of a portion of the skin from beneath the chin, which was dissected off, turned up and united after the manner of hare-lip', which was painted in the Westminster Hospital.[550] The museum reasserted Hunter's celebrated status in London, vital in a medical marketplace in which practitioners depended on reputation to attract students to their courses and schools. Surgeon Peter Clare (1738–1836) wrote of Hunter's collection that, '[i]t does him honour

[548] Godlee, 'The Hunterian Oration', p. 508.
[549] Ibid., p. 508.
[550] Royal College of Surgeons, Lists of Drawings and Paintings, MS0007/1/4/4, (2) List of Paintings in the Library of the College, 1820.

in the present, and must certainly endear him to future eyes.'[551] Indeed future generations were so committed to Hunter's presentation of the collection, that those lecturing within the museum relied on his arrangements rather than reorganizing the preparations to better suit their own schemes. Lecturing in 1833 Charles Bell stated that 'I have a distinct well-marked path before me, – as if a finger-post were erected. I have to go along the gallery of the museum of this college, and to place before you from thence the preparations of Mr. Hunter, and to endeavour to follow, in my lectures, the course he took in preparation of them.'[552]

Much of the value of the preparations lay in the circumstances of their creation, not merely in their finished identity. The process of creating them was an important facet in their use in medical education, as the practices involved often mirrored those techniques that would be vital to surgeons when actually performing operations; a steady hand, a keen eye, and an ability to work closely with others. The process helped students to acquire what William Hunter described at 'a kind of necessary Inhumanity' needed to not only dissect a corpse, but also to dispassionately cut into the living flesh of a patient during operations.[553] The creation of preparations was taught in most medical schools around the capital, as possessing them was becoming more important in an increasingly crowded medical marketplace, in which practitioners needed to display their expertise and credentials through ownership of such items. The

[551] Peter Clare, *A New and Easy Method of Curing the Lues Venerea, by The introduction of Mercury into the System through the Orifices of the absorbent vessels on the Inside of the Mouth with the Remarks of Dr Hunter and Mr. Cruikshank in favour of this Practice… By Peter Clare, Surgeon* (3rd edn, London: Printed for T. Cadell, in the Strand, 1780), pp. xx–xxi.
[552] Charles Bell, 'Anatomy and Physiology Lecture on the Hunterian Preparations in the Museum of the Royal College of Surgeons, London', *Lancet*, 16 November 1833, pp. 279–280.
[553] Hunter quoted in Ruth Richardson, *Death, Dissection, and the Destitute: The Politics of the Corpse in Pre-Victorian Britain* (Chicago: University of Chicago Press, 2001), p. 31. See also, Lynda Payne, *With Words and Knives: Learning Medical Dispassion in Early Modern England* (Aldershot and Burlington: Ashgate, 2007).

process of creating preparations began with a corpse. By the eighteenth century, most manuals of anatomy were in agreement that the first introduction to human anatomy a medical pupil should receive was witnessing a dissection. Physician John Coakley Lettsom (1744–1815) proclaimed, rather sententiously, that 'the knowledge of Anatomy is essential to human comfort; and to prevent the acquisition of this knowledge, is an act of inhumanity'.[554] Furthermore, opening the corpse was not only considered the route to fully appreciating human anatomy; through the development of pathology it had, by the nineteenth century, become the gateway to understanding disease. Examining and charting the actions of disease on the body of the live patient could only take one so far and, as physician Thomas Pole (1753–1829) asserted 'truth [could] only be arrived at by the subsequent inspection of those bodies which have been the unsuccessful objects of attempts to heal'.[555] This sentiment began the majority of dissection manuals, with authors desperate to legitimise the practice of dissection within a society that had more than a few reasons to view it with hostility and revulsion.

The public response to dissection in the eighteenth and early nineteenth centuries was generally extremely negative. Though surgeons had been guaranteed the legal right to dissect the bodies of executed criminals since the sixteenth century, the public made their displeasure with the practice known, actively trying to stop surgeons taking away corpses after public executions. The attendant rioting outside Tyburn prison was a contributing factor in moving executions from there to the more remote Newgate, as well as a general shift over

[554] John Coakley Lettsom, *Hints Respecting Human Dissection* (London, 1795), p. 11.
[555] Thomas Pole, *The Anatomical Instructor; Or, An Illustration of the Modern and Most Approved Methods of Preparing and Preserving the Different Parts of the Human Body, and of Quadrupeds, by Injection, Distention, Corrosion, Articulation, Maceration, Modelling, &C. With a Variety of Copper-Plates. By Thomas Pole, Member of the Corporation of Surgeons in London* (London: Printed by Couchman and Fry; and sold by the author, No. 11, Talbot-court, Gracechurch-street; and by W. Darton and Co. No. 55, Gracechurch-Street., 1790), p. xxix

the nineteenth century towards private, rather than public, executions.[556] With the growth of the voluntary hospital movement in the eighteenth century, surgeons of these institutions often asserted their right to dissect unclaimed corpses of patients who died in house. The general public though were intensely critical of hospital surgeons who dissected the bodies of their patients without waiting any time at all for relatives to claim the body, a practice that was said to be widespread within the hospitals.[557] What was considered worse than this by far though was the practice of surgeons purchasing dead bodies from the so-called 'resurrectionists', the grave robbers who made a living supplying the medical schools of the capital with freshly unearthed cadavers. Infamously, the surgeons' desire for fresher cadavers led to resurrectionists William Burke (1792–1829) and William Hare (*b*.1792/1804) hurrying along the process by murdering numerous people, whose bodies they then sold to surgeons who were only too eager to overlook the conspicuous freshness of the corpse. The reality was that to compete for students in London, teachers needed bodies, as dissection was the foundation of medical education, research and practice in this period.[558] Though it was intended to end the practice of bodysnatching, the passing of the 1832 Anatomy Act saw the public's attitude towards the surgeons become even more negative, as the Act gave medical practitioners the legal right to the bodies of the poor who died in workhouses and hospitals.[559]

Within this intensely antagonistic climate, surgeons had to adopt strategies to persuade the public that they were not the bloodthirsty megalomaniacs they were so often made out to be, and to prove that dissection was an unfortunate

[556] Richardson, *Death, Dissection and the Destitute*, p. 75.
[557] MacDonald, *Human Remains*, p. 29.
[558] A. W. Bates, *The Anatomy of Robert Knox: Murder, Mad Science and Medical Regulation in Nineteenth-Century Edinburgh* (Eastbourne: Sussex Academic Press, 2010), p. 10.
[559] Richardson, *Death, Dissection and the Destitute*, p. xv.

necessity that medical practitioners would perform stoically, almost unwillingly, for the good of humanity.[560] Joseph Henry Green (1791–1863) began his own manual on dissection with the familiar sermon on the importance of anatomy before advising the reader that investigating the corpse first hand was imperative, even though '[i]dleness may pursuade, and the natural aversion to the sight and touch of the dead, may inforce [*sic*] an opinion, that anatomy is to be gained at the cheap rate of turning over the unsoiling pages of a quato'.[561] Admitting that surgeons as well as the general public had a 'natural aversion' to meddling with cadavers, and that this was a 'soiling' practice served to underline the heroism of the surgeon, depicting them as altruistic men braving the unsavoury atmosphere of the dissecting room for the benefit of humanity. This notion also serves to raise the status of the final preparations, as it denigrated the ability of atlas images to effectively teach the student, praising instead the investigations into real flesh, made lasting by the creation of preparations.

Making preparations was considered a complex art, and one that all surgical pupils were encouraged to acquire.[562] There were a multitude of different forms of preparation. Some were simply body parts washed clean of blood and immersed in alcohol, known as 'white preparations', which were considered more durable as they had had all the blood, 'the most putrescent part', washed out of

[560] MacDonald, *Human Remains: Dissection and its Histories*, p. 26.
[561] Green, J. H., *The Dissector's Manual By J. H. Green, Demonstrator of Anatomy at St Thomas's Hospital* (London: Printed for the Author; and sold by E. Cox, Medical Bookseller, St. Thomas's Street, and 39, High Street, Southwark, 1820), p. xlvii
[562] John Shaw, *A Manual of Anatomy; containing rules for displaying the structure of the body so as to exhibit the elementary views of anatomy, and their application to pathology and surgery: to which are added, observations on the art of making anatomical preparations: by John Shaw; being an outline of the demonstrations delivered by him, to the students in the school of Great Windmill Street. Second edition* (London: Longman, Hurst, Rees, Orme and Brown, Paternoster Row; T. and G. Underwood, Fleet Street; and Burgess and Hill, Great Windmill-Street, 1822), p. 411.

them before being immersed in preserving spirits.[563] Some were more complex, being parts injected with solutions containing coloured dyes or mercury, and some were body parts filled with coloured resin then immersed in acid to destroy all the flesh leaving just the hardened injection.[564] These varying types required many different skill levels, for instance, preparations made by maceration – soaking the flesh in order to clean and soften it – required relatively little manual dexterity compared with injected preparations. One moderately simple macerated preparation was the skull. 'Put the whole head, without disturbing the flesh or brains, into a pan' explained physician Robert Hooper (1773–1835), '[w]hen sufficiently macerated, all the soft parts will come away with the periosteum; then detach the vertebrae, and wash out the brain'; Hooper also added that to ensure speedy maceration, the pan should be put in a warm place 'to facilitate putrefaction'.[565]

For pathological preparations – those that arrested specific and unique symptoms of an individual body in crisis – wet preparations were said to be more accurate in showing 'the natural structure, and to preserve the morbid appearances'.[566] Furthermore, with morbid symptoms now being considered the physical seat of disease in the body, rather than just a sign of an intangible illness, the pathological preparation had the potential to be considered as more than a

[563] Ibid., p. 431.
[564] Samuel J. M. M. Alberti gives a thorough description of the processes of making various types of preparation. Alberti, *Morbid Curiosities*, pp. 68–80.
[565] Robert Hooper, *The Anatomist's Vade-Mecum: Containing the Anatomy, Physiology, Morbid Appearences, &c. of the Human Body; the art of making anatomical preparations &c. To which are added, anatomical, physiological, medical, and surgical questions. The ninth edition By Robert Hooper M.D. Of the University of Oxford, and the Royal College of Physicians in London; Fellow of the Linnaean Society; Physician to the St. Mary-le-bone Infirmary, &c.* (London: Printed for Longman and Co., T. and G. Underwood, J. Callow, Burgess and Co.; and Adam Black, and Stirling and Slade, Edinburgh, 1819), p. 338–339.
[566] Shaw, *A Manual of Anatomy,* p. 431.

representation, but as containing disease itself.[567] This raised concerns when it came to dissection and preparation and there were instances where the corpse itself was considered to be a potential threat to the dissector, as in the case of those who had died of rabies, or 'canine madness', whose bodies, Pole advised, should not be dissected.[568] Venereal disease was another condition that rendered the corpse particularly dangerous, with some asserting that the disease could be spread from cadaver to operator during a dissection. Some dismissed this a merely a convenient cover story for those surgeons who contracted the disease during other, less professional, activities, although Pole accepted the possibility, allowing that 'from the facility with which fluids are carried into the system by means of the lymphatics, it is easy to suppose, that when morbid matter has been introduced under the cuticle, it may produce a corresponding disease'.[569] Morbid parts were certainly considered to need different treatment to healthy structures whilst being prepared. Robert Hooper wrote that morbid parts should be soaked following their removal from the body before being preserved, advising that '[t]hese preparations foul a great quantity of spirit, and should therefore be kept in stopper-glasses, from which the spirit can easily be removed, and fresh put in, until the preparation ceases to foul the spirit.'[570] The corrupting nature of the morbid flesh was testament to the idea that diseases had their own identities, separate to the actions of the living body's constitution, and could therefore still reside within the dead body, ready to infect anyone who came into contact with it.

Yet the threat of the venereal corpse was not the only problem with making preparations of venereal symptoms. Scottish surgeon Robert Knox (1791–

[567] Maulitz, *Morbid Appearances*, p. 18.
[568] Pole, *The Anatomical Instructor,* pp. lxxiv.
[569] Ibid., pp. lxxv–lxxvi.
[570] Hooper, *The Anatomist's Vade-Mecum,* p. 338.

1862) was pessimistic about the true value of such preparations. Knox had significant experience of creating and collecting preparations, as from 1825 until 1831 he had held the position of conservator to the museum of the College of Surgeons of Edinburgh.[571] As well as managing the museum, Knox also taught there, delivering courses on Pathological Anatomy in the museum using its collections.[572] He left this post ignominiously in 1831 after repeated attempts by the College to get rid of him in the wake of the scandal he created by purchasing the bodies of sixteen of Burke and Hare's victims.[573] Following this, Knox's career took a tumultuous turn. Once the most celebrated anatomy teacher in Edinburgh, the 1830s saw him failing in several applications to university positions, instead reduced to teaching in various smaller anatomy schools, and embarking on lecture tours of Britain. Knox became highly critical of the medium of preparations, claiming that most of them 'cannot be preserved for any length of time, retaining their original colour and general appearance, without which it is manifest that they cannot serve as records of disease'.[574] Knox went on to single out a few pathological appearances that he deemed particularly ill suited to the medium.

> Structural changes produced by acute or even chronic inflammations it was absolutely hopeless to attempt preserving, so as to retain any semblance of their original appearance; with diseased joints it was, if possible, worse; highly

[571] Claire L. Taylor, 'Knox, Robert (1791–1862), anatomist and ethnologist', *Oxford Dictionary of National Biography*, (Oxford: Oxford University Press, 2004) [Consulted at http://www.oxforddnb.com/view/article/15787, (17 January 2011)].
[572] Edinburgh University Department of Special Collections, Class cards, class tickets, and testimonials of John Brown, Thomas S. Brown and William B. Clark (1824–1835), GB 237 Coll-1156, E2008.49, Cards of Mr William B. Clark, 1824–1835.
[573] MacDonald, *Human Remains*, p. 23.
[574] R. Knox, 'Original Lectures. Anatomical Museums; these Objects and Present Condition. Being the substance of a Lecture delivered before the Pathological Society of Birmingham, the Professors and Students of Queen's College, Birmingham, and before a Medical Audience in Edinburgh and in Glasgow', *The Medical Times: A Journal of English and Foreign Medicine, and Miscellany of Medical Affairs*, 18 July 1846, p. 307.

> inflamed membranes became perfectly colourless; pseudo-membranes could not be distinguished from original healthy structures; in short, it were endless to speak of what this method could not preserve – the difficulty would be in finding any morbid structure which it perfectly did. The preservation of cutaneous and venereal disease was, for obvious reasons, never attempted…[575]

Knox's claim that the creation of preparations of venereal symptoms was 'never attempted' was evidently untrue, as later in the same lecture he noted that medical practitioners often visited collections in search of preparations displaying venereal symptoms, only to find that 'the preparations contained in it are so altered as to be wholly unrecognisable, and therefore useless'.[576] Knox's younger brother Frederick (1794–1873), who had assisted Robert in making preparations, and curating the Edinburgh museum, demonstrated a more nuanced view in his 1836 publication *The Anatomist's Instructor, and Museum Companion*, a guide to creating preparations, and organising anatomical museums. Rather than denouncing the ability of preparations to show the effects of certain diseases at all, Frederick Knox focused on the specific appearances of diseases that *could* be adequately preserved. In the case of venereal diseases, Frederick highlighted the bones, particularly of the skull, writing that, '[t]he bones entering into the composition of the nose and its passages are subject to congenital deformity, and to syphilitic caries; and if the anatomist's wish is to preserve the effects of the disease on the osseous textures, of course *maceration* must be had recourse to.'[577] Certain appearances were suitable then for specific media, but venereal disease once again proved particularly contentious.

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[575] Ibid., p. 308.
[576] Ibid., p. 308.
[577] Frederick John Knox, *The Anatomist's Instructor, and Museum Companion: Being Practical Directions for the Formation and Subsequent Management of Anatomical Museums, by, Frederick John Knox, Surgeon, Conservator of the Museum in Old Surgeons' Hall* (Edinburgh: Adam and Charles Black; Longman, Rees, Orme, Brown, Green & Longman, London, 1836), p. 103.

Though he relied on the preparations for both educational and professional developments, John Hunter himself was not an uncritical exponent of the value of preparations and freely admitted that they did not simply record and stabilise appearances, but that there was a high level of artifice involved in their creation.[578] Unlike Knox though, Hunter did not consider that this detracted from their worth, rather he opined that students and practitioners had to learn how to see them in relation to the real body.[579] Hunter it seems did not agree with Knox about the value of preparations of venereal symptoms, and his museum contained many, especially those displaying carious bones (fig. 4.1). These were popular preparations; the museum of the Royal College of Surgeons in Edinburgh also had a large collection of bones displaying the same effects, usually caries, though also as inflammation and lesions on the bones.[580]

[578] Simon Chaplin, 'Nature dissected, or dissection naturalized? The case of John Hunter's museum', *Museum and Society,* 6:2 (Jul. 2008), p. 141.
[579] Ibid., p. 141.
[580] *Catalogue of the Museum of the Royal College of Surgeons of Edinburgh Part I. Comprehending the Preparations Illustrative of Pathology* (Edinburgh: Printed by Neill and Company, 1836).

Figure 4.1. A right tibia showing a 'sabre' shape following osteomyelitic changes to the shaft as a result of syphilitic infection. Dry preparation, *c*.1760–1793. © The Hunterian Museum at the Royal College of Surgeons, RCSHC/P 738.

That these carious bones were so often preserved as preparations representing venereal disease owes something of course to the relative ease of revealing and preserving them, simply by maceration and drying. However it was not just the convenience that made them a popular way to display the effects of venereal disease. This was a common symptom. From the first appearances of the disease in Europe it was recognised that it caused aching pains in the bones and joints. Pain in the bones was generally considered to indicate a particularly serious or advanced case of venereal disease that could prove curiously resistant to treatment. Surgeon Samuel Cooper (1780–1848) wrote that ‘nodes and the

chronic inflammation of bones from syphilis often make extra ordinary resistance to the power of every medicine but mercury'.[581] The effects on the bones of the face, particularly the collapse of the nose, struck the imagination of the medical community, and preparations of skulls that demonstrated this external corrosion were popular. One such preparation in John Hunter's collection preserved not only the bones, but also the nasal cartilage and membranes, representing the characteristic collapse of the nose in the later stages of the disease (fig. 4.2). Samuel Cooper too took special care to highlight the destructive effects of venereal disease on the face, writing, 'when it attacks the bones of the nose it renders them carious, by which they are consumed and the face sadly disfigured'.[582] Indeed, though caries were not just produced by syphilitic afflictions and were also a common symptom provoked by scrofula, preserved carious skulls tended to record the results of syphilis more than any other condition.[583] Out of the forty-three preparations of the 'bones of the head' listed in the Edinburgh Royal College of Surgeons museum, twenty-three of them were listed as venereal or syphilitic caries, with most of the rest being the effects of tumours and other sundry lesions.[584]

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[581] Samuel Cooper, 'Lectures on the Principles, Practice & Operations of Surgery, By Professor Samuel Cooper. Delivered at the University of London, Session 1832–1833', *London Medical and Surgical Journal*, Saturday 26 October 1833, p. 388.
[582] Samuel Cooper, *A Dictionary of Practical Surgery: Comprehending All the Most Interesting Improvements up to the Present Period: Also An Account of the Instruments, Remedies, and Applications Employed in Surgery; The Etymology and Signification of the Principal Terms; A Copious Bibliotheca Chirurgica; and A Variety of Original Facts and Observations, The Third Editions, Revised, Corrected, and Enlarged, By Samuel Cooper, One of the Surgeons to His Majesty's Forces; Member of the Royal College of Surgeons; of the Medical and Chirurgical Society of London; and of the Medical Society of Marseilles* (London: Printed for Longman, Hurst, Rees, Orme, and Brown; S. Highley and Son; J. Callow; E. Cox and Son; T. and G. Underwood; Anderson and Chase; Adam Black, Edinburgh; and Hodges and Macarthur, Dublin, 1818), p. 214.
[583] Cooper, 'Lectures on the Principles, Practice & Operations of Surgery', pp. 388–389.
[584] *Catalogue of the Museum of the Royal College of Surgeons of Edinburgh Part I.*, pp. 34–48.

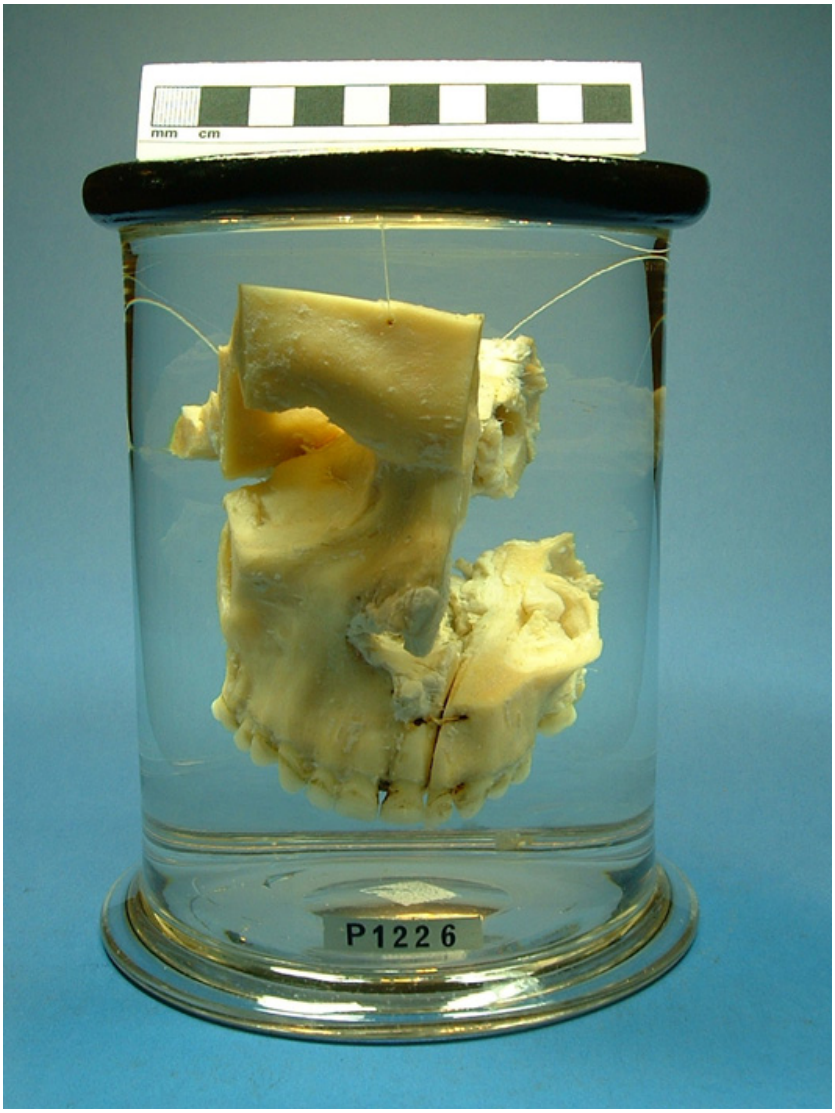

Figure 4.2. The facial bones with the mucous membrane of the nasal cavity, showing destruction of the bone and tissue of the nasal cavity as a result of syphilitic infection. Wet preparation, *c*.1760–1793. © The Hunterian Museum at the Royal College of Surgeons, RCSHC/P 1226.

These preparations were also seen as preserving the history of venereal disease for future practitioners. Joshua Brooke's museum went to auction in 1830, with the catalogue recording his possession of a number of syphilitic preparations along with other representations of the disease, including a painting of 'the dreadful effects produced by syphilis affecting the head and face: taken from a

patient in St. James's Infirmary'.[585] Within his collection, Brookes had a series of crania which 'exemplify the ravages of this dire malady on the bones of the head and face, which now, for the happiness of mankind, from improved practice, are likely rarely to recur. Therefore these monuments of this Protean disease are most probably the last and finest examples which may be offered for sale.'[586] The optimism on the part of the Lock Hospital governors and staff as to the curable nature of venereal disease discussed in chapter three was indeed widespread amongst the wider medical community, largely thanks to the efficacy of mercurial cures.[587] In such a confident climate, preparations of venereal symptoms were seen as preserving the appearances of what were becoming rare conditions, allowing future generations of medical practitioners access to recherché appearances. Furthermore then, these preparations indicated the perceived dominance of medical theory over venereal disease. These material representations then not only served to demonstrate medicine's control of the disease, they became relics of a disease that medical practitioners had almost defeated.

John Hunter's collection of pathological preparations was used for teaching in his private school, as well as forming part of the massive collection at his house in Leicester Square intended to impress any learned gentlemen who visited it.[588] Moreover, they were used as source materials for his published works. For Hunter, the preparations were considered as the solid facts of pathology, on

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[585] *Museum Brookesianum : a descriptive and historical catalogue of the remainder of the anatomical & zootomical museum, of Joshua Brookes, Esq. ... embracing an almost endless assemblage of every species of anatomical, pathological, obstetrical, and zootomical preparations, as well as subjects in Natural History ... which will be sold by auction, by Messrs. Wheatley & Adlard, at the Theatre of Anatomy, Blenheim Street ... on Monday, the 1st of March, 1830* (London: Printed by Richard Taylor, Fleet Street, 1830), p. 115.
[586] Ibid., p. 71.
[587] Williams, *The London Lock*, p. 2.
[588] Chaplin, Appendix 5B in 'John Hunter and the "museum oeconomy", 1750–1800', p. 364. See also Alberti, *Morbid Curiosities*, p. 169.

which he formulated larger theoretical conclusions.[589] We can see how the preparations were his starting point in one example from his 1786 *A Treatise on the Venereal Disease*, discussed in chapter two of this thesis, which was illustrated with a series of engravings showing pathological changes that were the results of venereal inflammation. The first plate in the book showed two dissected penises, the left one intended to show a slight stricture, but also demonstrating the presence of lacunae in the urethra (fig. 4.3). This plate, prepared by master engraver William Sharp (1749–1824), was taken from a drawing done by draughtsman William Bell (*d*.1792) who had been working with Hunter from around 1774 (fig. 4.4). Bell's source material was the preparation, itself preserved, indeed still preserved, in Hunter's museum (fig. 4.5). Though the preparation has been subject to conservation practices such as the changing of preserving liquid and surgical pins, and of course the general changes of appearance associated with over two hundred years spent in a jar, the preparation seems incredibly close in appearance to the subsequent drawing and engraving. The ownership of such preparations was therefore vital on numerous levels to the reputation of the celebrated medical practitioner such as Hunter. From pedagogy to publication, the collections of visual and material representations of venereal disease served to highlight his expertise on the subject.

[589] Cunningham, *The Anatomist Anatomis'd*, p. 142.

Figure 4.3. The penis slit open, showing a stricture in the urethra. Engraving by William Sharp, after William Bell, in John Hunter, *A Treatise on the Venereal Disease* (London, 1786). Image courtesy of the Wellcome Library, London.

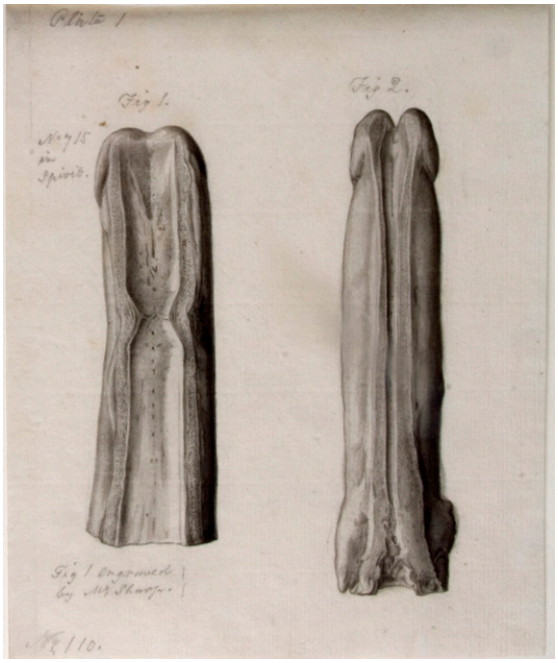

Figure 4.4. Two penises showing urethral strictures. Pencil drawing by William Bell, *c*.1744–1786. © The Hunterian Museum at the Royal College of Surgeons, RCSSC/HDB/4/2/394/3.

Figure 4.5. A penis, dissected to show the urethra and the annular stricture that had developed two inches from its external orifice. Wet preparation, *c*.1760–1793. © The Hunterian Museum at the Royal College of Surgeons, RCSHC/P 308.

The stricture preparation is likely a 'white preparation', made by simply draining the penis of the blood and preserving it in alcohol, those that John Shaw considered the most lasting.[590] Conversely, these were the very type of preparations that Robert Knox considered the most useless, opining that they were subject to degradation however they were preserved, and that it was often difficult to make out the salient appearance they sought to present.[591] The consideration of the preparations as useless however depends on a very specific idea of their use,

[590] Shaw, *A Manual of Anatomy*, p. 431.
[591] Cunningham, *The Anatomist Anatomis'd*, p. 235.

and Knox was only assessing their value in fixing and maintaining the appearances of diseases. Knox in fact noted that there were better ways of demonstrating the symptoms and appearances of venereal disease visually and materially, one of which was in the form of the wax models.[592]

Museums in the Marketplace

While preparations of venereal symptoms most often preserved and displayed the interior morbid changes of structure occasioned by venereal disease, such as carious bones, wax models and moulages exhibited the exterior, cutaneous symptoms of the living patient. Dermatological moulages were coming into wide use by the mid nineteenth century. Robert Knox deemed them the only suitable form of visual representation for cutaneous and venereal diseases. The macerated post-mortem symptoms were not sufficient to demonstrate the symptoms of the disease and venereal disease needed more layers of artifice and human interaction to accurately represent them. Moulages granted the necessary qualities to the representations of venereal disease, they showed a colour, depth and texture that pictures and preparations could not attain. For Knox, '[a] wax model has an immense advantage over all manner of drawings whatever; it is a model in relief, or perhaps a cast, it does not absolutely matter which, coloured after life, and therefore perfectly calculated to give to the eye a just and permanent impression'.[593] Though Knox warned that this method of representation was unsuitable for models of healthy anatomy, adding with characteristic vitriol that he would happily return these anatomical models 'into the shapeless mass of wax

[592] Knox, 'Original Lectures. Anatomical Museums', p. 327.
[593] Ibid., p. 327.

out of which they were originally formed, that thus converted into tapers, they might give light – in their present form they only spread darkness'.[594]

Wax has been a curiously mythologized material for historians, particularly historians of art. Highlighting an indexical relationship between wax and skin, film theorist Mark Sandberg writes that wax is a 'recording technology' in the same vein as photography, suggesting that the creation of representations in wax was less mediated than in other media.[595] Others emphasize a curious suitability it has for representing the human body, noting the historical uses of wax in the creation of effigies in funerary rites.[596] Several art historians studying medical wax models seem to suggest that it was essentially the qualities of the wax itself that made the models so meaningful. In this vein, Art historian Roberta Panzanelli writes that wax 'is tied to the processes of life: birth, metamorphosis, dissolution – and sometimes regenerations'.[597] Art historian and philosopher Georges Didi-Huberman writes of wax that, '[t]he reality of the material turns out to be more troubling because it possesses a viscosity, a sort of activity and intrinsic force'.[598] Similarly, art historian Uta Kornmeier writes that wax can 'exude such a strong corporeal presence that we are convinced, against our better judgement, that we are in the company of a fellow human being rather than a lifeless image'.[599] For these art historians, wax was meaningful as a

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[594] Ibid., p. 327.
[595] Mark B. Sandberg, *Living Pictures, Missing Persons: Mannequins, Museums, and Modernity* (Princeton and Oxford: Princeton University Press, 2003), p. 38.
[596] Pamela Pilbeam, *Madame Tussaud and the History of Waxworks* (London and New York: Hambledon and London, 2003), p. 1.
[597] Roberta Panzanelli, 'Introduction: The Body in Wax, the Body of Wax' in Roberta Panzanelli (ed.), *Ephemeral Bodies: Wax Sculpture and the Human Figure* (Los Angeles: Getty Research Institute, 2008), p. 1.
[598] Georges Didi-Huberman, 'Viscosities and Survivals: Art History put to the test by the material', in Roberta Panzanelli (ed.), *Ephemeral Bodies: Wax Sculpture and the Human Figure* (Los Angeles: Getty Research Institute, 2008), pp. 155.
[599] Uta Kornmeier, 'Almost Alive: The Spectacle of Verisimilitude in Madame Tussaud's Waxworks', in Roberta Panzanelli (ed.), *Ephemeral Bodies: Wax Sculpture and the Human Figure*

representational medium for the body because of its organic nature, its material resemblance to human flesh.

In many ways it is easy to come to this conclusion; wax moulages and models are unnervingly lifelike, more so than models made of plastic or plaster. However, rather than ascribing all the characteristics of wax models to the qualities of the material itself, it is important to recognise the artificiality of the models. The curious obsession with the verisimilitude of wax has been tempered somewhat by historians of science and medicine, who have been less enthralled by the nature of wax. Anna Maerker, writing on Italian anatomical Venuses argues that '[t]he apparent serenity of the artificial anatomies obscures the fact that they were surrounded by human interactions and frequent controversy'.[600] As well as recognising that these models were created and utilised by different people and in different ways, we must also consider other factors of their creation beyond their base material. In the process of making wax malleable, numerous other ingredients were added, often turpentine, along with dyes.[601] Whilst allowing for the similarities between wax and flesh, historian Nick Hopwood suggests that this alone did not guarantee that the models were useful or important, in particular noting how colour was added to the wax embryos he studies 'both naturalistically and schematically'.[602] The casting, moulding, colouring and the addition of artificial hair also contributed to the verisimilitude of wax models. The levels of artifice become even more obvious when we consider the method of creating models in wax. Writing on the process used by the Tussaud family to create their wax works, historian Pamela Pilbeam explains that first a fine plaster of paris

(Los Angeles: Getty Research Institute, 2008), p. 67. See also Pilbeam, *Madame Tussaud and the History of Waxworks*, p. 221.
[600] Maerker, *Model Experts*, p. 4.
[601] Cunningham, *The Anatomist Anatomis'd*, p. 246.
[602] Hopwood, *Embryos in Wax*, p. 36.

mask would be applied to the skin, before molten wax was poured into the plaster negative; when this had hardened, the wax positive would be hand coloured, and adorned with hair, glass eyes and false teeth.[603]

Within London's thriving medical marketplace wider public fascination with both wax models and preparations was rife.[604] The eighteenth century saw the birth of the public museum in Britain, centred in London. In his exhaustive study of the museums, exhibitions and sundry other attractions in the city, literary scholar and historian Richard Altick argues that the emergence of these entertainments represented a 'Grand Tour mentality' that sought to simultaneously experience the wider world whilst capturing and bringing it home to Britain.[605] The mid eighteenth century was the period in which collections of the wonders of the world that had previously been cloistered away by wealthy society elites were made public. The establishment of the British Museum in 1753, after Sir Hans Sloane bequeathed his massive collection of natural history objects to the nation, typifies this move.[606] An emergent public hunger for access to natural history collections, artworks, mechanical objects and medical models demonstrated that, as Altick writes '[k]knowledge, however conveyed, had become a profitable commodity'.[607] Natural history collections, and cabinets of curiosity had commonly featured medical objects from the seventeenth century.[608] Within this new public realm of museums and exhibitions, the medical museum provided the public not only with diverting curios to entertain them, but also with

[603] Pilbeam, *Madame Tussaud and the History of Waxworks*, p. 28.
[604] Porter, 'Medical Lecturing in Georgian London', p. 92.
[605] Altick, *The Shows of London*, p. 23.
[606] Carla Yanni, *Nature's Museums: Victorian Science and the Architecture of Display* (New York: Princeton Architectural Press, 2005), p. 24.
[607] Altick, *The Shows of London*, p. 23.
[608] Claudia Swan, 'Making Sense of Medical Collections in Early Modern Holland: The Uses of Wonder' in Pamela H. Smith and Benjamin Schmidt (eds), *Making Knowledge in Early Modern Europe: Practices, Objects and Texts, 1400–1800* (Chicago and London: University of Chicago Press, 2007), p. 208.

a new site for the consumption of medical knowledge and practice. The *Lancet* was initially excited by the pubic anatomy exhibitions, considering that a more informed public would be less liable to fall victim to the machinations of quacks. Of one exhibition of wax figures, one reviewer wrote that 'we have no doubt that those non-medical visitors who witnessed [the] accurate effigies of the organs of the human frame had less disposition afterwards to trust their health to the tamperings of ignorant and unscrupulous quacks'.[609]

London was a city of innumerable diversions and entertainments, from the theatre to the pub, and these medical museums were part of a larger market for leisure.[610] As well as museums there were large fairs such as the annual Bartholomew Fair, which offered all manner of epicurean indulgences, rampant opportunities for gambling and fighting, and, a favourite pastime of many Londoners, the chance to gawp at a variety of freaks.[611] The anatomical museums founded in the city at this time frequently capitalised on this obsession with the freak show, displaying deviant anatomies alongside the standard. Amongst the more famous of these medical museums were those of Guillaume Desnoués, who brought his models from France to London in the 1730s, and Benjamin Rackstrow, who established his museum on the bustling Strand.[612] These museums were not exclusively devoted to standard anatomy, and frequently contained pathological models and preparations. One particularly admired pathological collection was that of Dr Felix Thibert who brought a collection of models and casts from Paris in 1845, which included 'some well-executed specimens of diseases of the skin, taken from cases treated in the hospital of St.

[609] 'Reviews and Notices of Books', *Lancet*, 1 March 1851, p. 242.
[610] Desmond, *The Politics of Evolution*, p. 12.
[611] Altick, *The Shows of London*, p. 35.
[612] Pilbeam, *Madame Tussaud and the History of Waxworks*, p. 5.

Louis, at Paris'.[613] In 1851, many of Thibert's models were exhibited at the Great Exhibition.[614]

Whilst the *Lancet*, as well as John Hunter and his fellow elite museum owners were mostly convinced of the importance of such models and preparations within the practice and pedagogy of medicine, these new public spaces in which these objects were moving could potentially undermine their identity as legitimate medical knowledge, transforming them into instruments of quackery and malice. A particularly striking example of this instability is the case of Joseph Kahn's museum. Kahn established his museum of anatomy in London in 1851, soon after which the *Lancet* deemed it 'a splendid scientific collection'. [615] However this reputation was not to last, and when the museum closed down in 1873 after protracted legal battles, the prosecuting solicitor Mr Collette requested that he be permitted to destroy the contents of the museum himself.[616] The request granted Collette took a hammer to the anatomical wax models that formed the majority of the museum, 'the fragments of which were then handed back to the defendants'.[617] What had happened in the intervening twenty-two years to make the models themselves so utterly irredeemable as objects of medical knowledge?

Kahn himself remains a shadowy character, probably Dutch, though others have claimed he was German, he came to London in 1851 with an exhibition that contained preparations, including 103 preserved foetuses, and wax models, amongst which was an impressive anatomical Venus which broke down into

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[613] 'Anatomical Museum', *The Standard*, Thursday 26 June 1845.
[614] *Official Descriptive and Illustrated Catalogue of the Great Exhibition of the works of industry of all nations, part IV, Colonies.- Foreign States, Division i.* (London: Spicer Brothers, Wholesale Stationers; W. Clowes & Sons, Printers, 29 New Bridge Street, Blackfriars, and at the Exhibition Building, 1851), p. 1218.
[615] 'Medical News: Dr Kahn's Anatomical Museum', *Lancet,* 26 April 1851, pp. 473–474.
[616] 'The Police Courts', *Daily News*, Friday 19 December 1873.
[617] A. W. Bates, 'Dr Kahn's Museum: Obscene anatomy in Victorian London', *Journal of the Royal Society of Medicine*, 99:12 (December 2006), p. 621.

eighty-five parts.[618] The Venus model was an important feature of the anatomical museums of the nineteenth century.[619] Taking the form of life sized recumbent nudes, the Venuses could usually be taken apart, revealing internal organs, usually highlighting the womb, which often concealed a model of a foetus. These models performed a similar function to the idealised and imagined perfect bodies seen in the anatomy atlases of the sixteenth and seventeenth century, and were designed to display an idealised anatomy.[620] Roberta McGrath has suggested that the role of the Venus in the public medical museum was to titillate rather than educate, and certainly the languid reclining figures often seem to 'suggest a sexualised female body that the observer, presumed male, might penetrate'.[621] One infamous Venus brought to London in the touring show of surgeon Abraham Chovet (1704–1790) in 1733 seems a disturbing admixture of the sexualised and the anatomised; it represented 'a woman chained down upon a table, suppos'd opened alive; wherein the circulation of the blood is made visible through glass veins and arteries'.[622] London's early eighteenth-century surgeons evidently did not have a problem with the overtly theatrical display and Chovet was appointed as an anatomical demonstrator at the Company of Surgeons in 1734.[623]

Kahn's own Venus, along with his preparations and models were evidently also popular in the city and he soon established his exhibition permanently at 315

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[618] Pilbeam, *Madame Tussaud and the History of Waxworks*, p. 139.
[619] Stephens, *Anatomy as Spectacle*, especially chapter 1 'The Docile Subject of Anatomy: Gynomorphic Waxworks in Eighteenth- and Nineteenth-Century Public Exhibitions', pp. 26–52.
[620] Lyle Massey, 'On Waxes and Wombs: Eighteenth-Century Representations of the Gravid Uterus', in Roberta Panzanelli (ed.), *Ephemeral Bodies: Wax Sculpture and the Human Figure* (Los Angeles: Getty Research Institute, 2008), p. 83. See also Thomas Schnalke, 'Casting Skin: Meanings for Doctors, Artists, and Patients' in Soraya de Chadarevian and Nick Hopwood (eds), *Models: the Third Dimension of Science* (Stanford: Stanford University Press, 2004), p. 215.
[621] McGrath, *Seeing her Sex*, p. 16.
[622] Quoted in Thomas N. Haviland and Lawrence Charles Parish, 'A Brief Account of the Use of Wax Models in the Study of Medicine', *Journal of the History of Medicine and Allied Sciences*, 25:1 (1970), p. 63.
[623] Ibid., p. 63.

Oxford Street where it quickly grew in both size and popularity, coming to house over 500 exhibits in its first years.[624] Amongst the models and preparations on display to the paying public was a special room 'set apart for members of the medical profession, in which the ravages of syphilis and gonorrhoea are very well shown'.[625] Though this room was advertised as solely for medical men, the reality saw any member of the public who could pay, male or female, admitted freely.[626] Kahn's was not the only such establishment. In 1852 the *Lancet* noted the opening of 'Reimer's Anatomical Collection' which, along with numerous anatomical waxes, also features 'illustrations showing the ravages of syphilis, gonorrhoea, &c., which no doubt will warn many young men who may visit this exhibition of the dangers attending indiscretions'.[627]

At first, the medical community welcomed the museum, especially anti-quackery crusaders such as the *Lancet*, however this goodwill did not last long and soured after Kahn, attempting to revive flagging public interest, went into business with the brothers Perry and Co., a group of unlicensed practitioners famed for selling cures for venereal disease through the post.[628] Kahn began using the museum to lecture on venereal diseases, simultaneously flogging the Perry-produced tract *The Shoals and Quicksands of Youth*, formerly published as *The Silent Friend*, a rather lurid guide to sexual health.[629] *The Silent Friend* reads as a rather hysterical extended advert for the Perrys' own venereal panacea the 'CORDIAL BALM OF SYRIACUM which has restored strength and vigour to

[624] Bates, 'Dr Kahn's Museum, p. 619.
[625] 'Medical News: Dr Kahn's Anatomical Museum', pp. 473–474.
[626] Bates, 'Dr Kahn's Museum, p. 620.
[627] 'Medical News', *Lancet*, 25 June 1853, p. 560.
[628] Bates, 'Dr Kahn's Museum', p. 620.
[629] Ibid., p. 620.

hundreds of debilitated individuals'.[630] *The Silent Friend* was by no means the only volume of its kind doing the rounds in nineteenth-century London. A comparable tract known as *The Secret Companion* produced by a company known as R. J. Brodie and Co. was popular at the same time. Suspiciously similar in style to *The Silent Friend*, Brodie's work advertised the 'CORDIAL BALM OF ZEYLANICA; or Nature's Grand Restorative, which has been the means of restoring to perfect health those who have been suffering from the greatest debility'.[631] Indeed, the similarities between these two tracts was explained by the *Lancet* in 1845 who revealed that '[t]hese men, under the assumed names of Perry, Curtis, Lucas, Brodie, &c. are chiefly members of one family, brothers and fathers, as nearly related by blood, in fact, as their publications are by filth.'[632]

The pseudo-medical tracts produced by the various branches of this nefarious family dealt with the reproductive organs of the body and warned extensively of the horrors that could befall the licentious. Both *The Silent Friend* and *The Secret Companion* were illustrated with images showing the degradation visited on the sufferer as a consequence of venereal disease, or even of masturbation. Many of the illustrations depicted the typical visual trope of the masturbator discussed in chapter one (fig. 1.2), the wasted and hollow-faced

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[630] Perry and co., *The Silent Friend: A Medical Work, on the disorders produced by the dangerous effects of onanism, all its dreadful consequences considered including Nervous and Sexual Debility, Impotency &c. and on Venereal and Syphilitic Diseases with Plain Directions for the Removal of Secondary Symptoms, Gonorrhoea or Clap, Gleets, Strictures, Whites, and all Diseases of the Urinary Passages, Without the Use of Mercury, Confinement, or Hindrance from Business; Followed by General Instructions for the Perfect Restoration of those who are incapaticated from entering into the holy state of Marriage; by the evil consequences arising from early abuse, or syphilitic infection; Illustrated by Engravings. By R. and L. Perry and Co., consulting surgeons, 4, Great Charles Street, Birmingham, and 41, Albion-street, Leeds.* (Birmingham: Published by the Authors, and sold by Strange, 21 Paternoster-Row; Wilson, 18 Bishopgate-street; Purkess, Compton-street, Soho; Jackson 7 Co. 130, New Bond-street, London; and by all Booksellers in the United Kingdom, 1841), p. 38.
[631] Brodie, *The Secret Companion, A Medical Work on Onanism or Self-Pollution*, p. 30.
[632] 'Review: *The Secret Companion. A Medical Work on Nervous Debility, and the Concealed Cause of Generative Infirmities in both Sexes*. In a sealed envelop, with full-length Engravings, &c. &c. Sixteenth Edition. By R. J. Brodie and Co., Surgeons. Sold by Sherwood, Gilbert, and Piper. 1845.' *Lancet,* November 1845, p. 563.

young man. Venereal diseases were represented far more dramatically though. A particularly disturbing image in *The Secret Companion* shows the face of a woman grotesquely deformed, her skin a blood red, her jaw twisted and her teeth protruding out of her mouth (fig. 4.6). The caption below the image reads '[r]epresenting the last stage of Lues Venerea where the Mouth nose & part of the face are destroyed from that disease & the baneful effects of mercury'.[633]

It is difficult for the historian to assess the aesthetics of Kahn's models themselves, as none of them survived the destructive actions of Mr Collette in 1873, and there are no depictions of them in any of the surviving museum catalogues. Historian A. W. Bates asserts that 'the syphilitic models were as sensational as anything in the Chamber of Horrors' at Madame Tussaud's, suggesting that they likely resembled the dramatic illustrations produced in the accompanying tracts.[634] Yet the approval of the *Lancet* in the early days of Kahn's operation suggest they must have been less frightful. In her PhD thesis, Maritha Rene Burmeister writes that as Kahn and the Perrys altered the purpose of the museum, the displays remained largely the same.[635] Given that all of Kahn's models were destroyed after the eventual obscenity trial, I would suggest that at least some of them were perhaps more vulgar and ostentatious than most accepted medical models, probably coming closer to resembling the images from the scare-mongering *Silent Friend* or *Secret Companion*.

[633] Brodie, *The Secret Companion, A Medical Work on Onanism or Self-Pollution*.
[634] Bates, '"Indecent and Demoralising Representations": Public Anatomy Museums in mid-Victorian England', p. 18.
[635] Maritha Rene Burmeister, 'Popular Anatomical Museums in Nineteenth Century England' (unpublished doctoral thesis, Rutgers, the State University of New Jersey, 2000), p. 216.

Figure 4.6. The last stage of Lues Venerea. Coloured engraving in R. J. Brodie, *The Secret Companion, A Medical Work on Onanism or Self-Pollution* (London, 1845). Image courtesy of the Wellcome Library, London.

These images though were not always so macabre in their aesthetic, and they often copied illustrations from medical publications produced by orthodox practitioners. One plate in the Perrys' *Silent Friend* shows a man with three large venereal growths on his face, one looking almost like a horn protruding from his forehead (fig. 4.7). This is a strikingly similar image to one included in Richard Carmichael's 1814 *Essay on the Venereal Diseases* illustrating three advanced

phagedenic ulcers on a patient's face (fig. 4.8).[636] This was not unusual in the early nineteenth century, images were frequently borrowed from one book to be reproduced in another, however, this does indicate the coalescence of official and illicit representational strategies within the medical marketplace.[637] Groups like the Perrys represented a new breed of unlicensed practitioner threatening orthodox medicine in the mid nineteenth century; they were not the flamboyant mountebanks of previous centuries. Rather they looked like licit medical practitioners, they spoke the languages of orthodox medicine such as pathology, and they embraced the formats of orthodox medicine to present their knowledge and sell their cures.[638] Along with Carmichael's images, *The Silent Friend* used the same learned medical language as Carmichael, vividly describing a variety of forms of chancre, including sloughing and phagedenic, demonstrative of their familiarity with official medical discourse. The overtly descriptive character of Carmichael though was not deemed sufficient to instil the requisite horror of venereal disease in the visitor to Kahn's museum, and *The Silent Friend* necessarily had to go beyond a mere nosological description of symptoms that Carmichael had given. Referring to the image copied from Carmichael, the Perrys warn that '[w]ith these appearances the face has been known to be completely covered… and not only is the breath offensive, but the other excretions become also affected by this putrid action, exhaling a very unpleasant effluvia'.[639] If the Perrys were to be believed, it was not just the ulcers pictured that the patient would suffer, they should also look forward to almost total bodily breakdown.

[636] Carmichael, *An Essay on Venereal Diseases*, p. 375.
[637] McGrath, *Seeing her Sex*, p. 59.
[638] Loudon, *Medical Care and the General* Practitioner, pp. 210–212.
[639] Perry, *The Silent Friend*, pp. 115–116.

Figure 4.7. Face of a man suffering from venereal disease. Engraving in Perry, *The Silent Friend, A Medical Work* (London, 1841), p. 115. © British Library Board, 1172.c.11.

Figure 4.8. Detail showing phagedenic ulcers on the face of a male patient. Drawing by R. L. West, engraving by J. Stewart, in Richard Carmichael, *An Essay on Venereal Diseases* (London, 1814). Image courtesy of the Wellcome Library, London.

The content of the books assume a familiarity with visual representations in use in other medical museums and schools as well as in well-known published treatises like Carmichael's. *The Silent Friend*, proclaiming the dangers of mercury as a cure, announced that '*Yes, the rotten skulls which are to be found in anatomical museums* – with all the other beautiful specimens of diseased bones, which in our younger days were so abundant in hospitals, in the great majority of cases *were the production of long and harassing courses of mercury*.'[640] Thus it was the unlicensed practitioner who rendered legible to the public the representational trope of the 'rotten skulls', seen in the atlases of William Cheselden (fig. i.1), Matthew Baillie (fig. 2.1) and in the museum of John Hunter (fig. 4.2). The Perrys' familiarity with the multiple forms of visual and material representation in a variety of places highlights the integration of various branches of medical practice within London's medical marketplace. Rather than a genteel cadre of educated practitioners using preparations to educate future elites whilst a bawdy group of quacks painted lewd pictures to scare the public, the sophisticated co-option of a visual culture inaugurated in elite formats such as the atlas enabled this group of illicit practitioners to situate themselves as legitimate within the medical marketplace, attracting both customers and prestige. Indeed, there are a number of recurring iconographic tropes that demonstrate the integration of elite and popular medical views of venereal disease.

One evident shared concern was that of the incredibly destructive nature of the disease on the body. Many of the preparations that depicted venereal disease in Hunter's museum were those of carious bones, a popular trope for medical illustrations of venereal disease, seen in both Baillie's 1803 atlas, and Robert

[640] Perry, *The Silent Friend*, p. 125.

Carswell's 1838 *Pathological Anatomy* (fig. i.2). Indeed the top fragment of skull that Baillie chose to use was drawn from a preparation housed in Hunter's museum, whilst the lower image was drawn from a preparation owned by John Pearson, then a surgeon at the Lock Hospital.[641] These 'rotten bones', as the Perrys referred to them, suggest an important element in the fear of disease was its evocation of physical decay and living death. The iconographic trope of the skeleton or skull as *memento mori* had been popular in medical and artistic imagery from the seventeenth century.[642] The skull in this incarnation reminded the viewer to consider their own mortality, to think on their certain death.[643] In the case of venereal disease, the *memento mori* became a threatening image that reminded the viewer not only of the inevitability of death, but of the possibility of the living death, physical erosion and intense pain of the disease. One popular print from the late eighteenth century depicted the decomposing skull of a prostitute who had died after contracting venereal disease (fig. 4.9). As explored earlier in this thesis the figure of the prostitute was an important locus for the fear of venereal disease, and this fear was often visualised by portraying her inevitable physical degeneration. In a poem detailing the morality, or lack of, in nineteenth-century London, poet John Lawrence described the disease infecting a woman fallen to prostitution thusly;

> A wily serpent coiling in her path;
> A barbed arrow planted in her breast;
> A deadly poison rankling in her veins,
> And menacing the citadel of life.

[641] Baillie, *A Series of Engravings,* p. 211–212.
[642] Sarah Tarlow, *Ritual, Belief, and the Dead Body in Early Modern Britain and Ireland* (Cambridge: Cambridge University Press, 2011), p. 75.
[643] Ludmilla Jordanova, 'Melancholy Reflection: Constructing an Identity for Unveilers of Nature', in Stephen Bann, *Frankenstein, Creation and Monstrosity* (London: Reaktion Books, 1994), p. 70.

> Ah, there disease anticipates at large,
> The putrefaction of the noisome grave;
> And causes by its slow consuming fires,
> The pale, cadaverous, and loathsome wretch,
> To rot alive in passion's putrid sink.[644]

The notion that this was a disease that rotted the sufferer alive was repeated throughout medical and lay cultures, from the 'rotten bones' of the medical museums and pathological atlases, to the prints and poetic imagery circulating amongst London's public. This was not a concern limited to venereal disease. Literary theorist Erin O'Connor highlights the case of Asiatic cholera that hit London in sporadic epidemics over the nineteenth century, the victims of which were so wasted so quickly 'that their corpses bore little resemblance to the people that had once animated them'.[645] The potential of certain diseases to provoke this living death heightened both the fear of contracting them, and the associated stigma.

[644] John Lawrence, *London in the Nineteenth Century, a Poem in Three Books by John Lawrence* (Wantage: Printed and Published by J. and G. Lewis; Sold also by J. Mason, 66, Paternoster Row, London; and other Booksellers, 1844), p. 48.
[645] O'Connor, *Raw Material*, p. 11.

Figure 4.9. A preserved skull of a woman who had been suffering from syphilis and who died in 1796. Anonymous engraving. Image courtesy of the Wellcome Library, London.

The repeated use of the skull in these contexts is important as it represents a fear not just of a living death brought on by venereal disease, but its horrific manifestations on the face in particular. Pseudo-medical tracts such as *The Silent Friend* and *The Secret Companion* concentrated on the horrific effects of venereal disease on the face more than any other part of the body. Contemporary medical accounts of venereal disease spoke widely of its disfigurement of the face, from the collapse of the nose to the quite frightening appearance of lesions and sores, which Samuel Cooper had described as leaving 'the face sadly disfigured'.[646] Indeed one of the earliest images of a venereal disease sufferer, taken from a seventeenth century medical text shows the face of a patient afflicted as monstrously deformed, almost inhuman (fig. 4.10). The dehumanising attack on the face remained a common visual trope within elite medical and public representations of venereal disease. Claudia Benthien has argued that the

[646] Cooper, *A Dictionary of Practical Surgery*, p. 214.

aesthetics of wax moulages that showed the destructive effects of dermatologic conditions reveals 'the nineteenth century's fear of these surface-destroying lesions', particularly their ability to permeate the skin.[647]

Figure 4.10. Head deformed as a result of the pox. Woodcut from Marco Aurelio Severino, *De Recondita Abscessuum Natura* (Naples, 1632), p. 123. Image courtesy of the Wellcome Library, London.

The distorted face had cultural resonance beyond the dichotomy of diseased or healthy, ugliness of the physical flesh suggested a corresponding ugliness of character.[648] In a study of physiognomy in the late eighteenth century Ludmilla Jordanova writes that '[w]hen late eighteenth and early nineteenth-

[647] Claudia Benthien, *Skin: On the Cultural Border between Self and the World*, trans. Thomas Dunlap (New York: Columbia University Press, 2002), p. 59.
[648] Sander L. Gilman, *Creating Beauty to Cure the Soul: Race and Psychology in the Shaping of Aesthetic Surgery* (Durham and London: Duke University Press, 1998), p. 30.

century medical people looked, they saw far more than patients and diseases; they perceived a natural and/or divine universal order and they invested that order with aesthetic value.'[649] The practice of physiognomy in the eighteenth century was devoted to reading the signs of the passions of the mind on the face. The Swiss physiognomist Johann Caspar Lavater (1741–1801) began his celebrated 1778 work on physiognomy by extolling the magnificence of the human form, created in God's own image, exclaiming '[b]y how many strange and various languages, motions, and signs, does this created image of God discover the divinity of his original! Revealed in the human face, what majestic expression!'[650] Any distortion of this divine face had the potential therefore to indicate a deformed and damaged character. Eighteenth- and nineteenth-century images frequently invoked the visual language of physiognomy to persuade readers of the character of their subjects. One contemporary sketch of notorious resurrectionists-turned-murderers Burke and Hare 'gave Burke's skull the shape of a man in thrall to the animal passions, and turned Hare into a cunning fox'.[651] Perhaps surprisingly Lavater mentioned little about the various ways in which disease changed the face, though he did indicate that illness could be discerned in sufferers faces. 'The patient has frequently the mien of his disease' explained Lavater, adding that '[t]his mien of which I speak, cannot possibly escape the least attentive observer, especially in the ravages of the venereal disease'.[652] He went on to say about the diseased that, '[a] man whose look was formerly gentle and serene, and who with his face all on

[649] Ludmilla Jordanova, 'The art and science of seeing in medicine: physiognomy 1780–1820' in W. F. Bynum and Roy Porter, *Medicine and the Five Senses* (Cambridge: Cambridge University Press, 1993), p. 131.
[650] Johann Caspar Lavater, *Essays on physiognomy; calculated to extend the knowledge and the love of mankind. Written by the Rev. John Caspar Lavater, Citizen of Zurich. Translated from the last Paris edition, by the Rev. C. Moore… Illustrated by several hundred engravings, accurately copied from the originals…* Vol. 1. (London, 1797), p. 4.
[651] MacDonald, *Human Remains*, p. 24.
[652] Lavater, *Essays on Physiognomy*, p. 124.

fire, fixes a disturbed and wild eye upon me, always fills me with apprehension of a deranged understanding'.[653] Sufferers then were not merely ill in their bodies, their distorted faces revealed the state of their mind and character.[654]

As well as the wealth of vivid imagery available to London's public, textual accounts of venereal disease often also focused on the corrosive effects it had on the face, and the intimidating potential it had in this way to erase identity and render the victim as unrecognisable. In Voltaire's novel *Candide*, the titular hero encounters a man ravaged by disease whom he at first does not recognise because, '[t]he visage of this poor wretch was livid, his lips were covered with froth, his eyes half turned in his head, and the image of death strongly imprinted on his lean and fallen cheeks'. The man, in a surprisingly upbeat fashion, relates that he suffers many diseases including fevers, asthma, and venereal disease. As Candide remarks on the poor man's seemingly indefatigable optimism in the face of his great suffering it is revealed that he is in fact Candide's former mentor Dr Pangloss who tells him that all is for the best. Though immediately following this Candide finds that '[t]he effort which he made in pronouncing these words, cost him the last tooth, which he spitted out with a great quantity of corrupted matter, and expired a very few moments after.'[655] Likewise we can hear this tendency in a poem by writer Robert Dodsley (1703–1764) entitled 'Pain and Patience, an ode'. Dodsley wrote,

> He whose hot blood excites to dangerous joy,
> And headlong drives to seek the lewd embrace,
> Startled at length, shall in his face descry

[653] Ibid., p. 124.
[654] Sander L. Gilman, *Making the Body Beautiful: A Cultural History of Aesthetic Surgery* (Princeton and Oxford: Princeton University Press, 1999), p. 49.
[655] Voltaire, *A Collection of the tales, and small pieces of Mons. De Voltaire. In two volumes…* (Vol. 2, Edinburgh, 1792), p. 193. See also Gilman, *Making the Body Beautiful*, p. 51.

> The mark indelible of foul disgrace:
> Ulcers obscene corrode his akeing [*sic*] bones;
> And his high raptures change to deep-felt sighs and groans.[656]

In order to warn people away from licentious behaviour, Dodsley focused on the disfiguring marks of venereal disease, referred to here as 'foul disgrace' that would besmirch the face and elicit terrible pain. The choice made by unlicensed practitioners like the Perrys to depict the horrific effects of venereal disease on the face above all else, was not merely a ploy to terrify the public into buying cures; these representations were thoroughly embedded within a shared medical and public culture that feared, either tacitly or explicitly, these most degrading of symptoms.

[656] Robert Dodsley, 'Pain and Patience, An Ode', *The Blind Beggar of Bethnal Green. A Dramatic performance: with several instructive and entertaining pieces…* (Philadelphia, 1777), p. 49.

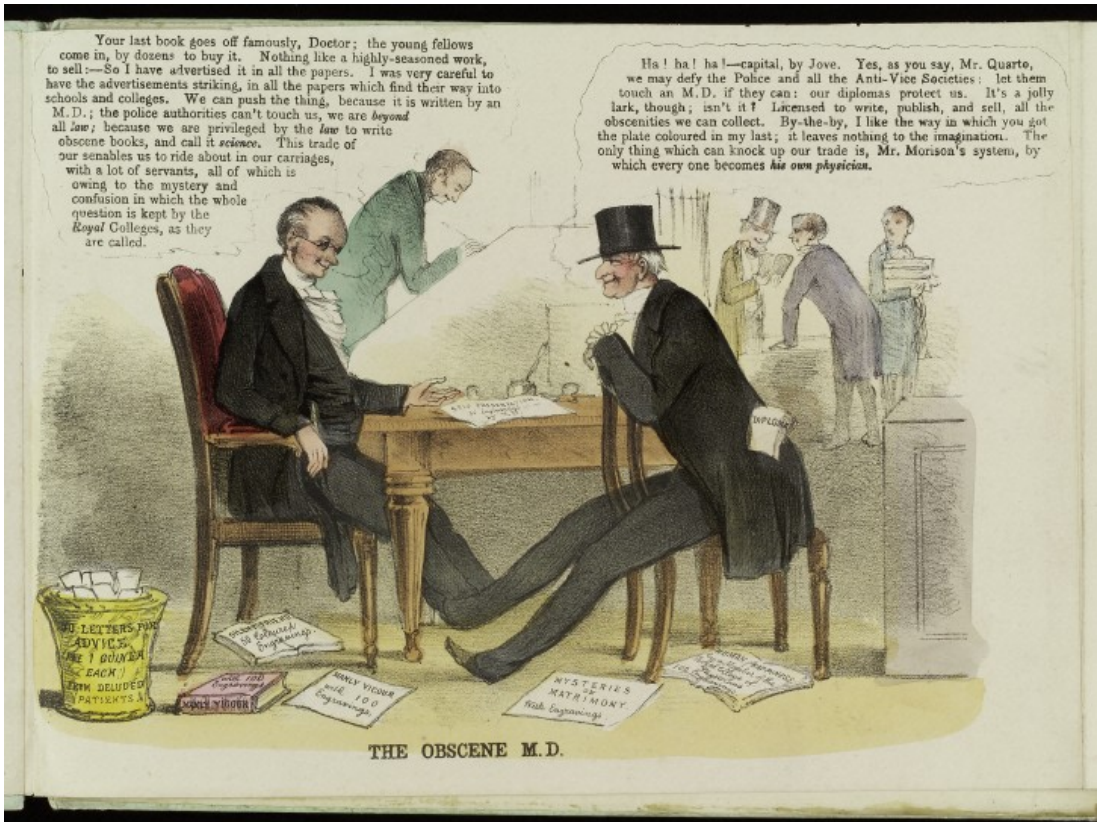

Figure 4.11. A doctor who write books of sexual advice talking to his cynical publisher. Coloured lithograph (London, 1852). Image courtesy of the Wellcome Library, London.

Publications like *The Silent Friend* and *The Secret Companion* became so common around London that they were the subjects of an 1852 cartoon, roundly denouncing both the doctors and publishers who engaged in producing them (fig. 4.11). The man on the left is the unscrupulous publisher who gleefully boasts that '[w]e can push the thing, because it is written by an M.D.; the police authorities can't touch us, we are *beyond* all *law*; because we are privileged by the *law* to write obscene books, and call it *science*'.[657] The expansion of literacy and print at

[657] The full text on the image runs thus; Publisher: 'Your last book goes off famously, Doctor; the young fellows come in, by dozens to buy it. Nothing like a highly-seasoned work to sell:- So I have advertised it in all the papers. I was very careful to have the advertisements striking, in all the papers which find their way into schools and colleges. We can push the thing, because it is written by an M.D.; the police authorities can't touch us, we are *beyond* all *law*; because we are privileged by the *law* to write obscene books, and call it *science*. This trade of ours enables us to ride about in our carriages, with a lot of servants, all of which is owing to the mystery and confusion in which the whole question is kept by the *Royal* Colleges, as they are called.' – The Obscene MD: 'Ha! ha! ha! – capital, by Jove. Yes, as you say, Mr. Quarto, we may defy the Police and all the Anti-Vice

the end of the eighteenth century led to new social concerns over what was being read, resulting in the establishment of various moralising groups, such as the Society for the Suppression of Vice in 1802, who worked to prosecute those associations and individuals they considered as promoting immorality.[658] Though the Society managed to prosecute groups for offences such as violating the sanctity of the Sabbath, they had much less luck when it came to medical publications, despite a Royal Proclamation issued in 1787 which aimed to 'suppress all loose and licentious Prints, Books and Publications'.[659] Even the Obscene Publications Act, passed in 1857, had little initial effect on the trade in such licentious medical books, rather it merely gave magistrates new powers to allow the police to seize obscene materials intended for publication.[660] As equally thrilled at this lax state of affairs as his publisher, 'the obscene MD' in the cartoon responds with '[i]t's a jolly lark though; isn't it? Licensed to write, publish, and sell, all the obscenities we can collect. By-the-by, I like the way in which you got the plate coloured in my last; it leaves nothing to the imagination.' Scattered around the floor beneath the two men in the image are various famous works of their unsavoury oeuvre, including *The Silent Friend* seen under the chair of the publisher on the left.

The Silent Friend and associated cures the Perrys sold through the museum served to reverse Kahn's flagging fortunes and it appears he

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Societies: let them touch an M.D. if they can: our diplomas protect us. It's a jolly lark though; isn't it? Licensed to write, publish, and sell, all the obscenities we can collect. By-the-by, I like the way in which you got the plate coloured in my last; it leaves nothing to the imagination. The only thing which can knock up out trade is Mr. Morison's system, by which every one becomes *his own physician*.' Image courtesy of the Wellcome Library, London.

[658] Alan Hunt, *Governing Morals: A Social History of Moral Regulation* (Cambridge: Cambridge University Press, 1999), pp. 67–73.

[659] McGrath, *Seeing her Sex*, p. 55.

[660] Tom Lewis, 'Legislating Morality: Victorian and Modern Legal Responses to Pornography', in Judith Rowbotham and Kim Stevenson (eds), *Behaving Badly: Social Panic and Moral Outrage, Victorian and Moral Parallels* (Aldershot and Burlington: Ashgate, 2003), p. 147.

wholeheartedly embraced his new practices. He set up offices above the museum where he could see patients who had been shocked by what they saw in the museum and who thus suspected they might end up similarly disfigured. In the course of a few years, Kahn's museum became little more than a front to sell various cordial balms to anxious visitors.[661] As he grew richer, Kahn grew more reviled, not only in the medical press, with the *Lancet* branding his museum 'disgusting and immoral, so determinedly arranged for the purposes of depraving the minds of the ignorant and unwary', but also by that sector of the public who had initially sought out Kahn's treatments.[662] In July 1857 an anonymous patient who had gone to Khan with a suspected case of clap took Khan to court after he had charged the patient twenty pounds to treat what he had diagnosed as spermatorrhoea. Sometimes referred to as 'lost manhood' or 'seminal weakness', spermatorrhoea was a vague category that could cover a host of symptoms.[663] When the patient did not get well he approached Kahn again who then charged the poor man a further thirty pounds to cure what was then declared to be pox. When the man still did not recover he sought Kahn out again, but was this time met with threats rather than a refund, in a sorry tale that Bowen May, the lawyer for the prosecution, recounted. 'Perhaps the most atrocious part of this case is, when the young man said "You've not cured me; give me back my money!" and the doctor replied, "If you dare ask for that, I shall accuse you of masturbation," … which was utterly false, and a piece of rascally conduct on the part of the defendant'.[664] This revelation caused a 'sensation' in the courtroom, the deputy judge hearing

[661] Bates, 'Dr Kahn's Museum', p. 620.
[662] 'The Action Against Kahn of Coventry Street, For Extortion, Suppression of Obscene Quackery', *Lancet,* 15 August 1857, p. 175.
[663] Stephens, *Anatomy as Spectacle,* p. 55.
[664] 'Bloomsbury County Court: July 30th, 1857 (Before mr. Lefroy, Deputy Judge)', *Lancet*, 15 August 1857, p. 150.

the case, Mr Lefroy, exclaimed 'Oh! Even if it were true, it would be a monstrous thing for a medical man to assert', which was met with rowdy applause from the courtroom.[665] Perhaps unsurprisingly after that outburst, Lefroy found for the plaintiff and Kahn was ordered to pay back the initial twenty pounds to the patient, though it was recorded that the doctor voluntarily also refunded the second payment of thirty pounds.[666]

Shortly after this case, Kahn himself disappeared, likely fleeing back to the continent. This did not deter the Perrys though who continued to run the museum under Kahn's name, selling their cures and pamphlets to the poxed and anxiously healthy alike. It was not until 1873 that anyone was able to successfully prosecute the Perrys and close down the museum. As it transpired, it was to be The Society for the Suppression of Vice who finally managed to prosecute them under the Obscene Publications Act. Shortly afterwards of course, the society's representative in court, Mr Collette, took his hammer to the contents of the museum and it was lost for good.[667] That the models and preparations could not be rehabilitated in a medical context is telling indeed. In the late eighteenth century the Paris School of Medicine seized control of the collection of 'seductively erotic waxes' owned by the Duc d'Orleans after his execution, for use in their medical school. Likewise, the University of Dublin purchased Desnoués' collection of models to use in its anatomical classes.[668] Not all popular exhibition models fared so well though. One of the first exhibitions of Venuses shown in eighteenth-century London was referred to in one review as a 'filthy French figure', 'a large

[665] Ibid., p. 150.
[666] Ibid., p. 153.
[667] Bates, 'Dr Kahn's Museum', p. 621.
[668] Pilbeam, *Madame Tussaud and the History of Waxworks,* p. 5.

disgusting Doll', and 'as indecent as it is wretched'.[669] That these Venuses and the Kahn models were considered so completely beyond redemption demonstrates the instability of the models as accepted objects of medical knowledge within the medial marketplace, and shows how much their epistemological worth was tied up with contemporary attitudes towards quackery, commerce and vice. The idea of multiple interpretations of the models became a threat that necessitated the control of the spaces in which these models were allowed to move.

It is telling indeed that it was the Obscene Publications Act that did away with Kahn's models. Historian Lynda Nead has argued that within the metropolis of London, the Act was a way of tacitly regulating a new visual culture, 'a specific form of viewing/looking, made possible by mass cultural production and the space of the street'.[670] In a city where prints were in wide circulation, viewable by any and all in myriad shop windows, it was not just the medical profession that was beginning to express concern regarding what sectors of society should be viewing certain images. Medical museums were more frequently being associated with obscenity and vice as the century wore on. Rackstrow's museum, though marketed as a medical collection was sited just around the corner from London's infamous Holywell Street, off the Strand, which was a hub for the trade in pornography.[671] Indeed, the 1857 Obscene Publications Act was a central factor in putting an end to the public anatomy museum as popular entertainment, and removing the medical preparations and models from the public sphere, cloistering

[669] Ibid., p. 843.
[670] Lynda Nead, 'Mapping the Self: Gender, Space and Modernity in Mid-Victorian London', in Roy Porter (ed.), *Rewriting the Self: Histories from the Renaissance to the Present* (London and New York: Routledge, 1997), p. 179.
[671] Pilbeam, *Madame Tussaud and the History of Waxworks*, p. 6.

the artificial body away into a newly regulated and professionalized medical sphere emerging from the mid nineteenth century onwards.[672]

Conclusion

Portraying the horrifying effects of venereal disease on the face was a common representational trope in the eighteenth and nineteenth century, one that spoke of a pervasive contemporary fear of the disease. But this was not a fear that was only rooted in the shame of contracting a disease via licentious or immoral behaviour; rather this represented an attendant dread of a disease that stripped the sufferer of their physical identity, even of their humanity. Despite the shared iconographical tropes of orthodox and illicit medical representations of venereal disease, this convergence does not suggest any profound agreement as to the nature of the disease, or even a new unified acceptance of the visual; if anything, these similarities served to further destabilize the ability of visual representation to be considered as a useful format for medical knowledge. The case of Kahn's museum demonstrates that the epistemological instability of visual representations did not come from a fundamental divergence in the kind of information they were displaying about venereal disease. Though unlicensed practitioners like the Perrys were sometimes more dramatic in their imagery, they were essentially still rooted in orthodox medical representational strategies, evidenced by their co-option of Richard Carmichael's images. Instead the instability came from the seductive prowess of the images in the medical marketplace. They attracted the public to quacks rather than orthodox medical practitioners, and denigrated the reputation of established medical elites. In 1858, after one of the *Lancet*'s characteristically

[672] Bates, 'Dr Kahn's Museum', p. 618.

violent outbursts against the quacks at Kahn's museum, London newspaper *The Era* published a lengthy defence of the exhibition asserting that

> As a collection of works of anatomical and physiological art, the exhibition is unique in construction and masterly in purpose; and we have no hesitation in saying that the student of medicine will acquire sounder ideas of physiology and pathology, and juster and more indelible notions of the natural and relative situation of parts, from an hour spent in Dr. Kahn's Museum than he could obtain in a month from the dissecting-room of the lecturer.[673]

When the Perrys were eventually prosecuted, it was not the selling of useless cures that the medical profession particularly objected to. Kahn's prosecution was all about the models, not the medical practice. Just after the seizure of the models by the police under the auspices of the Society for the Suppression of Vice, the *Lancet* again lent its voice to the proceedings stating that '[w]e must enter our protest against any assumption that the models and other contents of such museums are fit for public exhibition, for they are in our opinion unfit, and all exhibitions of the kind should be prohibited by law.'[674] By the mid nineteenth century the orthodox medical disciplines were attempting to take full control of the visual discourse. The *Lancet's* denigration of the Kahn models as obscene represented an attempt to distance their own extensive use of images, models and preparations from those of the unlicensed practitioner. This trend will be seen in much greater detail in the next chapter, as calls for the reform of medical education began to come under increasing scrutiny and new legislation. The desire for visual and material representations of medicine would become even

[673] 'Dr. Kahn and "the Lancet"', *The Era*, Sunday 28 February 1858.
[674] 'Kahn's Museum', *Lancet*, 8 March 1873, p. 355.

more heightened as medical practice and pedagogy moved into new institutions such as the London University.

5

Venereal Disease Institutionalised

> A teacher of anatomy … must have a set of preparations, to show all, and every change that can be produced by disease; and consequently, he must have a museum of a very considerable size, and drawings, and books…[675]

> Tables were covered with preparations, yet nothing was to be seen – if seen, nothing was understood. The museums deserted by the student and junior practitioner – the elder and more experienced walking in only occasionally to investigate some point in morbid anatomy interesting to a case in hand. Then wax was tried, and paintings in oil and water colours – all failures… [676]

London was flush with preparations and models, from the museums of elite surgeons like John Hunter, to the public exhibitions warning of the dangers of masturbation. Yet as the proliferation of these objects increased, so did anxieties about their identity. We saw in the last chapter how, by the mid nineteenth century, medical orthodoxy was becoming increasingly alarmed by the use of such visual representations by unlicensed practitioners, and this chapter moves on to deal with the responses to this perceived threat. By this period, the use of such visual representations was so ingrained in medical practice and education that it was understood that, as surgeon and president of the Royal College of Surgeons in 1833 George James Guthrie (1785–1856) wrote, medical teachers needed 'a museum of a very considerable size'. This chapter explores the attempts of

[675] House of Commons Parliamentary Papers, 1834 (602), *Report from the Select Committee on Medical Education: with the Minutes of Evidence and Appendix. Part II. Royal College of Surgeons, London. Ordered, by The House of Commons, to be Printed 13 August 1834*, p. 36.
[676] Knox, 'Original Lectures. Anatomical Museums', p. 309.

medical orthodoxy to gain control of visual representation by issuing edicts such as Guthrie's about the necessity of museums. However, the consequence of this zeal for collecting visual representations was that, as Robert Knox asserted, the number of these objects was so overwhelming that, 'nothing was to be seen – if seen nothing was understood'. They were rendered meaningless by their ubiquity.

This chapter represents an ostensible twist in the tale of venereal disease and visual culture. Throughout this thesis, I have explored the various ways individual practitioners sought to negotiate and control the disparate meanings of venereal disease through the use of visual representations; however when we come to the responses of institutions emerging in the mid nineteenth century we see very different concerns arising. The teaching institutions of nineteenth-century London collected visual representations almost maniacally. The Royal College of Surgeons denounced teachers who did not have sufficient museums and refused to license their students, while the unlicensed practitioners built up their collections in attempts to raise their status. Medical teachers squabbled over ownership of museums and new institutions employed artists and practitioners to augment their burgeoning collections. What was missing amidst this fervour was discussion of the specific diseases or medical processes represented in these drawings, models and preparations.

Arguably, a full consideration of the multiple identities and meanings of visual representations of venereal disease must take into account the ways in which the meaning of such representations went beyond their depiction of the disease. Within this chapter I explore two museum collections that included depictions of venereal disease; pathologist Robert Carswell's paintings created for the medical school of the new London University, and the wax moulages made by

modeller Joseph Towne for the museum at Guy's Hospital. These two individuals utilised many similar representational strategies in representing venereal disease to those we have already been introduced to, such as J. Holt, Richard Carmichael and John Hunter. However, the aim of this chapter is to highlight how the institutions commissioning these paintings and models were less interested in the potential of these representations to display the disease and more concerned with the power of visual representations to advertise status in the medical marketplace and to fight battles over emergent professionalism. To these institutions, such images and objects did not define venereal disease, they defined the institution.

This was a period in which battles were being fought over new medical identities, with the traditional medical hierarchy of physicians, surgeons and apothecaries struggling to suppress new competition in the medical marketplace from dispensing druggists, unlicensed quacks and general practitioners.[677] The use and control of visual representations was one tactic employed by all of these groups. Historian Samuel Alberti has noted that the 'the large-scale institutionalization of the material culture of anatomy in the second quarter of the nineteenth [century] constituted an unprecedented qualitative and quantitative shift in the form and function of the collections'.[678] It is these shifts in meaning that this chapter explores, focusing particularly on the efforts by various bodies in the mid nineteenth century to control these meanings within these new spaces.

This was a time when Britain was undergoing tremendous political upheaval; there was growing dissatisfaction with industry and agriculture, and society was becoming increasingly vocal about its unhappiness.[679] There was mass

[677] Loudon, *Medical Care and the General Practitioner*, pp. 133–134.
[678] Alberti, *Morbid Curiosities*, p. 19.
[679] Desmond, *The Politics of Evolutions*, p. 10.

objection to an unpopular government and a corrupt parliamentary system that meant they could rely on the so called 'rotten boroughs' – constituencies with few voters, controlled by government officials – to hold onto power.[680] The rapid industrialisation and urbanisation of the eighteenth century had resulted in the emergence of several large industrial towns inhabited by a new middle class that found itself with less political power than that held by these boroughs. Calls to extend the franchise and eradicate the rotten boroughs resulted in the 1832 Reform Act, which redistributed parliamentary seats to the larger urban towns, as well as giving the vote to more sectors of society.[681] Within this climate of reform calls for medical reform, of licensing and education, reached their apex, demonstrated by the formation of new medical journals such as Thomas Wakley's radical *Lancet* in 1823 and the establishment of the London University in 1826.

For medical practitioners 1832 also saw the passing of the Anatomy Act, which granted anatomists legal rights to the bodies of those who died in workhouses.[682] In the wake of the passing of the Anatomy Act, parliament was put under further pressure to examine the training of all medical practitioners across the capital. Reform-minded MP Henry Warburton (1784–1858) formed a Select Committee in February 1834 to investigate

> the state of Medical Education, as prescribed by the regulation of the several Universities, Medical and Surgical Colleges or Faculties, and Apothecaries' Companies, and as actually practised at various Schools of Medicine, Surgery and Pharmacy; and also into the state of Medical, Surgical and Pharmaceutical Practice, in the three divisions of the United Kingdom.[683]

[680] Eric J. Evans, *The Great Reform Act of 1832*, (2nd edn, London: Routledge, 1994), p. 10.
[681] Desmond, *The Politics of Evolution*, p. 10.
[682] Richardson, *Death, Dissection and the Destitute*, p. xv.
[683] HCPP, *Report from the Select Committee on Medical Education: with the Minutes of Evidence and Appendix. Part II. Royal College of Surgeons*, p. iii.

This chapter then first introduces what the Select Committee Report revealed about attitudes to museums and collections before going on to examine Carswell and Towne's collections within the context of their respective institutions.

The Meaning of Museums

The 1834 Select Committee questioned representatives of the three medical corporations as to what they considered to be the necessary forms and standards of medical teaching in the capital. One recurring line of questioning directed at representatives of the Royal College of Surgeons was the necessity of having a museum in order to be a recognised teacher of anatomy and pathology. Guthrie stated that 'a dead body is not alone sufficient for teaching anatomy. A man who teaches from a dead body only, is a demonstrator, not a teacher of anatomy'.[684] This sentiment was echoed throughout the questioning, surgeon Benjamin Brodie (1783–1862) denounced teachers without museums, saying that they 'generally prove to be what are called grinders: that is, they instruct pupils to pass their examinations with the smallest possible quantity of knowledge'.[685] Surgeon Benjamin Travers (1783–1858), remarking on the prevalent use of wet preparations used in teaching around the capital, added that such collections were an unequivocal necessity in teaching 'especially in morbid anatomy'.[686]

At this point in the century, the Royal College of Surgeons still controlled the granting of medical licenses for surgeons in the capital and they mandated that students had to have taken a certain number of classes in Anatomy, Physiology and Surgery, as well as witness a specific number of dissections, before they

[684] Ibid., p. 36.
[685] Ibid., p. 117.
[686] Ibid., p. 129.

could sit their exams. This was a power frequently abused, as in 1824 when the College altered their bylaws to state that only courses at the London hospitals and run by approved surgeons would be accepted as valid; this move was seen as a dishonourable attempt to steer students away from private schools and into hospitals, where many of the College fellows themselves taught.[687] All classes had to be approved by the Court of Examiners of the College. This entailed representatives of the College assessing teachers individually, a system which Warburton evidently thought flawed, as he asked several times during the Committee interviews about the possibility of the College drawing up some publication setting out the minimum standards for a museum. Guthrie claimed that '[t]he thing is impossible, particularly with regard to the morbid structures; inasmuch as many of them might not be obtained in the course of two, or three, or four years.'[688]

The reputation and survival of a teaching institution therefore could stand or fall on the quality of its museum. Possessing a museum essentially functioned as an acceptable form of advertising within a system that condemned overt soliciting for patients or students as quackish.[689] As teaching more and more became the remit of London's hospitals, the private anatomy schools were struggling and only approval from the Royal College of Surgeons guaranteed students. This unfortunately left many teachers in a catch twenty-two situation of not being recognised by the College because they did not have enough preparations, whilst not being able to procure bodies from which to make

[687] Desmond, *The Politics of Evolution*, pp. 158–159.
[688] Ibid., p. 72.
[689] Burmeister, 'Popular Anatomical Museums in Nineteenth-Century England', p. 224.

preparations precisely because they were not recognised by the College.[690] In August 1833, a Mr William Dobson of Princes Street in Westminster applied to the court of examiners to recognise him as a suitable teacher. In his application he recounted that he had been curator at the Thackrah museum in Leeds 'and prepared continually, during that time, various and important anatomical preparations'.[691] The Court wrote back two weeks later asking him to renew his application once he had completed one full course of lectures and sent them a 'list of the preparations, casts, and drawings contained in your museum'.[692] Dobson wrote back a month later, having delivered most of his course of lessons, complaining that he could not procure enough bodies to dissect and from which to make preparations, ending mournfully with 'I humbly submit that without the means of teaching being afforded me, I could not comply with your direction to give a full course of anatomy.'[693] There were many other instances of teachers being put out of business by the College's capricious uses of its power. In 1831, Wakley recounted the tale of Joshua Brooke's school that was initially recommended by Astley Cooper, a fellow of the College, but later was refused official recognition after the College decided not to recognise any summer anatomy classes.[694] Following this, Brookes told Wakley 'apparently with an aching heart, that the impression produced by the College regulation was so strong against his school – produced such a general impression throughout the

[690] Ruth Richardson, '"Trading assassins" and the licensing of anatomy', in Roger French and Andrew Wear (eds), *British Medicine in an Age of Reform* (Abingdon: Routledge, 1991) p. 87.
[691] House of Commons Parliamentary Papers, 1834 (602), *Report from the Select Committee on Medical Education: with the Minutes of Evidence and Appendix. Part II. Royal College of Surgeons, London. Ordered, by The House of Commons, to be Printed 13 August 1834,* Appendix 33: Correspondence between the Court of Examiners of the Royal College of Surgeons, and Mr. *William Dobson*, of Princes-street, Westminster, respecting the Recognition by the said Court, of him as a Teacher, p. 55.
[692] Ibid., p. 56.
[693] Ibid., p. 56.
[694] Desmond, *The Politics of Evolution*, p. 159.

country, that his certificates would not be received, that his class was broken up, and he was obliged to dispose of this theatre and the whole of his museum'.[695]

The Royal College of Surgeons themselves were not immune from the need to demonstrate their professional status through ownership of a museum. Indeed, I would argue that their acquisition of John Hunter's museum in the late eighteenth century was one reason for their being granted a Royal Charter in 1800. The story of how they managed to take control of the museum illustrates the importance of collections for the reputation of institutions. On 16 October 1793, after a 'very exciting quarrel with some of the members at the College of Surgeons', John Hunter 'dropped down dead in the attempt to suppress his feelings'.[696] Following the death of one of the most famous surgeon in London, his obituaries sang the praises, not only of Hunter's practical skills, but also the enormous value of his museum. In his will, Hunter left the collection to his nephew Matthew Baillie and his brother in law, Everard Home (1756–1832), stipulating that they offer the collection for sale to the British Government. If the government declined, Hunter dictated that it be offered in its entirety to foreign governments before Baillie and Home could consider breaking it up. Calls for the government to acquiesce and buy the collection outright were commonplace, with William Seward (1747–1799) recording in his collection of anecdotes that,

> [t]his Museum is now offered to sale to the British Parliament, which, it is to be hoped, will, with its usual wisdom and liberality, secure to the Nation the entire and perpetual possession of so useful and so valuable a collection; a collection

[695] 'London College of Medicine. Report of the proceedings of the public meeting of members of the medical profession, held in the great room at the Crown and Anchor Tavern, London, On Wednesday, March the 16th, 1831: Joseph Hume Esq. M.P. in the chair', *Lancet*, 26 March 1831, p. 855.
[696] R. Chambers, *The Book of Days: A Miscellany of Popular Antiquities in connection with The Calendar including Anecdote, Biography & History Curiosities of Literature and Oddities of Human Life and Character… Vol. II* (London: W. & R. Chambers, 1832), p. 459.

> unrivalled in the History of Science, and which the Philosopher and the Patriot must regard as an object of the greatest national concern and think with extreme regret on the remotest possibility of its being separated, or of its being permitted to decorate or to enlighten any other Country, but that in which it was made.[697]

Another periodical asserted that the king of Spain had 'made an unlimited offer to the family of John Hunter: but the British Parliament wished to secure to this country so invaluable a possession'.[698] Indeed Parliament did eventually accede to the request after a committee had questioned both Baillie and Home, among others, on the perceived value of the collection to the nation.

All medical persons questioned by the committee agreed that the collection was irreplaceable. Baillie answered that the collection was unique as 'unless a Person should arise with the same Reputation in these Pursuits; which last Circumstance induced many Persons of different Countries to send Specimens of various Animals to Mr. *Hunter* for Examination, which would not have been sent to a Person of less Celebrity'.[699] The committee were keen to establish how ownership of the museum would benefit the country. When questioned on the importance of the collection to the Public, surgeon William Cruickshank (*d*.1810/11) answered unequivocally that '[a]natomical Collections have given more Ardour to Young Men, and been the Means of making better Physicians and Surgeons than ever existed before'.[700] For Cruickshank, the value of the collection was not merely from the advantages of using preparations in teaching, but also

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[697] William Seward, *Anecdotes of distinguished persons, chiefly of the present and two preceding centuries. Illustrated by Engravings, the Fourth Edition, … Vol. II* (London: Printed for T. Cadel Jun. And W. Davies, in the Strand., 1798), p. 468.
[698] Robert John Thornton, 'Sext. XIX Life of John Hunter', *The Philosophy of Medicine, or medical extracts on the nature of health and disease Including the Laws of the Animal Oeconomy, and the Doctrines of Pneumatic Medicine by A Friend to Improvements* (Vol. I, 4th edn, London: Printed by C. Whittingham, Dean-street, Fetter-Lance etc., 1799), p. 394.
[699] HCPP, *Report from the Select Committee on Medical Education: with the Minutes of Evidence and Appendix. Part II. Royal College of Surgeons,* p. 513.
[700] Ibid., p. 514.

from the inspiration it provided for new generations taking up medicine. The committee went on to probe the interviewees on just how the collection was to be utilised, to which physician David Pitcaird (1749–1809) replied that, although there were a variety of ways to use the museum, 'perhaps the best Mode would be that which Mr. *Hunter* himself proposed to apply it, which was, by giving Lectures upon the general Physiology of Animal Nature, and illustrating those Lectures by shewing [*sic*] the Preparations contained in his Museum'.[701] Seemingly determined to uncover that Hunter's museum was not unique, the committee went on to question Joseph Planta (1744–1827), librarian to the British Museum, asking if he knew of any other collection in any country of similar value or composition. Planta responded that 'I have heard much of Fontanas' Collection at *Florence*, but I do not think that Collection would be of so much Utility as Mr. *Hunter's*, because it consists only of Models'.[702]

Satisfied that the collection was financially viable, potentially useful to the nation, and superior to the collections of any other country, the committee agreed to purchase the museum for 15,000 pounds. The collection was to be given to the Company of Surgeons, on the condition that they open it for two days per week for fellows of the College of Physicians and members of the Company of Surgeons, that they draw up a descriptive catalogue of the museum holdings, and hire someone to be on hand to explain all the preparations.[703] This marked a change in the Company's public responsibility, control of the museum meant they were responsible for a collection that was of huge significance in medical

[701] Ibid., p. 515.
[702] Ibid., p. 516.
[703] House of Commons Parliamentary Papers, 1834 (602), *Report from the Select Committee on Medical Education: with the Minutes of Evidence and Appendix. Part II. Royal College of Surgeons, London. Ordered, by The House of Commons, to be Printed 13 August 1834*, Appendix 36: Grant from the Government to the Royal College of Surgeons, of the Museum of the late John Hunter, p. 61.

education in the capital, a field in which they had not been traditionally involved, with the exception of the administering of examinations.[704] The Company began preparations to receive the museum, establishing a Board of Curators and a resident conservator and enlisting Everard Home and William Clift to begin drawing up the catalogue.[705] This was a period of enormous change for the surgeons, as the Company moved premises to the grandiose site at Lincoln's Inn Fields, and was granted a charter in 1800 becoming the Royal College of Surgeons of London.[706] In 1806, after finding the new college building would not be adequate for housing Hunter's collection, parliament agreed to give the Surgeons 15,000 pounds for a new museum building.[707]

Delays and financial troubles dispensed with, the new buildings went up and the collection was moved to the site with relatively little trouble; the real bone of contention over the museum would turn out to be the production of the descriptive catalogue. Home, appointed as the first conservator of the museum, along with William Clift, a long time employee of Hunter's, set about cataloguing the thousands of items.[708] Though the collection was fully installed in the College by 1814, by the time the Commons Select Committee on Medical Education had produced their report in 1834, the descriptive catalogue was still not finished. The Committee questioned Clift over this state of affairs, as he was supposedly partly responsible for the production of the catalogue. Clift then recounted the

[704] Lawrence, *Charitable Knowledge*, p. 90.
[705] 'Petition of Royal College of Surgeons, for Leave to present a Petition', *Journals of the House of Commons*, 61 (23 May 1806), p. 336.
[706] N. B. Harte, *The University of London, 1836–1986: An Illustrated History* (London: The Athlone Press, 1986), p. 63.
[707] 'Surgeons petition, reported', *Journals of the House of Commons*, 61 (1 July 1806), pp. 470–472.
[708] HCPP, *Report from the Select Committee on Medical Education: with the Minutes of Evidence and Appendix. Part II. Royal College of Surgeons*, p. 44.

unfortunate reason for the delay, as told to him by Home, whilst the two were travelling together in 1823.

> Sir Everard Home began by telling me, that an accident had very nearly occurred at his house: that it had been nearly on fire: that the engines came, and the firemen insisted upon taking possession of his house. They saw the flames coming out of the chimney. He did not wish to admit them, but they insisted upon being admitted. I asked him, how it happened; and then he told me, that it was in burning those manuscripts of Mr. Hunter.[709]

The papers in question were Hunter's notes accompanying the preparations in the museum, case histories of morbid specimens and detailed notes on the pathological preparations, all crucial to the production of the catalogue, as well as to the recognition of the preparations themselves with Guthrie admitting that without a full catalogue 'the utmost difficulty, of course, existed in making out what each preparation was intended to represent'.[710] Home claimed that Hunter had requested on his deathbed that the manuscripts be burned. Clift was mortified.

> I felt that all those hopes that I had entertained, were entirely frustrated and destroyed. I considered that my life had been spent in the service of that collection, and I hoped to have lived to see those papers beneficially employed. When I had made inquiry respecting the principal of them, and he told me they are all gone, I said to him, "Well, Sir Everard, there is only one thing more to do." He said, "What is that?" I said, "To burn the collection."[711]

After Clift discovered Home's reckless actions, he attempted to get back any of Hunter's manuscripts that might have escaped the ostensible betrayal. Clift wrote to the Board of Curators, who in turn wrote repeatedly to Home, who

[709] Ibid., p. 65.
[710] Ibid., p. 46.
[711] Ibid., p. 66.

claimed again and again that all the papers were destroyed. Finally Home relented and sent back some remaining manuscripts, mostly relating to the pathological collection of the museum, but the Board of Curators were dissatisfied with this stating that 'in the Hunterian Collection are 1,673 preparations of morbid anatomy; and that the manuscripts transmitted by Sir Everard Home do not contain the explanations of so many as 100 of such preparations'.[712] Finally, Home sent back more remaining notes relating to the pathological preparations and the Board of Curators decided that that was to be the end of the matter, although some months later it was noted that there were still thirty of the pathological preparations that did not have accompanying notes.[713]

Throughout the argument, Home persisted in his claim that Hunter had asked him to burn the manuscripts, though Clift insisted that this was a lie and that Home had burned them for more nefarious reasons. 'I knew that that week Sir Everard had received back from the printer the last proof of his second volume of Lecture on Comparative Anatomy' Clift told the committee, going on to state explicitly, 'and that he had used [Hunter's] papers very largely in the composition of that work'.[714] Seemingly most people aware of the case were perplexed. Surgeon William Lawrence, professed a confusion as to Home's motives, stating that '[i]t was one of those strange events, that you would not have taken precaution against.'[715] However, the consensus that entered the public's mind was that Home had burned the manuscripts because they were the source for the

[712] House of Commons Parliamentary Papers, 1834 (602), *Report from the Select Committee on Medical Education: with the Minutes of Evidence and Appendix. Part II. Royal College of Surgeons, London. Ordered, by The House of Commons, to be Printed 13 August 1834*, Appendix 40: Return from the Trustees of the Hunterian Collection, of any Minutes of Evidence of Correspondence relating to the Destruction of a Portion of the Hunterian Manuscripts, p. 73.
[713] Ibid., p. 75.
[714] HCPP, *Report from the Select Committee on Medical Education: with the Minutes of Evidence and Appendix. Part II. Royal College of Surgeons*, p. 64.
[715] Ibid., p. 162.

scandalous acts of plagiarism alleged by Clift. Chamber's *Book of Days* recorded that 'this disgraceful transaction remains beyond a doubt'.[716]

Clift and Home's bitter dispute was not the only incidence of squabbles breaking out over ownership of museums. In 1829 the Board of Governors at St Thomas's Hospital were required to step in to pay off two warring surgeons and regain control of the museum at the hospital. In 1820, the museum at St Thomas's was owned by two surgeons, Henry Cline (*d*.1820) and Astley Cooper, who taught courses together using the collection. That year, Cline died and Cooper drafted in Joseph Henry Green, who had served his apprenticeship at St Thomas's hospital previously under Henry Cline, as well as Cline's father, also called Henry (1750–1827). Green had already been helping Cooper and Cline junior with their lecture courses before Cline's death and seemed the natural choice to replace him. To secure the joint ownership of the museum and teaching assets, Green was to pay Astley Cooper 1000 pounds. A receipt, signed by Cooper and dated 3 August 1820, confirms that Green paid 'one thousand pounds in full consideration for one half of the collection of anatomical preparations and preparations of morbid parts contained in the museum of St Thomas's Hospital'.[717] For five years, Cooper and Green taught alongside each other harmoniously at St Thomas's.

Suddenly though, in 1825, Cooper resigned from his position as lecturer at St Thomas's to move to Guy's hospital, inaugurating a four year public argument between him and Green over who had the right to the museum. The first fracture in the friendship came when Cooper asked Green to appoint his nephew, Bransby Cooper (1792–1853), as his replacement. According to Bransby Cooper, Green

[716] Chambers, *The Book of Days,* p. 459.
[717] Wellcome Library, MS.7804/2, Receipt recording payment of £1000 from Joseph Henry Green to Astley Paston Cooper upon the former's taking over the part of the Museum formerly held by Henry Cline, 1820.

promised to endorse his candidacy to the hospital governing board, but instead supported the candidacy of John Flint South. Astley Cooper felt his nephew had been cheated out of a position that was rightfully his, as Bransby, along with another nephew of Cooper's, Charles Aston Key (1793–1849), had been assisting with lectures at St Thomas's for some time.[718] Following this, both Coopers began teaching at Guy's hospital, which had traditionally sent their students to St Thomas's for lectures, the two men requesting that half of the museum holdings be transferred to Guy's.[719] Green refused the request arguing that the museum should remain as a complete collection. So Bransby Cooper, along with Key, wrote an impassioned plea to the Grand Committee of Governors of St. Thomas's Hospital in which they laid out this convoluted history and staked their claim on half of the museum. Bransby and Key wrote that they '*only claim the preparations of Sir A. Cooper, made with his own hands, at his own expense and under his own roof-*'.[720]

Bransby and Key's letter was printed in the *Lancet*, much to the alarm of Green who was quick to produce his own response to the Committee of Governors of St Thomas's, demanding it too be published in the *Lancet*. In this, Green argued that he owed nothing to Astley Cooper or any of his relatives, as he had for many years assisted Cooper for no pay.[721] In response to this, Bransby and Key wrote back to the committee, a letter also then published in the *Lancet*, refuting Green's numerous points and claiming that it was wholly unfair that, as the collection had been mostly built up by Astley Cooper, that his family were

[718] Eilidh Margaret McInnes, *St Thomas' Hospital* (Springfield: Charles C Thomas, 1963), p. 86.
[719] 'The Memorial of Charles Aston Key and Bransby Cooper, Esquires, to the Grand Committee of Governors of St. Thomas's Hospital', *Lancet,* 15 October 1825, p. 133.
[720] Ibid., p. 133.
[721] [Joseph Henry Green] 'Museum at St. Thomas's Hospital', *Lancet,* 5 November 1825, p. 224.

being denied use of it.[722] Not content with merely another riposte via the *Lancet* Green published a pamphlet on the subject, a pompous and convoluted piece of writing that the *Lancet* leapt upon with glee. Accusing Green of obscuring the facts, an editorial ran '[m]ystery is ever the order of the day with Mr. J. H. Green; on whatever matter he speaks or writes, no sooner does he open his lips or touch his pen than it instantly becomes clouded and confused', before going on to label him 'the Surgical Eclipse', because of his ability to blot out the truth.[723] The caustic review of the pamphlet went on to attempt to untangle the web of accusations and slander that had already occurred between Bransby Cooper, Charles Aston Key and Joseph Henry Green, eventually determining that Green was probably in the wrong, but offering no solution.

This finally came four years later with an indenture dated 16 January 1829 wherein the Board of Governors of St Thomas' agreed to pay both Astley Cooper and Green 1000 pounds each to buy them out of the Museum. This gave complete control and ownership of the museum to St Thomas's Hospital as the governors were 'desirous of securing the permanent use and benefit of the said collection or Museum to the Surgical and Medical School of the said Hospital'.[724] Until 1825, St Thomas' and Guy's Hospitals had co-operated in the education of medical students, to such an extent that they were known as the 'United Hospitals', it was this argument that ensured their separation as they began to compete to attract medical students and lecturers.[725]

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[722] [Bransby Cooper and Charles Key] 'To the Grand Committee of St. Thomas's Hospital', *Lancet*, 19 November 1825, p. 300.
[723] [Green, J. H.,] 'Museum at St. Thomas's Hospital: A Letter to Sir Astley Cooper, Bart., on certain Proceedings connected with the Establishment of an Anatomical School at Guy's Hospital by J. H. Green, F.R.S. &c. &c.', *Lancet,* 14 January 1826, p. 552.
[724] Wellcome Library, MS.7804/26, Transfer of Green's rights to Corporation of London, 1829.
[725] McInnes, *St Thomas' Hospital,* p. 86.

The difficulty in transferring ownership of the museum during this tiresome four-year argument demonstrates the bitterly contested nature of who had the right to use the preparations, the only uncontested point being that they were valuable. At one point, Green had asserted that even though Astley Cooper had added the majority of the preparations, his continued use of them over his thirty-three year tenure had meant many of them had deteriorated, though he never considered that this rendered them worthless.[726] For their part, Bransby Cooper and Key bit back that they would gladly take the deteriorated specimens off Green's hands 'leaving Mr. Green in quiet enjoyment of that part of the original collection which retains its original value'.[727] Their value as teaching aids went unquestioned throughout the debacle as all parties tried to keep control of them. Both the transfer of Hunter's museum in the first decade of the nineteenth century and the wrangling over St Thomas's in the 1820s demonstrates that this was a period when medicine was obsessed with amassing visual and material representations of its doctrines. Museums were a prerequisite for the elite practitioner in the eighteenth century, but it was the nineteenth century when they became essential to establishing and legitimising emerging and expanding institutions such as the Royal College of Surgeons, the grand teaching hospitals and the new London University.

The seemingly incessant squabbling over ownership of museum collections of preparations, models and drawings might initially suggest that by the nineteenth century these were items of uncontested value in medical discourse, however as we have seen in the previous chapters of this thesis, visual representations were never uncritically accepted within medicine. Indeed, in many

[726] Green, 'Museum at St. Thomas's Hospital', p. 225.
[727] [Cooper and Key] 'To the Grand Committee of St. Thomas's Hospital', p.297.

respects, that the mania for gaining control of museums and collections exhibited by institutions such as the Royal College of Surgeons, and individuals like Green and Cooper, only served to further undermine the potential of the visual representation to claim knowledge of a specific disease like venereal disease.

However, amidst all the hysteria over museums, there were voices of dissent shouting to be heard. Though the Select Committee recorded the Surgeons' edicts on the use of museums in teaching, they did not record the voices speaking out against the unquestioned accumulation of any and all preparations and models, especially those that said that not all such visual representations were of equal worth. Robert Knox, the Edinburgh radical whom we met in the previous chapter, was one of these voices of dissent. In 1846 Knox delivered a lecture on anatomical museums before the Pathological Society of Birmingham, as well as audiences in Edinburgh and Glasgow. This lecture was published in the *Lancet*, its caustic warnings about the state of the country's museums finding a suitable home in Wakley's radical journal. As mentioned in the previous chapter, Knox was in a strong position to comment on the subject, from 1825 until 1831 he had been conservator to the museum of the College of Surgeons of Edinburgh.[728]

His lectures on anatomical museums seem tinged with a bitterness directed at the establishment that had rejected him. Here he laid out in detail the problems with the contemporary anatomical museums, highlighting their expense and the fact that students had mostly abandoned them. Having failed to gain acceptance in London at the Royal College of Surgeons, Knox also devoted much time to

[728] Taylor, 'Knox, Robert (1791–1862), anatomist and ethnologist'.

denigrating them, accusing them of not being worthy of the collection of John Hunter.

> Mr. Hunter's great work… unfortunately handed over by the government to the corporation of surgeons – a strictly professional and practical body – to whom the bones of mammoths, fossil, or recent skeletons of vertebrata, and dissections of the invertebrata, were of no more value tha[n] so many objects of curiosity or *virtu*. The result has been unfortunate for science and for the medical art, and must in the end prove embarrassing to the college or corporation; it has withdrawn science from its legitimate place – the British Museum…[729]

This was the crux of Knox's argument. The collections amassed by institutions and schools of anatomy extended beyond the remit of the institutions. The Royal College of Surgeons simply did not need the extensive comparative anatomy collection; it was an institution that should have been solely devoted to the health and diseases of humanity. Likewise, Knox attacked the museums of anatomy schools that contained pathological preparations that, he proclaimed, 'belong in *hospitals,* where all lectures on the practice of physic and of surgery, whether systematic or clinical, ought to be delivered'.[730] Knox's lecture was not a wholesale denouncement of the virtues of visual representations, rather an indictment of the institutions that collected these objects with a mania that had little to do with the advancement of medical knowledge, and everything to do with the personal and professional vanities of their staff.

According to Knox the museums around London, had been 'deserted by the student and junior practitioner'.[731] It is difficult to recreate how these contemporary museums were used and to what extent they had been 'deserted',

[729] Knox, 'Original Lectures. Anatomical Museums, p. 307.
[730] Ibid., p. 307.
[731] Ibid., p. 309.

however some sources suggest that many of London's museums were in fact dynamic spaces.[732] One account of the London University course on the 'Nature and Treatment of Diseases' suggests that the university museum was one such space.

> These lectures are illustrated by a large collection of drawings, made from cases exhibiting the various structural changes effected by disease: and also by preparations from the Museum of Anatomy. Whenever it is practicable, recent morbid specimens will be presented to the class. The drawings are placed in frames in the museum after each lecture, for more particular examination; and the preparations are arranged for reference during the whole progress of the course.[733]

Far from Knox's view of a staid and empty hall of preparations merely collecting dust, London University's displays were regularly changed to suit a current lecture series or dissection.

This situation likely differed from institution to institution. The Royal College of Surgeons museum, coming under particular attack by Knox for obvious reasons, probably did itself no favours by taking such a long period of time to prepare the descriptive catalogue to accompany its holdings, and there is evidence suggesting that in the early nineteenth century at least, it was unwilling to share its collection with outsiders. Edinburgh Professor John Thomson for instance once dispatched a colleague to make drawings of preparations in the College museum for use in his lectures but was asked to state more specifically what he wanted to draw before the College would grant permission as, according to Abernethy, it was 'the intention of the board of curators, when the museum has been adequately described, to publish an account of whatever might be found in it

[732] Alberti, *Morbid Curiosities*, p. 125.
[733] 'Account of the Medical and Surgical Schools of London, For the Session 1830 – 31', *Lancet,* 25 September 1830, p. 9.

peculiarly interesting; believing, from the documents in possession of the College, that they could do this better than it could be done by others'.[734] This insularity on behalf of the College, perhaps understandable during a period when it was under such sustained attack by radicals and reformers, seems to have only served to keep people out of the museum that was supposed to be of such value. Indeed, perhaps the most ferocious critic of the College, Wakley condemned their treatment of the museum, rather than the collection itself decrying that 'the Hunterian Museum – that collection which no pupil can view for five minutes without carrying away with him knowledge which must prove useful to the latest period of his life, that Museum was literally closed against the profession for twenty-seven years'.[735]

The idea that such museums were uncritically amassing preparations, models and drawings solely in order to enhance a professional reputation further destabilises the ability of visual representations to be considered as useful objects in knowing particular diseases. Debates about the usefulness of visual representation were rife in the capital. Preparations and models played an important role in medical education, but their position was tenuous. For example, any suggestion that models could be suitable substitutes for the dissection of bodies would generally be met with scorn. In 1832 French physician Dr Auzoux (1797–1880) brought a collection of wax models to London to show before the Westminster Medical Society. Auzoux was a firm proponent of using models to teach, so, although he had trained as a physician, he never went into medical

[734] House of Commons Parliamentary Papers, 1834 (602), *Report from the Select Committee on Medical Education: with the Minutes of Evidence and Appendix. Part II. Royal College of Surgeons, London. Ordered, by The House of Commons, to be Printed 13 August 1834*, Appendix 32: Address to the Council of the Royal College of Surgeons in London, by Mr. Abernethy upon his Election as President, on the 14th day of July 1826' Select Committee Report, p. 52.
[735] 'London College of medicine', p. 853.

practice, choosing instead to establish a model factory in 1825.[736] However, the president of the Society took pains to rephrase Auzoux, and to point out the limitations of the medium.

> He [Auzoux] did not mean to say that the actual dissection of the human body could, but means of this lay-figure, be wholly dispensed with. This figure would not show the membranes lining the cavities of the body; it would not impart to the pathologist any ideas of the feel, the palp, the consistence, and resistance of the natural organic tissues and therefore dissection would be always necessary; but this machine would meet, and satisfy that hitherto unavoidable necessity of constantly referring to nature.[737]

Auxoux's were anatomical waxes, which were created to represent parts of the healthy body, rather than the models in the public museums discussed in the previous chapter, or the moulages made in hospitals, which both recorded symptoms of disease (fig. 5.1).

[736] Haviland and Parish, 'A Brief Account of the Use of Wax Models in the Study of Medicine', p. 68.
[737] 'Saturday, February 4, 1832. Dr. Sigmond in the Chair. Clastic Anatomy' *Lancet,* 11 February 1832), p. 704.

Figure 5.1. An example of a wax anatomical model. Anonymous, nineteenth century. Image courtesy of the Science Museum, London.

Indeed, preparations and models were no sure-fire way to demonstrate medical knowledge on their own. One example is the case of surgeon John Miller (*b*.1800) who had been employed by Joseph Green at St Thomas's hospital to make preparations and models for Green's lectures. In 1838 Miller sought to prove his authority on the topic of embryology, as he was not well know in London so intended to ask the editors of several medical journals to 'examine the preparations before they noticed them, to prove the truth of the drawings, and the description in the paper which I have lately published, for surely what men of

such credit would vouch for, no one would dispute.'[738] Richard Owen (1804–1892), then conservator of the Hunterian Museum, was eager to view the collection, though Miller was aware that Owen too was also working on embryology so refused to show him any preparations. When Owen asked what was the smallest human ovum Miller had seen, Miller 'showed him the appearance in a small model of wax; when he said that he would not believe that the appearance which I represented really existed'.[739] In this case, the model was useless without the attendant preserved specimen it was based on. Artistry too could prove distracting. Reporting on a wax model of the otic ganglion in 1835 the *Lancet* recorded that '[t]he imitation is so close, so signally striking and true, that the mind is unavoidably turned from contemplating the obvious purpose of the design, to dwell on the marvellous skill of the artist. So nearly animate is the model, that we might almost suppose it to be traced by the hand of Prometheus.'[740] This is redolent of criticisms levelled against Alibert's 1806 atlas of dermatology *Descriptions des maladies de la peau*, discussed in chapter two, where the 'richness and beauty' of the engravings was deemed distasteful in the depiction of illness.[741] Yet despite the potential instabilities and unreliability of models, preparations and drawings, they were still being churned out at a vast rate in London. The following section explores how those creating visual representations of venereal disease for the museums and collections of new institutions negotiated these pitfalls in attempting to make their representations meaningful.

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[738] 'Sketch of the Life of John Miller, Author of "Discoveries in Embryology"', *Lancet*, 26 May 1838, p. 299.
[739] Ibid., p. 300.
[740] 'Model in Wax, coloured, of the Otic Ganglion and its Neighbouring Parts. Published by Schloss, 1835', *Lancet*, 26 December 1835, p. 511.
[741] 'Review: *Description des Maladies de la Peau*', pp. 449–450.

Robert Carswell and Joseph Towne

With the Royal College of Surgeons exercising such tight control over teaching in the capital, those excluded by the system turned elsewhere. In 1826 the first major rival to the College's monopoly on medical licensing was established, in the form of the medical school at the University of London, which would later become University College London.[742] The very first statement by the council of the University professed the need for a university in the capital to rival the Scottish universities, and to circumvent the edicts of Oxford and Cambridge that refused admission to religious dissenters.[743] Plans were laid out for a large medical school within the new university, with classes in Anatomy, Physiology, Morbid and Comparative anatomy, and Surgery.[744] The initial response from radicals was lukewarm, the *Lancet* in particular seemed unimpressed by the new endeavour stating that '[w]e do not look to the new establishment, as a source from which any immediate or striking advantages, with a view to the amelioration of the existing system of medical education, can be expected to result.'[745] The *Medical Gazette* went further in their condemnation, complaining that the governing body of the medical school were mostly lawyers and merchants, rather than medical men.[746] Others disagreed and saw the establishment of the University as a chance to improve education standards. One correspondent of the *Lancet* saw the university as bringing education closer to a French model. 'I was truly gratified to hear that a clinical hospital was to be attached to the medical school of the

[742] Stephen Jacyna, 'Medicine in Transformation, 1800–1849', in William F. Bynum, Anne Hardy, Stephen Jacyna, Christopher Lawrence, E. M. Tansey (eds) *The Western Medical Tradition, 1800–2000* (Cambridge: Cambridge University Press, 2006), p. 21.
[743] Michael Sanderson (ed.), *The Universities in the Nineteenth Century* (London and Boston: Routledge and Kegan Paul Ltd., 1975), p. 9.
[744] *Statement by the Council of the University of London Explanatory of The Nature and Objects of the Institution* (London: Printed for Richard Taylor, Red Lion Court, Fleet Street. For Longman, Rees, Orme, Brown, and Green; and John Murray, Albemarle Street., 1827), p. 16.
[745] 'London University', *Lancet*, Saturday 2 August 1828, p. 561.
[746] Desmond, *The Politics of Evolution*, p. 34.

London University' stated the writer; going on to argue that clinical instruction, rather than lectures was 'the only rational mode of instruction'.[747]

Wakley went on to change his mind about the London University as it proved to be a lasting endeavour. Inspired by its endurance, in 1831, he held a meeting announcing the formation of his own radical enterprise, an alternative to the Colleges of Surgeons and Physicians, which he called the London College of Medicine. Any 'legally qualified' practitioner could join, and the College would have a council and president who were elected annually, and would hold examinations without requiring that students attend any specific College mandated courses. This was also Wakley's attempt to destroy the hierarchical distinctions between physicians, surgeons, apothecaries and others, as any Fellow admitted to the College of Medicine would uniformly be referred to as 'doctor'.[748] At the initial meeting Wakley asked his audience to consider the success of the London University, at that time still working without a decree of parliament or a Royal charter recognising it, stating bombastically that '[t]he London University *will* receive a charter; it is working well for the public; is entitling itself to government protection, and will receive it.'[749] As hopeful as Wakley was, the University would not receive a charter, nor the ability to grant degrees, until 1836 when a Royal Charter amalgamated it with London's other new university King's College.[750] In its early years, like all new teaching institutions in the capital, the University needed to abide by the licensing regulations of the various medical

[747] 'Copy of a Letter to a Physician, on the Comparative Positions of the Medical Profession in France and England: Mountaubau, France, May 10, 1828', *Lancet*, Saturday 2 August 1828, p. 587.
[748] 'London College of Medicine', p. 855.
[748] 'London University', p. 857.
[749] 'London College of Medicine', p. 855.
[749] 'London University', p. 858.
[750] F. M. L. Thompson, 'The Architectural Image', in F. M. L. Thompson (ed.), *The University of London and the World of Learning, 1836–1986* (London and Ronceverte: The Hambledon Press, 1990), p. 10.

companies. In their first statement, the University council were certain to state that '[a]ttention will also be paid to a due compliance with the forms required by the Royal College of Surgeons and Company of Apothecaries, in their examinations.'[751] With this in mind, they were eager to establish a large teaching museum, not only to secure them the approval of the Royal College of Surgeons, but also a good reputation amongst the medical elite of the capital.

In order to do this, the University turned to Robert Carswell, appointing him the first Professor of Pathological Anatomy and curator of their burgeoning museum in 1828. At this time, Carswell was in France preparing a collection of watercolour drawings of pathological cases observed in the state hospitals of Paris and Lyon. The University, keen to benefit from Carswell's endeavours in France, allowed him to remain there to add to the collection that would go on to form an important part of Carswell's lectures, as well as to occupy an important part in the University museum.[752] Carswell grew up in Paisley attending Paisley Grammar School where he likely first took drawing lessons. He became an artist and etcher, his first medical commission coming from Professor of Anatomy and Physiology at Glasgow University, James Jeffray (1759–1848), who encouraged Carswell's burgeoning interest in medicine.[753] He began his medical studies at Glasgow, also taking courses in Edinburgh where his skills as an artist came to the attention of surgeon and physician John Thomson (1765–1846) who commissioned him to

[751] *Statement by the Council of the University of London*, p. 16.
[752] Stephen Jacyna, 'Robert Carswell and William Thomson at the Hôtel-Dieu of Lyons: Scottish views of French Medicine' in Roger French and Andrew Wear (eds) *British Medicine in an Age of Reform* (London and New York: Routledge, 1991), pp. 111–113.
[753] Peter O. Behan and Wilhelmina M. H. Behan, 'Sir Robert Carswell: Scotland's Pioneer Pathologist', in F. Clifford Rose and W. F. Bynum (eds), *Historical Aspects of the Neurosciences: A Festschrift for Macdonald Critchley* (New York: Raven Press, 1982), p. 273–274.

create a series of pathological drawings for him.[754] Carswell accompanied Thomson to France during his medical studies in order to make drawings of the pathological cases to illustrate Thomson's lectures in Edinburgh.

Carswell later returned to France to continue this endeavour with Thomson's son William. Travelling to France was common for medical students during the period, students wishing to benefit from better provision of cadavers on which to perform dissections than were available in England.[755] Whilst resident at the Charité in Paris, Carswell and William Thomson recorded the number of dissections in one week in August, noting that there was at least one per day, sometimes up to three.[756] Unheard of in England, in France the majority of the thirty thousand patients treated every year in the hospitals would be dissected.[757] These dissections were intended as both pathological investigations into causes of death as well as teaching opportunities for hospital pupils. The notes Carswell and Thomson made suggest they were present at a large number of such dissections, often accompanying written notes with small sketches.[758] Though gaining great insight into the practices of pathological anatomy and the structures of the French hospitals, Carswell and Thomson were less than impressed with the state of the hospitals in general. Whilst at the Hôtel Dieu in Lyon in 1823 and 1824, Thomson recorded that '[t]he beds seem by no means secured against vermin – in taking down the bandages of a fractured thigh which had remained for a considerable

[754] Locock, Charles, President of the Society, 'Annual General Meeting', *Proceedings of the Royal Medical and Chirurgical Society of London*, 9 February 1858, pp. 52–54.
[755] Jacyna, 'Robert Carswell and William Thomson at the Hôtel-Dieu of Lyons', p. 110.
[756] Edinburgh University Department of Special Collections, Papers of Sir Robert Carswell (1793–1857), GB 237 Coll-170, Gen.591, Carswell's notes (2), 1817–1825.
[757] Desmond, *The Politics of Evolution,* p. 41.
[758] EU, GB 237 Coll-170, Gen.591, Carswell's notes (2), 1817–1825.

time untouched I have seen the bugs crawl forth in swarms so that the surgeons could not proceed with his examination'.[759]

Carswell though showed less interest in the state of the hospitals themselves than in what was to be gleaned from the dissections that went on regularly within them. Whilst William Thomson was fascinated by the surgical activities at the hospital, Carswell's interest in the clinical aspects of care were limited to a fascination with patterns and progressions of symptoms. Stephen Jacyna writes that Carswell was interested in patients only as 'the loci of disease', paying scant attention to their own narratives of their conditions, choosing instead to focus on close observation of their symptoms in life, and in the dissecting rooms.[760] This attention to the pathological rather than the therapeutic was demonstrated in several of Carswell's drawings made during his time in France. In one particularly striking image, Carswell depicted a patient from the Hôpital de la Salpétrière in Paris, first showing the external appearance of the man's face, grotesquely distorted by syphilitic symptoms, accompanied by two details from the interior of the cranium after the dissection (fig. 5.2). The descriptive notes below all three views suggest that Carswell was uninterested in the multiplicity of symptoms the man might have demonstrated, such as the vividly coloured rash spreading across the forehead, but instead was focused on how these external symptoms were indicative of the internal actions of the disease. In this case, Carswell was particularly fascinated by the thickening of the bones of the cranium that had produced the troubling ulcerations of the skin shown in the top image. For Carswell, the outward clinical manifestation was secondary to the primary

[759] Ibid., p. 357. Also quoted in Jacyna, 'Robert Carswell and William Thomson at the Hôtel-Dieu of Lyons', p. 114.
[760] Jacyna 'Robert Carswell and William Thomson at the Hôtel-Dieu of Lyons', pp. 121–124.

action of the disease within the body, demonstrated by the extraordinary attention to detail especially in the two images of the dissected skull which demonstrate the fine fissures on the front of the interior of the skull, as well as the nodes of new bone formation on the exterior, as the skull had thickened due to the action of the disease. Indeed Carswell's notes reveal that his particular interest lay in attempting to understand the actions of disease within the body, especially how the disease spread between different tissues or organs, a fascination that required the close observation and linking of these external and internal manifestations of pathology.[761]

[761] Ibid., pp. 123–124.

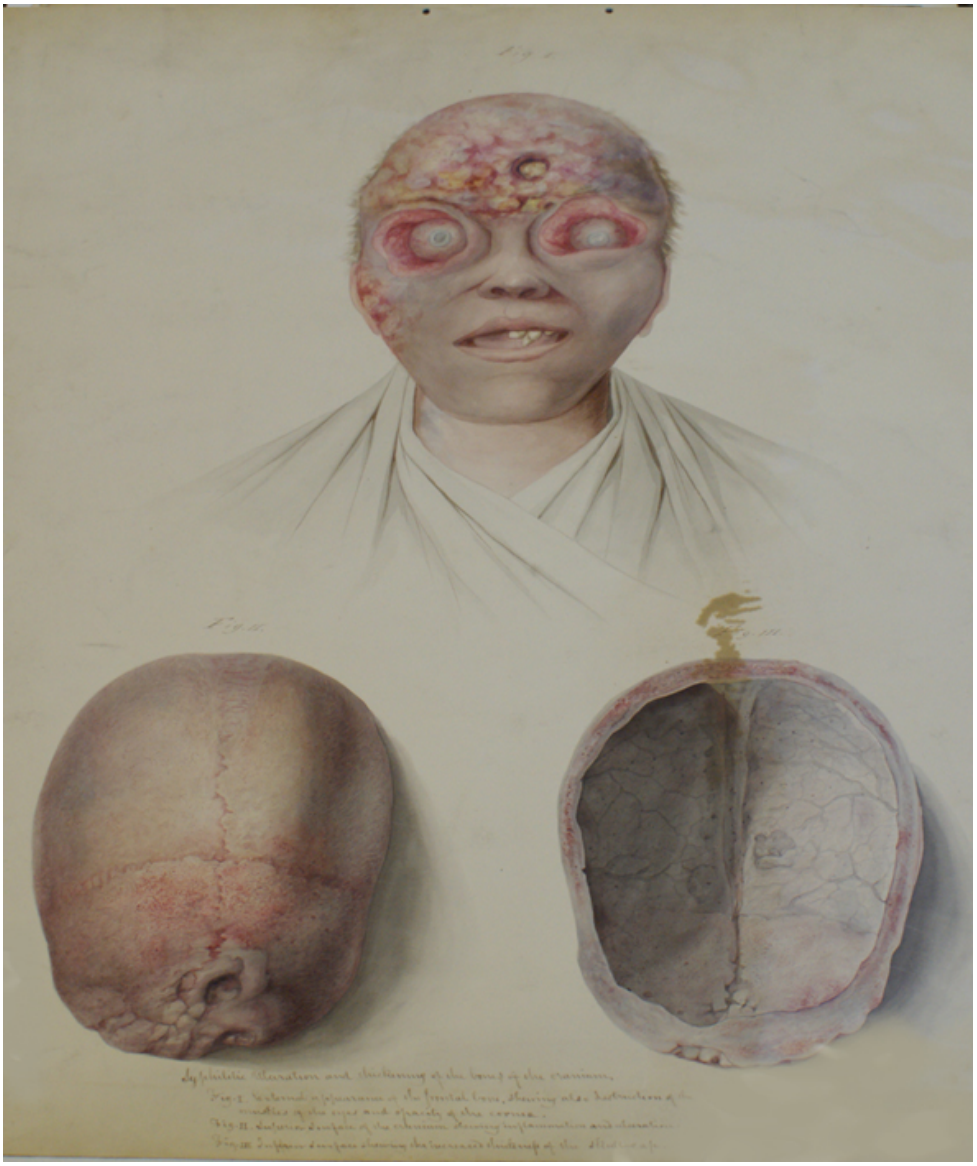

Figure 5.2. Syphilitic ulceration and thickening of the bones of the cranium. Watercolour by Robert Carswell, Hôpital de la Salpétrière, Paris, July 1830. University College London Special Collections, Hc528.[762]

When Carswell came to publish his atlas *Pathological Anatomy* in 1838, it was this dedication to observation and detail that was to win him such praise from the medical community. One enthusiastic review highlighted Carswell's evident skill in linking the appearances of the living symptom with the dead alteration in

[762] Full text below images reads: 'Syphilitic ulceration and thickening of the bones of the cranium. Fig. I. External appearance of the frontal bone, shewing also destruction of the muscles of the eyes and opacity of the cornea. Fig. II. Interior surface of the cranium shewing inflammation and ulceration. Fig. III. Interior surface shewing the increased thickness of the skull-cap.'

order to theorise on actions, declaring that although 'actions' were invisible to the artist, the process of drawing was a vital tool in conceptualising them.

> The artist cannot show the deposition of red matter in the bone of an animal fed on madder, but he may depict the colour from its first blush to the deepest redness. He cannot picture the blood *becoming* muscle, nor fat removing and replacing this, fibre by fibre, any more than he can exhibit the process of petrifaction, when stone it usurping the place of vegetable tissue. But he can seize the results, and represent the various stages of those processes. … so the pathologist, by taking anormal [*sic*] productions at their origin, and following them through their course, must come to general principles which comprehend the most diversified of such productions, in whatever organ or organism they may be found … Their aggregate constitutes the science of pathological anatomy…[763]

Here the use of drawings to collect abnormal appearances becomes the process of rationalizing the disease, of breaking it down to component stages and appearances to formulate general principles. This visual collecting of symptoms becomes the very process of pathological enquiry that was to make Carswell's name back in London.

Indeed, of particular interest for Carswell was the identification of frequently recurring symptoms that would alert the practitioner to the way the disease was progressing within the body, but that were also the basis for his discerning general principles of pathology. The idea of separating a theoretical discussion of the general principles of pathology from clinical applications that Jacyna has identified as the 'beginning of pathology as a science separable from clinical pathology'.[764] In the service of identifying frequently occurring symptoms, the specialist hospitals were of particular value, giving Carswell access to a large

[763] 'Review: Carswell on Tubercle', p. 328.
[764] Jacyna, 'Robert Carswell and William Thomson at the Hôtel-Dieu of Lyons', p. 123–124.

number of patients all suffering the same disease in various stages. In 1830 Carswell spent much time during September and October in the Hospice des Vénériens in Paris, an institution that, like the London Lock, was intended for the treatment of venereal disease. This was where he completed the majority of his drawings of syphilitic patients.[765] Here, most of the drawings show the clinical manifestations of the disease rather than post-mortem appearances, all of the drawings from the Hospice des Vénériens are of localised symptoms, mostly patients' genitalia in isolation detailing the most common first appearances of venereal disease; chancre on the penis, buboes on the groin and phymosis or paraphymosis. Compared to drawings he made at the Hôpital St. Louis or the Salpétrière which show patients' faces, limbs, and bodies, the Vénériens drawings look to have been completed quickly, they are also smaller. Extraneous detail such as pubic hair was kept to a minimum, painted quickly and simply, opposed to the minute detail visible in the rendering of symptoms (fig. 5.3).

[765] During this time Carswell also drew patients suffering from venereal diseases in the Hôpital St. Louis, the Hôpital de la Salpétrière and the Hôpital des Pitié.

Figure 5.3. Chancre and paraphimosis. Watercolour by Robert Carswell, Hospice des Vénériens, Paris, October 1830. UCL Special Collections, Hc503.

From the surviving drawings completed in the Hospice des Vénériens, Carswell looks to have been collecting variants of the classic symptoms of venereal disease, seeking the general in the multitude of differing appearances. Time at the Hospice gave Carswell the opportunity to observe the differing forms these classic symptoms could take depending on patient, or stage of the disease, yet these are factors which do not appear relevant in Carswell's drawings, or the accompanying notes on the pages. He does not record patient names or ages at the Hospice, nor attending physicians or accompanying case notes. Instead, the series seems to be a collection of the variants of symptoms, taken together as an illustration of a protean disease that can be defined by this set of early onset

symptoms, though not limited to specific characteristic appearances. Indeed, the Hospice images seem to simultaneously confirm and undermine the idea of characteristic symptoms, they all show ostensibly the same effects of the disease, but they rarely look alike.[766] For instance, the two images reproduced here (figs. 5.3 and 5.4) painted in October 1830 at the Hospice, both show a patient with a chancre on the penis, though the first (fig. 5.3) is accompanied by paraphimosis – a retraction of the foreskin – and the second (fig. 5.4) by a large bubo on the groin above the right leg. The chancres too take different forms in each image, the first showing two separate patches of ulceration on the glans and the foreskin, the second showing two sores close together on the shaft of the penis. Depicting the difference in appearance of two supposedly similar symptoms seems to have been of value to Carswell during his time at the Hospice, and indeed was a vital skill of the professional pathologist he would later come to epitomize.

[766] Daston and Galison, *Objectivity*, p. 69.

Figure 5.4. Chancre and bubo. Watercolour by Robert Carswell, Hospice des Vénériens, Paris, October 1830. UCL Special Collections, Hc507.

The display of the variety of appearances that a single disease could take, whether by drawings, preparations or models, was an important facet of the medical museum, one which the institutions controlling them seemed to be aware of. In his testimony before the Select Committee on Medical Education, George James Guthrie stated that for a teacher to adequately teach pathology and successfully explain the changes in the bodily tissue brought on by disease, '[i]t is not only necessary that he should have preparations, to enable him to show all, and every one of those changes; but the varieties of them'.[767] Indeed, it was explicitly stated in a review of Carswell's collection at the University museum that the defining virtue of the collection was not explicitly the artistic skill of Carswell, but his dedication to the accumulation of this multitude of symptoms.

[767] HCPP, *Report from the Select Committee on Medical Education: with the Minutes of Evidence and Appendix. Part II. Royal College of Surgeons*, p. 36.

> He who would represent morbid structures with accuracy, must not only be an artist but a profound pathologist, for it is not pictorial effects, but scientific facts, which are to be sought out and delineated. Rarely has anything in this way been achieved more perfectly than in the immense collection of drawings accumulated at the London University. … By careful analysis [Carswell] has shown the morbid appearances of those diseases at their commencement, and has followed them through the whole course of their development, – throwing withal such truth into his representations as to make them not only serve as splendid illustrations, but as permanent facts for study and demonstration.[768]

Here, rather than 'pictorial effects', it is the repeated and careful observation and accumulation of appearances represented in the collection that creates its scientific value. The dedication to observation and visual recording is the virtue of the pathologist over and above any perceived artistic flair. The desire of the new institutions to accumulate large numbers of images was also aligned with the desire for the representations of disease to show a range of possible symptoms.

However, for Carswell, this was not enough, and he saw that individual paintings produced in other hospitals had different important features. In contrast to the relatively small scale drawings of localised symptoms depicted in Carswell's drawings from the Hospice des Vénériens, his drawings of venereal patients from the Hôpital St. Louis and the Salpétrière demonstrate a different protocol for recording symptoms. The earliest of these, painted at the St Louis in 1829 shows the face of a patient whose nose and upper lip are covered with red and green tinged growths, identified by Carswell as syphilitic tubercles (fig. 5.5). The image is altogether more elaborate than the smaller images from the Hospice, and clearly demonstrates Carswell's artistic gifts. Another crucial difference between this image and the smaller scale drawings from the Hospice des

[768] 'Review: Carswell on Tubercle', p. 326.

Vénériens is the presence of two small holes at the top of the page, probably for hanging the picture in the museum or lecture theatres of the London University. The wider display of these more grandiose images may account for the more artistic rendering of the elements included in the picture. Unlike the images of localised genital symptoms, details extraneous to the symptoms are here included and indeed it appears Carswell took great care over them. The hair of the patient emerging from under the headscarf is minutely drawn with a fine brush while the striped scarf is so detailed that we can even see the pin in the centre keeping the material together. This is similar in style to Holt's paintings of patients from the London Lock Hospital discussed in chapter three which demonstrate the importance of recognisably individual case studies to the development of pathology. Sander Gilman has identified a trend in the depiction of disease wherein the patient, or sufferer of disease, is imagined and imaged as elided with the disease itself; Gilman writes, '[t]he portrait of the sufferer, the portrait of the patient, is therefore the image of the disease anthropomorphized.'[769] This iconography that amalgamated the disease with the sufferer is particularly resonant of the pathological paradigm that understood disease as resident within the physical body, and posited that local, external symptoms could prescribe the diagnosis of the disease.[770]

[769] Gilman, *Disease and Representation*, p. 2. See also Gilman, 'Lam Qua and the Development of a Westernized Medical Iconography in China', p. 63.
[770] Maulitz, *Morbid Appearances*, p. 75.

Figure 5.5. Syphilitic tubercles of the face. Watercolour by Robert Carswell, Hôpital St. Louis, Paris, 1829. Special Collections, Hc372.

The symptoms depicted in images from St Louis and the Salpétrière are much more varied than those Carswell focused on in the Hospice des Vénériens, and range from the showing faces of patients such as the one just discussed, to limbs and bodies showing a wide variety of different symptoms, from ulcers to rashes. Carswell also seems to have taken more time over them, they are much larger in size than the Hospice ones, and also demonstrate his artistic flair much more clearly. It appears that whilst in the Hospice des Vénériens, Carswell

quickly developed a protocol for depicting the genital symptoms, eager to collect as many variants as possible. He painted them quickly, paying little attention to surrounding detail of hair or clothing, leaving them in stark contrast to the images from the general hospitals. This is potentially due to the general hospitals attracting venereal cases that did not present in the classic fashion with genital symptoms first, or that the general hospitals saw cases that were much more advanced than the hospice dealt with. The Hospice was established in 1792 with the hope of standardising therapies and providing a cheaper service to Paris's poor.[771] This would not be the only time the Hospice allowed the creation of images within its walls. In 1851 Philippe Ricord published an atlas entitled *Traité Complet des Maladies Vénériennes. Clinique Iconographique de L'Hopital Des Vénériens*, which were, similar to Carswell's images, mostly images of symptoms on the groin. Ricord, it seems, was at first hesitant to publish the images, consulting a senior surgeon who expressed his dismay at the number of useless images cluttering up the field and displaying nothing. Ricord though recounted that,

> J'allais être convaincu qu'il avait raison, lorsque dans le cours de notre converstation sur les maladies des organes génitaux, le savant chirurgien qui venait de jeter une si grande défaveur sur la représentation matérielle des faits anatomiques ou chirurgicaux, pour mieux me faire comprendre la nature de quelques cas remarquables dont il avait donné l'histoire, me montra… les planches qui accompagnaient son travail, et qui, en effet, quoique assez mal exécutées, me servirent beaucoup mieux que les bonnes descriptions que je venais d'entendre.[772]

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[771] Susan P. Conner, 'The Pox in Eighteenth-Century France', in Linda E. Merians (ed.), *The Secret Malady: Venereal Disease in Eighteenth-Century Britain and France* (Lexington: University Press of Kentucky, 1996), p.27.

[772] 'I was almost convinced that he was right, when in the course of our conversation on the diseases of the genitals, the scientist surgeon who had just thrown such discredit on the material representations of anatomical or surgical facts, in order to better demonstrate to me the nature of some remarkable cases he had just described to me, showed me… the plates which accompanied

Despite the apparent crudeness of the images, Ricord, like Carswell, was convinced of their explicatory power.

In contrast to the Hospice images, Carswell's paintings from the general hospitals demonstrate that he took more time over painting them; he had no set scheme for rendering symptoms quickly, no set position for the patient to pose in as in the Hospice images. Certainly one of the most striking pictures from the collection, painted at the Hôpital St Louis in June 1830 saw him utilise his artistic flair when painting the torso of a man covered with a patchy red rash (fig. 5.6). The elaborate composition in this image seems to get in the way of the dispassionate rendering of the symptoms familiar from the Vénériens images. The body is twisted, visually dismembered, shadows fall under the arm obscuring the effects of the rash spreading towards the back. The muscular torso and dramatic positioning of the figure echoes contemporary artistic depictions of the torso of the Apollo Belvedere, a classical statue that became an ideal standard of male beauty for neoclassical artists (fig. 5.7).[773] This was a commonly repeated image that artists would have studied and copied during their training, so it is likely that Carswell was familiar with it. In Carswell's painting a blanket modestly covers the genitals despite the symptoms appearing to continue down the leg and to the groin. Like the image of the patient in the green headscarf, this painting has two holes punched in the top of the drawing, meaning it was likely intended for display in a museum or lecture. Potentially Carswell took so much time over this

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his work, and which, indeed, although badly executed, were much more useful to me than the good descriptions that I came to hear.' Philippe Ricord, *Traité Complet des Maladies Vénériennes. Clinique Iconographique de L'Hopital Des Vénériens Recueil D'Observations, Suivies de Considérations Pratiques, Sur les Maladies Qui ont été Traitées dans cet Hopital; Par le docteur Philippe Ricord* (Paris: Just Rouvier, Libraire-Éditeur, Rue Du Faon-Saint-André, 1851), 'preface'. My translation.

[773] Wendy Wassyng Roworth, 'Anatomy is destiny: regarding the body in the art of Angelica Kauffman', in Gill Perry and Michael Rossington (eds), *Femininity and Masculinity in Eighteenth-Century Art and Culture* (Manchester: Manchester University Press, 1994), p. 50.

image because it represented a relatively rare symptom or complication of venereal disease and it would be considered valuable to have a representation of this in a lecture on the subject. The note at the bottom left of the painting lists the symptom shown as 'Pityriasis versicolor' a topical rash that Carswell or the attending physicians must have identified as having a link with venereal symptoms Carswell himself referenced it as such.

Figure 5.6. Pityriasis versicolor on the chest. Watercolour by Robert Carswell, Paris, June 1830. UCL Special Collections, Hc515.

Figure 5.7. The Apollo Belvedere. Etching by Richard Dalton, London *c*.1740. Image courtesy of the Wellcome Library, London.

The display of such highly artistic images in the museums and lecture halls of hospitals, corporations and the new universities suggests that these massive collections of images were not so highly sought after purely for their value as teaching aids, but also as spectacular advertisements for the grandeur of the establishment. The large scale, highly artistic and detailed paintings like these were the exceptions in Carswell's collection, and we see a similar situation in John Thomson's collection, most of which were drawn by his sons William and Allen whilst in France with Carswell. Whilst the bulk of the collection is devoted to small sketches, often in pen and ink with only a small addition of colour wash

to distinguish between parts, there are a few more spectacular images within the collection (fig. 5.8). Like Carswell's image of the twisting torso, the painting of the child with the face and arm covered in pustules painted by Thomson pays explicit attention to details extraneous to the main symptom. He took care to paint the folds of the child's bonnet as well as the wisps of hair poking out from under it. Furthermore, the bedclothes clutched by the child hide much of the symptomatic area. This looks less like an image demonstrating the pathology of a specific disease, and more like a portrait of a young patient suffering.

Figure 5.8. Portrait of a child covered with pustules on the face and arm. Watercolour by Allen Thomson, nineteenth century. © Glasgow University Department of Special Collections, MS GEN 1476A/8552.

Furthermore, as well as these artistic renderings serving as spectacular endorsements for the status of new medical schools, they also served to demonstrate the superior ability of the practitioner as a pathologist. Perhaps because of Carswell's artistic talent, the discipline of professional pathology in the University emerged as one intrinsically connected with visual representations, unlike the earlier emergence of pathology in the private schools. To many, artistic talent and the validity of the images were inextricably connected, as Carswell's obituary from the Royal Medical and Chirurgical Society of London recounted, his collection 'for artistic skill and accuracy of delineation and colouring, have never been equalled.'[774] This was vital for the development of pathology as a respected new discipline in the early days at the London University; Carswell's reputation could be seen to stand for the reputation of professional pathology itself. Jacyna writes that both Carswell and John Thomson were actively creating new medical identities for themselves; for Carswell this was the professional pathologist, based explicitly in the university as an educator rather than a practitioner.[775] With the focus on research and pedagogy, Carswell's devotion to the use of drawings became a key facet of this academic pathology that he came to embody at the London University.

Carswell's images were widely praised and the university obviously considered it worthwhile to keep the pathologist in Paris in order to built the collection, yet this collection was by no means considered less critically than the preparations discussed earlier. Perhaps unsurprisingly, it was Robert Knox who seemed most unimpressed by images like Carswell's. Knox was evidently troubled by the rendering of three dimensional symptoms into two dimensional

[774] Locock, 'Annual General Meeting', pp. 52–54.
[775] Jacyna, *Philosophic Whigs*, p. 5.

representations, asserting that 'no vivid and correct idea of any object, *which should be seen in relief naturally,* can ever be conveyed to the mind by a representation on a flat surface… [p]ictures are deceptions, not realities'.[776] Again though Knox singled out the inadequacies of the medium for displaying syphilitic afflictions recounting that '[i]n my younger days, I read all the illustrated works on skin diseases, on eye affections, and on Syphilis and Syphiliod diseases… and I cannot say that I ever derived the smallest practical information from such works. The impressions seem all too vague.'[777] The images in many of the pathological and dermatological atlases of the period to which Knox referred did indeed only show a limited selection of symptoms. As discussed in chapter two, it was often considered unwise to attempt to limit venereal disease to images of its wildly variant symptoms. Yet Knox remained likewise unimpressed with Carswell's collection at the London University. 'Exhibited annually to a few students, they seldom think it worth while examining them, and never hope to derive any practical benefit from their inspection.'[778]

The University of London was not the only teaching institution in the capital to commission large collections of visual representations, the city hospitals had, by the nineteenth century, firmly established themselves as teaching institutions. In 1826 a young wax modeller from Cambridge called Joseph Towne came to London to exhibit a model he had made of a human skeleton. The model impressed several physicians who saw it and Towne was promptly introduced to Astley Cooper who was then, following his spectacular exit from St Thomas's, a resident surgeon at Guy's Hospital. Cooper introduced Towne to the treasurer of

[776] Knox, 'Original Lectures. Anatomical Museums', p. 327.
[777] Ibid., p. 327.
[778] Ibid., p. 327.

Guy's who took him on as modeller to the hospital's new medical school.[779] His employment by the hospital administration itself, rather than by Cooper demonstrates the desire of the governors of Guy's to best augment their teaching facilities. This can be seen in contrast to J. Holt at the Lock Hospital, probably employed not by the hospital, but by surgeon Samuel Lane. Although the Lock accepted medical students, the hospital did not have its own museum, relying instead on its individual surgeons to provide visual material for students.

During his fifty-three year tenure at Guy's hospital, Towne made 537 wax models of various cutaneous diseases.[780] He worked predominately alongside surgeon John Hilton (1805–1878), and physician Thomas Addison (1793–1860), who was a well-renowned authority on cutaneous diseases.[781] Towne was famously secretive about his methods of creating the models, spending long periods of time working in complete silence, ignoring his assistants and rarely taking breaks.[782] Perhaps from a fear of dust corrupting the model, or anxious that onlookers should work out his closely guarded methods, Towne often worked on models under a cloth, '[i]f anyone approached, he would emerge, turtle-like, carefully covering the model and inquire what was wanted'.[783] Though secretive about his process, historian Thomas Schnalke affirms that Towne first created plaster negatives, casting the faces or body parts of Guy's patients directly, before using the negatives to make the wax moulage.[784]

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[779] John Maynard, 'Towne, Joseph (1806 – 1879), anatomical modeller', *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004) [Consulted at http://www.oxforddnb.com/view/article/27600, (10 July 2010)].
[780] Rafal Bialynicki-Birula, Engeniusz Baran, Tatiana Szymczak, *Dermatologic Moulages: An Atlas of the Wroclaw Collection* (Wroclaw: Cornetis, 2006), p. 18.
[781] Haviland and Parish, 'A Brief Account of the Use of Wax Models in the Study of Medicine', p. 69.
[782] Ibid., p. 70.
[783] Ibid., p. 70.
[784] Schnalke, *Diseases in Wax*, p. 66. See also Carl Dame Clark, *Molding and Casting for moulages workers, sculptors, artists, physicians, dentists, criminologists, craftsmen, pattern*

As well as Towne, there were other medical modellers working in London during the period; although, as their models have not survived, neither have their legacies. One frequently recurring character was a Mr H. B. Tuson, who seems to have worked at a number of London hospitals in the early 1850s. In a paper presented at the Medical Society of London in October 1852 on scald head, the author noted that the symptoms were so diverse that '[b]eautiful wax models of the disease in its various forms and stages, executed by Mr. Tuson, the artist, were exhibited by the author, in preference to attempting (what he conceived to be a very fallacious undertaking) a definition of the eruption.'[785] In a paper read before the Royal Medical and Chirurgical Society, Dr Murphy at St George's hospital recounted that, whilst performing a post mortem he had asked Tuson to draw some of the appearances he had uncovered. 'Mr. Tuson, however, soon found that coloured drawings could not faithfully represent them, and without his (Dr. Murphy's) knowledge made a beautiful series of models in wax, which will speak for themselves.'[786] Tuson is also is mentioned as 'the able modeller to University College', indicating he may have aided Carswell in the provision of museum holdings.[787]

Indeed, wax models were in frequent use within hospitals around the capital, either as pedagogical aids or even patient records. One surgeon at the London Hospital recounted the case of a patient admitted in December 1851 suffering from swelling of the testicle brought on by a syphilitic infection. By

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makers and architectural modellers. By Carl Dame Clark, PhD. (Butler: The Standard Arts Press, 1949), p. 79–82, and Bialynicki-Birula et al., *Dermatologic Moulages*, p. 15.

[785] 'Medical Society of London: Saturday, Oct. 23, 1852 – On the Constitutional Treatment of Scald Head and Ringworm', *Lancet*, 30 October 1852, p. 407.

[786] 'Royal Medical and Chirurgical Society: Tuesday, January 27, 1852 – Mr. Hodgson, President', Lancet, 7 February 1852, p. 158.

[787] 'Medical Society of London. Saturday, Feb. 22, 1851. – Dr. J. R. Bennett, President.', *Lancet*, 15 March 1851, p. 295.

January the following year the man had recovered somewhat, and the surgeon noted that '[o]n comparing the diseased part with a wax model of it taken when the man was admitted, the fungus was found reduced to a third of its original size'.[788] In this instance, the virtue of the models was their indexical relationship between symptom and representation, with the original cast taken directly from the patient. These models and the original casts were used alongside each other in hospital teaching. One lecture at Guy's used two models, one of a brain, the other a cast of the interior of the skull, to show that they did not fit together, perfectly demonstrating the presence of a quantity of cerebrospinal fluid, or 'the perfect water bed of the brain'.[789] In 1841 surgeon James Startin (1806–1872) established The London Infirmary for the Cure of Diseases of the Skin, renamed the following year as the London Cutaneous Institution for Treatment and Cure of Non-Infectious Diseases of the Skin.[790] The hospital offered courses of clinical lectures that were 'extensively illustrated by models in wax, cast from the patients in attendance, and further exemplified by the cases themselves as opportunities present'.[791] This further suggests that the benefit to be drawn by these preparations, models and casts was dependent on them being used in contexts where their meaning could be controlled and delimited by reference to other visual representations or even the original source of the representation; the patient.

[788] T. B. Curling, 'A Clinical Lecture on a Case of Granular Swelling of the Testicle, Consequent on Syphilitic Orchitis. By T. B. Curling, Esq., F.R.S., Surgeon of the London Hospital.', *Lancet*, 1 January 1853, p. 8.
[789] 'A Course of Lectures on Pain, and the Therapeutic Influence of Mechanical and Physiological Rest in Accidents and Surgical Diseases', *Lancet,* 18 August 1860, p. 158.
[790] Arthur Rook, 'James Startin, Jonathan Hutchinson and the Blackfriars Skin Hospital', *British Journal of Dermatology*, 99 (1978), pp. 215–219.
[791] 'Advertisements', *Lancet*, 27 September 1845, p. 356.

Whilst the waxes were considered aesthetically superior objects, more workaday materials like the casts also had many redeeming features. In 1837 the *Lancet* wrote that they,

> do not, indeed, possess all the beauty, or the precision of details, to be found in various preparations in wax, but they fully compensate for any deficiency in this respect by their lightness, elasticity, and hardness. These qualities permit of the constant use of the mould without any fear of injury, a circumstance which gives them a great superiority over all the works of this kind which have hitherto been submitted to our inspection.[792]

Indeed there was growing debate in the early nineteenth century over the suitability of different representational strategies and the types of materials used.[793] In the light of these debates, other materials were frequently employed to create models. In 1851 the *Lancet* reported on a new development in modelling technology; models made using gutta percha.[794] Gutta Percha was a natural rubber-like material, introduced into Europe from the East Indies in the 1840s. One treatise on the subject attributed its introduction to a surgeon, one Dr. Montgomerie, working in Singapore who came across a material which 'could be moulded into any form by dipping it into boiling water till it was heated through, when it became plastic as clay, regaining when cold its original hardness and rigidity'.[795] The material was used in the manufacture of a variety of items, from insulation for copper wires to miner's hats, but the medical uses for the substance

[792] 'Anatomical Models', *Lancet,* 4 March 1837, p. 832.
[793] Massey, 'On Waxes and Wombs: Eighteenth-Century Representations of the Gravid Uterus', pp. 96–97.
[794] 'New Inventions in Aid of the Practice of Medicine and Surgery', *Lancet*, 29 March 1851, p. 364.
[795] *The Discovery, History and Manifold Uses of Gutta Percha, Illustrated by An Engraving in Old Colours and Sixty Engravings on Wood* (London: Benjamin L. Green, 62, Paternoster Row, 1851), pp. 5–6.

were recognised early, with surgeons using Gutta Percha to make splints for club-foot and fractures, to make plasters for wounds, to manufacture stethoscopes, and for making false teeth.[796] One commentator found, and the *Lancet* agreed, that '[t]he advantages which this material has over papier-mache, wax, or plaster, is, that objects formed from it may be freely handled without being broken, and being painted in oil colour, models such as that forwarded to us can be washed when soiled.'[797] Most of the medical museums of London's various teaching institutions contained models made from a range of different materials.

By the 1860s Guy's Hospital Museum contained around 10,000 preparations, 4,000 drawings and around 400 of Towne's models of skin diseases, several amongst these displaying syphilitic afflictions.[798] The Towne models continue to be used to this day as teaching tools at the medical school of King's College London, and since their creation have been subject to much reorganisation and recategorising. The earliest surviving catalogue of Towne's models is from 1876. Written by the curator of the museum at this time, C. Hilton Fagge, it replaced the previous catalogue from 1854, which Fagge felt to be incomplete.[799] There are several incidences of Fagge reclassifying moulages as venereal that had previously been catalogued as other cutaneous diseases. One exemplary case is that of a moulage made of a patient referred to as E.D. who sought treatment in June 1834 for an extensive ulcer on his back (fig. 5.9). The model showed the lower back and buttocks of the patient and was described in

[796] Ibid., p. 30–33.
[797] 'New Inventions in Aid of the Practice of Medicine and Surgery', p. 364.
[798] 'Metropolitan Hospitals and Medical Schools', *Lancet*, 11 September 1869, p. 392.
[799] C. Hilton Fagge, *Catalogue of the Models of Diseases of the Skin in the Museum of Guy's Hospital by C. Hilton Fagge, M.D. Curator of the museum; assistance physician to and lecturer on pathology at the hospital; formerly demonstrator of cutaneous diseases* (London: J & A Churchill, New Burlington Street, 1876), p. ix.

great detail in the accompanying catalogue.

Figure 5.9. Circinate Syphiloderma. Wax model by Joseph Towne, *c*.1834. Image courtesy of the Gordon Pathology Museum, King's College London.

> It is slightly festooned, and is interrupted here and there by a narrow interval of healthy skin. Its surface is red, moist and oozing, the rete mucosum being exposed, probably by the removal of crusts most likely had covered it. There is slight exfoliation of the cuticle on both sides of the sore. The surface within is somewhat pigmented; this is doubtless, an indication that the sore was once smaller than now, and was spreading centrifugally at the time when the model was made.[800]

This description was accompanied by case notes recording that the patient had been suffering with this eruption for five years, but that twenty years previous he had been diagnosed with syphilis, which was treated with mercury. Fagge's

[800] Ibid., pp. 44–45.

catalogue went on to explain how this moulage was reclassified for the 1876 catalogue.

> In the former catalogue this model was designated "Ecthyma? Impetigo;" and, although the fact that the patient had had syphilis twenty-years back is mentioned, it does not appear that the eruption was regarded as a direct result of that disease. I venture to say however, that there is hardly any cutaneous affection which is more characteristic of syphilis than such a one as this, and I feel confident that it would at once have been cured by full doses of iodide of potassium, had that remedy been known at the time when the case came under observation.[801]

Here the model takes on a new identity as a tool of retrospective diagnosis, as Fagge, forty-two years after the model was made, reinterpreted the symptoms displayed, along with the supplied case history, in order to re-diagnose the patient. Whilst a fascinating element to the models, for the historian it necessitates a cautious consideration of which models were expressly intended to depict venereal disease at the time of their creation, and which have subsequently been re-diagnosed and re-categorized.

[801] Ibid., p. 45.

Figure 5.10. Inherited Syphilis. Wax model by Joseph Towne, *c*.1834. Image courtesy of the Gordon Pathology Museum, King's College London.

In other cases, the diagnosis of venereal disease actually impacted on the final model in a much more tangible way, with one woman so unwilling to accept a diagnosis of congenital syphilis in her child that she did not return to the hospital so that the moulage could be completed (fig. 5.10). The moulage is again described in detail 'the child is much emaciated, that its conjunctivae are affected with cararrhal [*sic*] inflammation, and its nostrils obstructed with crusts &c. It therefore lies with its mouth widely open, in order to breathe comfortably. The skin has lost its elasticity, and lies in folds about its limbs'.[802] The child was brought to Guys as an outpatient in 1834 but only turned up for one week, for a treatment which seemed to be working, when the mother stopped bringing the child in, 'and consequently the model could not be entirely finished. It is proper to observe that the woman always denied having had syphilis.'[803] In this case the plaster cast of the child had been taken and the addition of wax made, yet the finer

[802] Ibid., p. 57.
[803] Ibid., p. 57.

details of the symptoms were lost. This suggests that the creation of the model could have played a role in re-inscribing the stigma of venereal disease in the mind of the patient, or in this case, the patient's mother.[804] The model was an undeniable depiction of the disease the mother was determined to deny, it made the illness physical and suspended it in time.[805]

Towne's models, alongside the preparations and drawings also held at Guy's were used in several lectures on cutaneous diseases and syphilis.[806] Yet, like many of the collections discussed in this chapter, they were also deployed in order to demonstrate the credibility of Guy's hospital teaching. After all it was not so long since Astley and Bransby Cooper had failed to obtain the desired parts of St Thomas's Hospital museum collection and the museum at Guy's had to be built up from scratch. In 1830 the *Medico-chirurgical Review* covered the establishment and development of the museum noting that

> '[t]he department of casts and models forms too important a feature in the museum to be left unnoticed. In this department, youthful as is the museum, it is, perhaps not too much to say that it yields to none in this country. Its advantageous position in this respect must be attributed to the fortunate circumstance of the treasurer's having attached to the service of the hospital Joseph Towne, an artist who has the signal merit of having both created his art for himself, and arrived at such a proficiency in it, that his works, already very numerous, rival, if not surpass, those of the best and most distinguished masters of Florence and Bologna.'[807]

[804] Gilman, *Disease and Representation*, p. 6.
[805] Alberti, *Morbid Curiosities*, p. 6.
[806] Samuel Wilks, 'A Lecture on Syphilis. Delivered at Guy's Hospital Jan. 11th, 1867', *Lancet*, 9 February 1867, pp. 167–170.
[807] 'Review: Dr. Hodgkin's Anatomical Catalogue', *Medico-chirurgical Review*, August 1830, p. 369.

Towne's models became renowned around the city, and word of their excellence travelled even further afield. In 1859, American Professor of Surgery at the Medical College of Alabama J. C. Nott visited London in the hope of purchasing models with which to furnish his own college's museum. Nott recounted that, '[m]y information had led me to the conclusion that I should find little else for sale in London than the beautiful wax models of Mr. Joseph Towne… The models for which he has gained his greatest celebrity, are those of skin diseases, and I do not hesitate to say that they are incomparably superior to any made in Europe.'[808] Indeed, Towne sold models to medical museums all over the world, including as far afield as America, India, and Russia.[809] It appears that it was Towne himself, as much as the models he created, who was being used to display the elevated status of Guy's museum. This also demonstrates how the specific subjects of the models collected by an institution could affect its identity with Guy's hospital coming to be seen as exemplary in the study of cutaneous diseases because of Addison's expertise and Towne's models.

Conclusion

This chapter has explored what new teaching institutions, such as the London University, Guy's Hospital and the Royal College of Surgeons, themselves wanted from visual and material representations. Here we see that concerns over the ability or inability of such models to accurately and usefully represent specific conditions like venereal disease faded somewhat into the background, with institutions focused solely on accumulating a large quantity of representations.

[808] J. C. Nott, 'Medical Museums and Schools, with remarks on the Radical Cure of Hernia', *The New York Medical Press: A Weekly Journal of Medicine, Surgery, and the Collateral Sciences*, 14 January 1860, p. 37.
[809] E. J. Pyke, *A Biographical Dictionary of Wax Modellers* (Oxford: The Clarendon Press, 1973), p. 149.

From a preoccupation with the ability of images to define disease, in these new sites we see a fixation on these visual representations defining the practices of the profession. The arguments over ownership of collections such as that of the St Thomas's, and the bitter end to Clift and Home's friendship because of the fate of Hunter's manuscripts, demonstrates the desire of institutions in the nineteenth century to raise their reputation by recourse to these spectacular collections. That they were considered crucial to the education of students was written heavily into the 1834 Select Committee report with all questioned agreeing that a teacher must have a museum.

As these collections became the *sine qua non* of professional medical establishments though, they became subject to more criticism from those who opposed this establishment. Teachers who could not attract students because their classes were not recognised by the Royal College of Surgeons due to insufficient museums complained, understandably, that they could not get access to cadavers from which to take preparations if they were not already accredited. Though even in the most ferocious attacks on these museums, their essential existence was not questioned. Even Robert Knox's lectures did not call for the end of museums or the dismantling of all forms of visual representation. He concluded that 'it will not, I hope, be imagined that I recommend the removing from museums all anatomical specimens; on the contrary, there are many points of disease which can be well illustrated by the present method'.[810] Instead, he called for more attention to be paid to the forms these representations should take and in particular to what diseases and processes they were supposed to represent. Indeed, the move of these visual representations into new professional institutions did nothing to

[810] Knox, 'Original Lectures. Anatomical Museums', p. 328.

secure their identity or the identities of the diseases they depicted and venereal disease remained an unstable concept even by the mid nineteenth century.

6

Conclusion

> It is by the Thames, that the foreigner should enter London. The broad breast of this great river, black with the huge masses that float upon its crowded waters, – the tall fabrics, gaunt and drear, that line its melancholy shores, – the thick gloom through which you dimly catch the shadowy outline of these gigantic forms – the marvellous quiet with which you glide by the dark phantoms of her power into the mart of nations – the sadness, the silence, the vastness, the obscurity of all things around – prepare you for a grave and solemn magnificence.[811]

This is how James Gilbert opened his 1851 *Visitor's Guide to London*. Though written as a tourist guide to the city in the year of the Great Exhibition Gilbert's was not a brash or celebratory London, but a dark, melancholic city whose own magnificence seemed to weigh heavily upon it like a smog. Indeed, London's 'thick gloom' obscured to the foreign visitor an undercurrent of disease and depravity that infected the capital in the forms of rampant prostitution, drunkenness and endemic venereal disease. Yet this was not an undercurrent that would remain secret for long once the visitor alighted on the 'melancholy shores'

[811] James Gilbert, *Gilbert's Visitor's Guide to London; Containing the Completest Information Connected with the Localities, Customs, Public Buildings, Amusements, and Resources of The Capital of Great Britain, an Indispensable Handbook for Travellers and Foreigners Desirous of Possessing an Accurate Knowledge of the British Metropolis Previous, and During their Visit to The Great Exhibition of 1851to which is Appended "Sunday in London" or Excursions to the Vicinity, with a map* (London: James Gilbert, 49, Paternoster Row, 1851), p. 6.

of the capital. By the second half of the nineteenth century venereal disease had not slowed its rampage through the city and its omnipresence was obvious. Newspapers were full of doctors advertising '[p]rivate hints for cure of secret disease, seminal weakness &c', proffering their services in London's crowded streets.[812] Though Dr Kahn himself had fled his museum and others like it were still going strong, with groups like the Perrys advertising their cordial nostrums. Furthermore, the establishment of the Lock Hospital and the prodigious number of pamphlets, treatises and tracts on the subject of venereal disease appearing during this period indicates a fascination with venereal disease by all within London's medical marketplace.

The late eighteenth to the mid nineteenth century was a period in which paradigmatic shifts in how disease was conceptualised were underway; from a humoural conception of health as the perfect balance of the four vital fluids of the body that rendered disease as an invisible, intangible and ultimately unknowable essence, to a pathological conception of disease that saw it inscribed physically on and within the flesh of the body.[813] The techniques that inaugurated this shift were profoundly visual, exemplified by a new emphasis on close observation of patients in hospitals; Foucault's 'clinical gaze'. The 'gaze' was a shift in perception that relied on the new technologies of the clinic developed in the eighteenth and nineteenth centuries. Physician Leopold Auenbrugger (1722–1809) developed the percussive method in the eighteenth century, placing his ear to the body and tapping or striking it to discern telltale sounds of structural changes

[812] 'Advertisements & Notices', *Reynold's Newspaper*, Sunday 1 January 1854, p. 15.
[813] John O'Neill, 'Foucault's Optics: the (In) Vision of Mortality and Modernity', in Chris Jenks (ed.), *Visual Culture* (London: Routledge, 1995), p. 192.

within.[814] In the early years of the nineteenth century French physician René Théophile Hyacinthe Laennec (1781–1826) developed the practice of auscultation with his new invention the stethoscope, which listened for changes in normal function of the interior body.[815] These technologies and practices sought to make a disease resident within the body legible to those outside of that body. As Foucault wrote, '[t]he sight/touch/hearing trinity defines a perceptual configuration in which the inaccessible illness is tracked down by markers, gauged in depth, drawn to the surface, and projected virtually on the dispersed organs of the corpse.'[816] Within this new perceptual understanding of disease visual representation served multiple purposes. Images could arrest key symptoms to define the stages or forms of a disease, models and casts could record the progression of a condition in one individual patient, and preparations showed medical students the specific changes of structure of the internal body that would hint at the actions of disease.[817]

As we have seen though, it was not just these theoretical changes within the world of the clinic that prompted a turn to visual representations of venereal disease. Images had a number of virtues within the medical marketplace of the eighteenth and nineteenth centuries. They could capture specific appearances of pathology to share with other medical practitioners. Collecting and displaying them in museums and schools served to advertise the status of a practitioner; either explicitly, as in the case of the aesthetically spectacular models that

[814] Bernike Pasveer, 'Representing of Mediating: A History and Philosophy of X-ray Images in Medicine' in Luc Pauwels (ed.), *Visual Cultures of Science: Rethinking Representational Practices in Knowledge Building and Science Communication* (Lebanon: University Press of New England, 2006), p. 45.
[815] Bynum, *Science and the Practice of Medicine in the Nineteenth Century*, p. 37.
[816] Foucault, *Birth of the Clinic*, p. 202.
[817] Steve Sturdy, 'Making sense in the pathology museum', in Andre Patrizio and Dawn Kemp (eds), *Anatomy Acts: How we Come to Know Ourselves* (Edinburgh: Birlinn, 2006), pp. 114.

attracted patients into the museums of lost manhood scattered around London, or tacitly, in collections amassed by medical teachers who needed to build a good reputation to be recognised by licensing bodies such as the Royal College of Surgeons.

The multitude of representational possibilities and practices devoted to venereal disease that this thesis has discussed – the drawings, paintings, casts, moulages, models and preparations – demonstrate attempts by their creators to define the disease. We have seen various ways practitioners attempted to control the interpretation and meaning of venereal disease by bounding it within the medium of visual representations. Venereal disease continued to elude new medical understandings of disease. As visual representations came to be regularly employed in pathology and dermatology practitioners theorizing on the disease sought to take advantage of this to attempt to stabilize and systematize this most protean of disorders in the same way. As Gilman has argued, these medical men sought to utilise the 'fantasy of the validity of "art" to present a controlled image of the world'.[818] Concomitantly, this also necessitated a struggle to control the interpretation of the visual representations themselves; by placing a minutely detailed preparation next to a clearly delineated drawing, by accompanying atlas engravings with blocks of explicative text, by snatching models from the hands of those not deemed qualified, and stowing them away in new institutions.

Indeed, the legitimacy of visual representation was often just this; a 'fantasy'. Just as the multitude of interpretive possibilities of the visual could destabilise the disease they depicted, so the uncertain disease itself could undermine the descriptive power of the visual. The protean nature of venereal

[818] Gilman, *Disease and Representation*, p. 2.

disease rendered many representational media epistemologically unstable. The case of the atlases produced by Robert Willan, Thomas Bateman and Richard Carmichael in the early nineteenth century demonstrates this instability, with Bateman declaring that the disease defied visual representation.[819] Attempts to standardize views of disease in other media often fared little better. Pathological preparations for instance were by their very nature idiosyncratic in appearance, as symptoms that one pathologist might chose to illustrate a disease could be quite different to those which another would chose. As Samuel Alberti writes, in contrast to normality 'deviance is limitless'.[820] After Everard Home burned John Hunter's manuscripts describing his pathological preparations, George Guthrie expressed his frustration that without the notes 'the utmost difficultly, of course, existed in making out what each preparation was intended to represent'.[821] Once again venereal disease proved a particularly awkward condition to display as a preparation, Robert Knox declaring it pointless to even attempt such an endeavour.[822]

[819] Bateman, *Synopsis,* p. 328.
[820] Alberti, *Morbid Curiosities*, p. 6.
[821] HCPP, *Report from the Select Committee on Medical Education: with the Minutes of Evidence and Appendix. Part II. Royal College of Surgeons, London*, p. 46.
[822] Knox, 'Original Lectures. Anatomical Museums', p. 307.

Figure 6.1. A lecture at the Hunterian Anatomy School, Great Windmill Street. Watercolour by Robert Blemmel Schnebbelie, 1830. Image courtesy of the Wellcome Library, London.

This state of affairs was no different in educational practices. In the medical schools and universities, images and models were by no means epistemologically sound, and they needed the support of text or even other images to convey the meaning intended by the teacher. Historians have often argued that medical education has been neglected in historical study until very recently, seen as, in Vivian Nutton and Roy Porter's words, 'a peaceful backwater'.[823] The case of visual culture though, with its images and objects that straddle practice and pedagogy, demonstrates how integrated education was in medical thought and research. The array of visual and material representations discussed in this thesis served to support each other in the arena of medical education. One 1830 painting

[823] Quoted in Kier Waddington, *Medical Education at St Bartholomew's Hospital, 1123–1995* (Woodbridge: The Boydell Press, 2003), pp. 1–2.

of a typical anatomy lecture demonstrates the proliferation of these objects in lectures, common from the early nineteenth century (fig. 6.1). This is a lesson at the Great Windmill Street anatomy school, established by William Hunter in 1746.[824] The students are standing or sitting around the crowded benches of the high-ceilinged lecture theatre. In the centre of the semicircle of attentive students, under the glow of the bright gaslight, stands the teacher, gesturing at a selection of skulls and fragments of bone lying on the table before him. On the rear wall hang charts, models of various body parts, and drawings and paintings of human and animal anatomy. Finally, suspended high above the heads of students and teacher alike a human skeleton seems to dispassionately survey the scene. By the mid nineteenth century medical teaching had become dependent on the mass of visual representations seen in the painting. The visual served to elucidate the verbal lecture and vice versa and each preparation, model or drawing was supported and clarified by the wealth of other explicative visual representations adorning the walls of the hall.[825]

Within the lecture hall students observed, took notes and sometimes copied the images shown before them (fig. 6.2). Frederick Knox wrote in 1836 that the art of drawing was nigh on essential for the student of medicine. 'It will repeatedly prove to him, that when he imagines that he is perfectly acquainted with every thing about a part, he in reality knows little or nothing. It is also one of the best kinds of short-hand writing with which I am acquainted.'[826] Of course, as we have seen, the first half of the nineteenth century saw an enormous outpouring of medical scribbling, a practice not just limited to the lecture hall. In the hospitals

[824] Zachary Cope, 'The Great Windmill Street School of Anatomy', in *Some Famous General Practitioners and other Historical Essays* (London: Pitman Medical Publishing Co. Ltd., 1961), p. 62. Pp. 62–86.
[825] Alberti, *Morbid Curiosities*, p. 144.
[826] Knox, *The Anatomist's Instructor, and Museum Companion*, p. 138.

and infirmaries of the nineteenth century medical practitioners were busying themselves with pencil and paper as well as needle and knife. Allen Thomson sketched several patients in the Leith infirmary in the mid nineteenth century, as well as abroad whilst accompanying his brother William and friend Robert Carswell to France in the 1830s (fig. 6.3). These were raw, almost crude, drawings that were not intended to illustrate a lecture or accompany a medical text. Likewise the watercolours created by J. Holt in the London Lock Hospital, and Robert Carswell in the Hospice des Vénériens. Whilst both created several large and visually stunning portraits of patients at these institutions these were outnumbered by those smaller, quicker, and less polished images that displayed only a chancre, a patch of skin or an ulcerated lip (fig. 6.4). This was increasingly how practitioners were thinking about pathology. Robert Willan formulated his nosology of cutaneous diseases after spending innumerable hours in the Carey Street Dispensary sketching patients' symptoms.[827]

From the late eighteenth to the mid nineteenth century more and more visual representations of venereal disease appeared within the various spaces of London's medical marketplace. Fundamentally, these were attempts to control the disease through limiting it to lines on a page, or marks in wax, yet we have seen over the course of this thesis that this control was never wholly attained. Venereal disease seemed to defy any form of visual representation foisted upon it, and likewise, the multiple meanings and interpretations of visual representations could to little to standardise or explain the nature of the disease.

[827] Crissey et al., *Historical Atlas of Dermatology*, p. x.

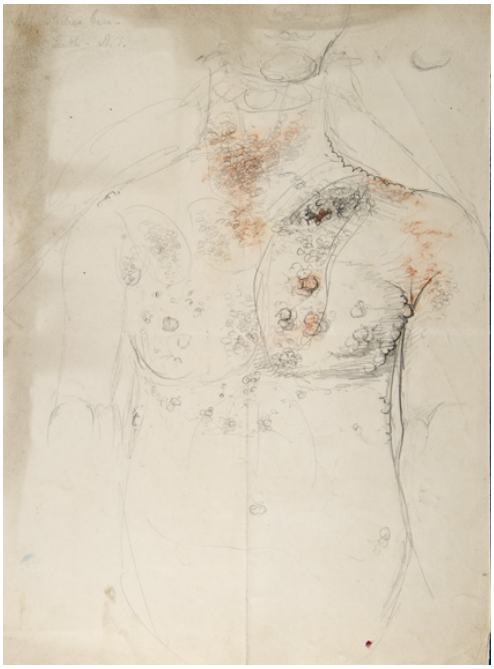

Figure 6.2. (left) Illustrations of anatomy. Pen and pencil sketches by Thomas Graham, 1834. Notebook containing notes of lectures on natural philosophy by Mr Russel, anatomy by Dr Monro and chemistry by Dr Hope, delivered at the University of Edinburgh (December 1834). Opp. p. 2. Image courtesy of the Wellcome Library, London.

Figure 6.3. (right) Mr Kellie's case, Leith. Pencil and coloured chalk sketch, by Allen Thomson, nineteenth century. Glasgow University, Department of Special Collections, MS GEN 1476A/8537.

Figure 6.4. Chancre of the upper lip. Watercolour by Robert Carswell at the Hospice des Vénériens, Paris, October 1830. UCL Special Collections, Hc526.

Though this thesis draws to a close in the 1860s, this was by no means the end to the debates over venereal disease and visual representation. The epilogue to this tale sees yet more political, social and medical reform directed at the disease, and still more discussion and development of visual representational techniques. The 1860s saw Parliament begin to turn its attention to the endemic nature of venereal disease in Britain enacting the first Contagious Diseases Act in 1864, repealing and replacing it with the second in 1866, and finally extending this in 1869.[828] The London Lock Hospital, having already moved to a larger, purpose-built, institution in 1848, opened a second house specifically for outpatients in 1862.[829] After almost fifty years of struggling for reform, a period that had seen the 1815 Apothecaries Act, the 1832 Anatomy Act and the 1834 parliamentary investigation into medical education, it was to be the 1858 Medical Act that was to enact the most drastic reorganisation of medicine. The Act established the General Medical Council (GMC), which regulated standards of medical training, as well as initiating a register listing qualified doctors.[830] Historian Irvine Loudon argues that by 1860, medical practice in the capital had been thoroughly restructured and out of this was emerging a nascent medical 'profession'.[831] Indeed it was the establishment of the GMC that is frequently seen as marking the final disintegration of the hierarchy of physicians, surgeons and apothecaries and inaugurating a new formalised medical profession, which could encompass new categories of doctor such as the general practitioner.[832]

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[828] Bartley, *Prostitution*, p. 202.
[829] Williams, *The London Lock*, p. 73.
[830] Francis Michael Glenn Willson, *The University of London, 1858–1900: The Politics of Senate and Convocation* (Rochester, NY: The Boydell Press, 2004), p. 87.
[831] Loudon, *Medical Care and the General Practitioner*, p. 3.
[832] Mark Davies, *Medical Self-regulation: Crisis and change* (Aldershot: Ashgate, 2007), p. 15.

These newly reorganised medical communities were also finding new ways to deal with venereal disease. The second half of the nineteenth century saw the emergence of germ theory necessitating further reconceptualisation of the workings of disease.[833] Moreover, historian George Weisz has shown that this newly unified medical profession felt a '*collective desire to expand* medical knowledge' that led to the emergence of specialisation.[834] New disciplines that had appeared in the early nineteenth century such as pathology and dermatology were codified as separate fields of medicine with their own university departments and chairs and were joined by other new specialisms such as neurology, haematology and, most importantly here, venereology.[835] Venereology initially emerged as a sub-specialism of dermatology, but by the early twentieth century had evolved into its own distinct discipline.[836] Despite the distinction of syphilis and gonorrhoea in the 1830s, which some historians have seen as inaugurating the modern concept of syphilis, in the late nineteenth century the identities and symptoms of these two diseases were still ill defined.[837] The 1870s saw syphilis become known as 'the great imitator' as its symptoms were still considered so protean.[838]

Neither did the second half of the nineteenth century see the end of concerns and questions about the use of visual representations of the disease. The birth and growth of dermato-venereology initiated the heyday of the wax moulage, and this was an important element in the legitimisation of the

[833] Michael Worboys, *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865–1900* (Cambridge: Cambridge University Press, 2000), p. 5.
[834] George Weisz, 'The Emergence of Medical Specialization in the Nineteenth Century', *Bulletin of the History of Medicine*, 77:3 (Fall, 2003), p. 539.
[835] Rosemary Pringle, *Sex and Medicine: Gender, Power, and Authority in the Medical Profession* (Cambridge: Cambridge University Press, 1998). p. 101.
[836] George Weisz, *Divide and Conquer: A Comparative History of Medical Specialization* (Oxford: Oxford University Press, 2006), p. 217.
[837] Davidson and Hall, *Sex, Sin and Suffering*, p. 3.
[838] Crissey and Parish, *The Dermatology and Syphilology of the Nineteenth Century*, p. 218.

profession. Although the traditional narrative of the medical marketplace posits the mid nineteenth century and the reorganisation of medical practice as the time when the marketplace model gave way to a medical profession uninfluenced by competition, many historians have argued that, in fact, competition was never truly eradicated.[839] Even within a supposedly non-competitive medical system, credibility and status had to be negotiated for new disciplines and the continued use of visual and material representations was to be crucial in this endeavour. Schnalke has argued that this was a much more insular practice in this period, with moulages serving to enhance statuses 'at the level of individual physicians' and clinics, rather than advertising the discipline in wider medical culture or indeed, outside of medical discourse.[840] As well as wax, of course, this was the period in which photography began to play a central role in medicine.

First emerging in the late 1830s, photography did not come to prominence in medical work until the mid century, when it began to be used in hospitals such as Bethlem to record the progress of patients.[841] Despite its use in hospitals however, the mass dissemination of medical photographs in printed books was not possible until the technology to produce plates directly from photographs was developed in the 1870s.[842] Photography offered a new element to the visual control of disease, what Daston and Galison have termed 'mechanical objectivity'.[843] The photograph did not require a skilled artist or modeller, theoretically anyone could point a camera at a patient and take their picture. To

[839] Michael Brown, 'Medicine, Quackery and the Free Market: The 'War' against Morison's Pills and the Construction of the Medical Profession, *c*.1830–1850', in Mark S. R. Jenner and Patrick Wallis (eds), *Medicine and the Market in England and Its Colonies,* c.*1450*–c.*1850* (Basingstoke: Palgrave Macmillan, 2007), p. 257.
[840] Schnalke, 'Casting Skin', p. 221.
[841] Gilman, Seeing the Insane, p. 166.
[842] Michelle Facos, *An Introduction to Nineteenth-Century Art* (Abingdon and New York: Routledge, 2011), p. 216.
[843] Daston and Galison, *Objectivity*, p. 120.

the mind of the nineteenth-century viewer the camera removed the subjectivities of the image creator, meaning that, as literary theorist Jennifer Green-Lewis has argued, 'the eye behind the camera must be perceived to be the eye not of the individual but of society'.[844] For the nineteenth-century medic, this form of objectivity offered an ostensibly less mediated image than did drawings or paintings, yet maintained the virtue of indexicality of casts and moulages. Many scholars have written on the fallacy of thinking that photographs represent objective truth. Historians Daniel M. Fox and Christopher Lawrence argue that, rather than providing a way of accurately picturing reality without the mediating hand of the artist, photography 'merely made it easier and cheaper to record and duplicate the sort of images which for centuries artists had made by hand'.[845] Yet photography did inaugurate a new and very different relationship between observing and representing to that in which the images explored within this thesis operated.[846]

[844] Jennifer Green-Lewis, *Framing the Victorians: Photography and the Culture of Realism* (Ithaca: Cornell University Press, 1996), p. 182.
[845] Daniel M. Fox and Christopher Lawrence, *Photographing Medicine: Images and Power in Britain and America since 1840* (New York: Greenwood Press, 1988), p. 7.
[846] Daston and Galison, *Objectivity*, p. 124.

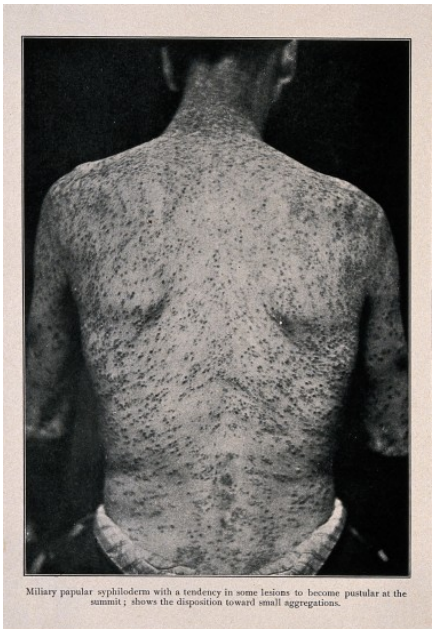

Figure 6.5. (left) A rash on the back of a man suffering from syphilis. Photographic print 1905. Image courtesy of the Wellcome Library, London.

Figure 6.6. (right) Pityriasis versicolor on the back. Watercolour by Robert Carswell at the Hôpital St Louis, Paris, June 1830. UCL Special Collections, Hc514.

Photography though by no means solved the problems of controlling representation and interpretation for medical practitioners. In their early incarnations, photographic representations had to be legitimized in the same way that the engravings, models and paintings of the eighteenth century were especially through the referencing of older iconographic strategies. For example, in dermatological photographs bodies were depicted in similar positions to those in older images (figs. 6.5 and 6.6). Furthermore, the camera did not automatically eclipse older technologies. Moulages continued to be made until well into the nineteenth century, and the Lock Hospital, and others around London, continued to employ artists to draw and paint their patients until the early twentieth century.[847] Technologies were even combined with photographs of wax moulages,

[847] Royal College of Surgeons, London Lock Hospital and Rescue Home, MS0022/6 (5), Drawings of Patients by S. A. Sewell, 1915–1925.

rather than patients themselves, illustrating many dermatology textbooks of the late nineteenth and twentieth centuries as doctors considered the moulages to be so accurate that they could easily stand in for the real patient (fig. 6.7).[848]

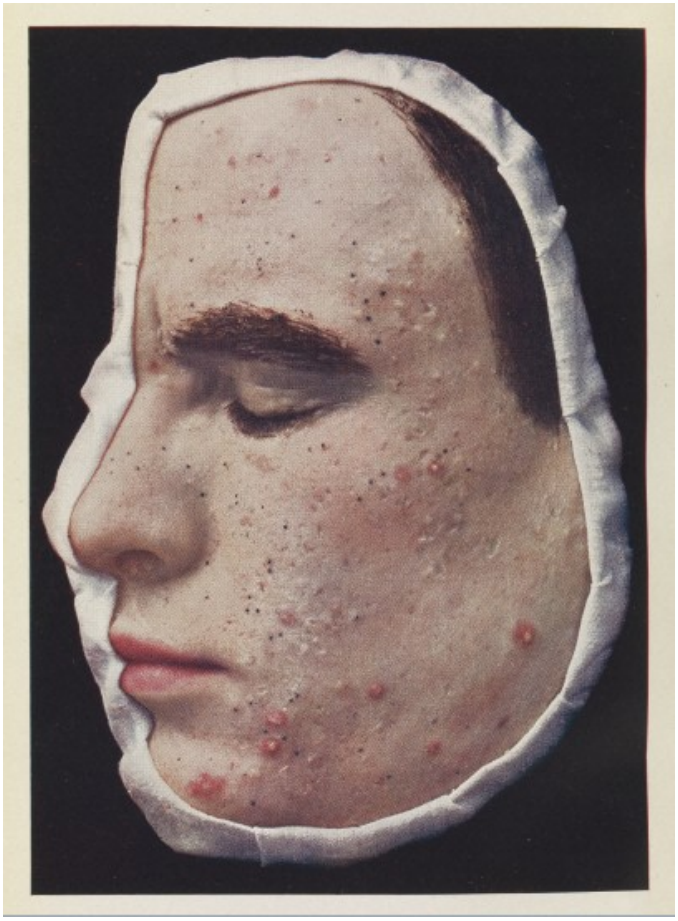

Figure 6.7. Image of a man with Acne Vulgaris. Photograph of a wax moulage in Norman Walker, *An Introduction to Dermatology* (Edinburgh, 1925). Image courtesy of the Wellcome Library, London.

Now of course we have a convenient defining image of venereal disease from under the microscope (fig. 6.8). I argued in the introduction to this thesis that we must historicise a reductive assumption that elides looking with visually representing in the eighteenth and nineteenth centuries. This assumption is understandable in our contemporary medical culture where seeing has become inextricably amalgamated with representing. In the case of the syphilis spirochete

[848] Schnalke, 'Casting Skin', p. 218.

Treponema pallidum and other microscopic phenomena the only way to see the object is to represent it. Medical imaging technologies are now the methods by which we first see the body and disease; ultrasound, PET, CT or MRI scanners have become extensions of the eye of the physician.[849] These scan images though do not merely extend the range of vision; they are creations of data rather than depictions of an observable phenomenon, as Daston and Galison have argued, they are more *presentation* than *representation*.[850]

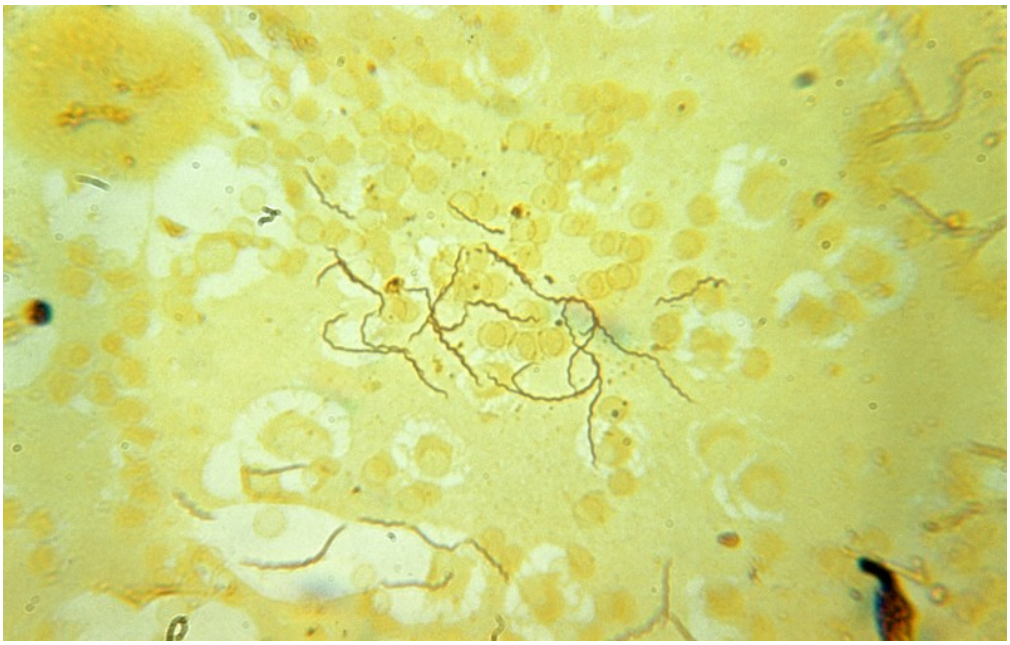

Figure 6.8. *Treponema pallidum*. Microscopic examination, mid twentieth century. Image courtesy of the Wellcome Library, London.

This saturation of the visual is not confined to medicine of course; modern life in its totality is now overwhelmingly visual.[851] We are told that our lives are suffused with images; they are plastered on our streets, beamed into our homes

[849] José van Dijck, *The Transparent Body: A Cultural Analysis of Medical Imaging* (Seattle: University of Washington Press, 2005), p. 4.
[850] Daston and Galison, *Objectivity*, p. 383.
[851] Some variety of this sentiment has begun innumerable works on visual culture. For example; 'The world we inhabit is filled with visual images.' Marita Sturken and Lisa Cartwright, *Practices of Looking: An Introduction to Visual Culture* (Oxford: Oxford University Press, 2001), p. 1; 'Modern life takes place onscreen.' Nicholas Mirzoeff, *An Introduction to Visual Culture* (London and New York: Routledge, 1999), p. 1; 'We live in a visual world.' Richard Howells and Joaquim Negreiros, *Visual Culture* (2nd edn: Fully revised and updated, Cambridge and Maldon: Polity Press, 2012), p. 1.

and workplaces, and everywhere inescapable, making us passive consumers of visual information.[852] However, at the same time as we are supposedly uncritical of these images, we are thoroughly obsessed with their meaning. Mitchell addresses this 'double consciousness' contemporary society has about images, asserting that we see them as immensely powerful even going so far as to ascribe agency to them, whilst loudly proclaiming that, of course, they are merely inert reflections of culture.[853] Of course they are never inert, and they never merely reflect, they go beyond mimesis and reveal the deeper socio-cultural contexts of their creation. Moreover, their present day dominance was not always so assured; they are not natural, their value is historically constructed.[854] From medical diagnostic scanning technologies to pedagogical picture atlases and plastinates that are used to train doctors, medicine's visual components have been invested with the weight of so much scientific authority that we rarely question their histories, identities or other potential meanings. Yet they have a multitude of interpretations beyond their immediate medical contexts and have become invested with tremendous moral content. Consider the emotional responses to foetal ultrasound images or the furious debates over the ethics of displaying plastinated human cadavers in public museums.[855] Whilst visual representations as images, scans or models have a central role in creating and transmitting twenty-

[852] Mirzoeff, *Am Introduction to Material Culture*, p. 9.
[853] William J. Thomas Mitchell, *What do Pictures Want? The Lives and Loves of Images* (Chicago and London: The University of Chicago Press, 2005), pp. 6–11.
[854] Ian Hacking has identified a trend amongst social constructionists when discussing the idea of 'inevitability'. Going further than claiming that 'X need not have existed, or need not be at all as it is', they go on to argue that 'X is quite bad' and that '[w]e would be much better off it X were done away with, or at least radically transformed'. By no means do I wish to argue that medical imaging technologies should be 'done away with', I have only sought to demonstrate in this thesis that they are not the natural and inevitable products of progress or rationalisation. Hacking, *The Social Construction of What?*, pp. 6–7.
[855] van Dijck, *The Transparent Body*, chapters 3, 'Bodyworlds: The Art of Plastinated Cadavers', pp. 41–63 and 6, 'Ultrasound and the Visible Fetus' pp. 100–117. See also John D. Lantos (ed.), *Controversial Bodies: Thoughts on the Public Display of Plastinated Corpses* (Baltimore: The Johns Hopkins University Press, 2011).

first-century medical knowledge this legitimacy was never inevitable. The case of venereal disease explored in this thesis offers an exemplar of how this legitimacy was negotiated slowly, not only in relation to changing theories, but also within a tangled web of people, practices, economics, institutions and communities.

Abbreviations

BL	British Library
EU	Edinburgh University Department of Special Collections
GU	Glasgow University Department of Special Collections
HCPP	House of Commons Parliamentary Papers
RCS	Royal College of Surgeons of England
RCPE	Royal College of Physicians of Edinburgh
UCL	University College London Department of Special Collections
WL	Wellcome Library, London

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