Roy Porter Student Prize Essay

Boils, Pushes and Wheals: Reading Bumps on the Body in Early Modern England

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Summary. Bodily bumps in early modern England were not simply collections of humors that needed to be lanced and drained. Diagnosis, prognosis and treatment of skin swellings comprised a deeply rich semiotics that both patients and healers read according to a range of biographical factors, incidents, sensations, observations and experiences. Using diaries and case histories in seventeenth-century surgical texts, this article explores how both patients and healers read and treated bodily bumps. It then looks at patients and healers together during medical encounters in order to show how both parties’ interpretations and observations of the body created a collaborative interpretation of health. The article shows that, long before the development of physical diagnosis in the nineteenth century, surgeons were pressing and prodding patients’ bodies to discern the nature and severity of external ailments. Thus, in addition to the patient narrative, touching and manipulating the body were often significant aspects of medical diagnosis and practice in the early modern period.

Keywords: surgery; patients; pain; early modern; patient–healer relationships

When Arthur Annesley felt a small pain in his stomach in 1671 he could only attribute it to the ‘great grief and sadnesse I haue [had] for about three months past’. He soon discovered a swelling about the size of an egg in the same spot. The cause, size and ‘dangerous’ location of this bump compelled Annesley to seek help from a surgeon named Mr Wiseman, who treated the swelling with a truss. Mr Wiseman was probably the eminent royal surgeon, Richard Wiseman, whose 1676 Severall Chirurgicall Treatises contained a lengthy chapter outlining various types of bodily bumps and their treatments. The lexicon of early modern skin swellings was extensive and complex; it included abscesses, wens, impostumes, boils, pustules, tumours, pushes, carbuncles, furuncles, botches, blains, buboes, tokens, pimples and wheals. To simplify these imprecise and shifting categories, I have chosen the all-inclusive yet rhetorically neutral term ‘bumps’.

In his text, Wiseman described a 64-year-old man who suffered from a ‘tense and shining’ swelling of a deep red colour that stretched from his knee down to his foot. Upon observing the man’s melancholic constitution, recent bouts of ague, and the timing and nature of his pain, Wiseman surmised that the swelling resulted from shifting...
humors on account of the ague. Treatment involved topical medicines to lessen the heat and ‘breath out the Humour’; special dressings to mitigate pain; directions for regulating diet; and an issue. As these two brief cases show, bodily bumps fit within a humoral framework of health in early modern England and Europe, in which bodies were comprised of four fluids whose balance, movement and expulsion were influenced by a wide range of personal and environmental factors. Yet bumps were more than simply collections of excess or obstructed humors that needed to be lanced and drained. Explaining and treating external swellings was a much more complicated enterprise. Diagnosis, prognosis and treatment comprised a deeply rich semiotics that both patients and healers read according to a range of intellectual commitments, biographical factors, incidents, sensations, observations and experiences. Examining how patients and surgeons interpreted the semiotics of bumps to read the physical body therefore textures our understanding of early modern perceptions of health and the body, as well as the patient–healer encounter.

This seemingly narrow focus on early modern bodily bumps is significant for pointing to the ways by which a much-neglected history of surgery refines our understanding of early modern patients. The history of the patient developed in the 1970s and 1980s when historians began criticizing older histories of medicine that extolled the progress of science and promoted the innovations of doctors. These scholars were concerned with the patient’s role in the development of modern medicine, specifically the shifting nature of the patient–healer relationship and the decline of patient authority by the nineteenth century. Subsequent historians began exploring patient experiences preceding this decline in authority and came to define early modern patients by their shared understanding of health with healers; the significance of their narratives in determining diagnoses and treatments; and their power of purse in an unregulated, competitive medical marketplace.

To recover these important roles of patient knowledge, voice and authority, scholars have emphasised the significance of the patient narrative in both shaping patient–healer relationships and defining medical diagnoses. As a result, historians have neglected to fully examine the ways reading, observing and touching the body were also central to patients’ conceptions of health and encounters with healers. Only Lucinda Beier’s work on Joseph Binns and a short article by Robert Jutte concentrate directly on surgical patients, although both present quantitative accounts of surgical categories and treatments.

Responding to Christopher Lawrence’s lament about the lack of scholarship on surgical knowledge and practice, Philip Wilson’s *Surgery, Skin, and Syphilis* places early modern surgery within the intellectual and social framework of one surgeon’s biography. Although Wilson’s use of case histories to reconstruct surgical knowledge and practice demonstrates their value as sources for exploring the surgical body, he does not fully analyse patients’ involvement in shaping that knowledge and practice.

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2Wiseman 1676, p. 39. An issue was an artificial wound created to drain excess fluid.
3These scholars are as varied as Michel Foucault, Nicholas Jewson and Charles Rosenberg. See Foucault 1994; Jewson 1974; Rosenberg in Vogel and Rosenberg (eds) 1979.
5Beier 1987, ch. 3; Beier in Lawrence (ed.) 1992; Jutte 1989.
7For his discussion of patients, see Wilson 1999, pp. 47–52.
A focused analysis of surgical case histories reveals that sufferers not only influenced diagnoses and treatments through their narratives of sickness, but also by means of their own, as well as their surgeons’ manipulations and examinations of the body. Together, patients and surgeons discerned the nature of bumps by engaging in a proto-form of physical diagnosis—a development that historians generally associate with nineteenth-century clinical medicine. Secondly, a focus on surgery reveals that external bodily signs were often ambiguous. As a result, both patients’ and healers’ observations and manipulations of the body informed a collaborative interpretation of health. Of course, practitioners’ dependence on the patient narrative versus physical manipulations of the body varied by ailment; perhaps bumps provided a smaller shared interpretive community than internal illnesses.

This article offers a history of this collaborative process by exploring the early modern surgical body as a site for reading external signs. Scholarship on venereal disease and physiognomy has clearly shown the extent of early modern concerns about appearances and the moral significance of bodily marks. Physical defects were external manifestations of deeper disorder and moral decay. Margaret Pelling’s work on barber-surgeons further reveals that what we might consider to be cosmetic or unproblematic was loaded with significance in early modern society. Common anxieties about bodily appearance shaped barber-surgeons’ daily work. Richelle Munkhoff’s study of the important and threatening role of searchers also highlights the significance of reading external signs for patients’ status. Searchers not only demonstrated the challenges and consequences of interpreting ambiguous plague sores, but the contradictions between signs as representing common notions of disease that even seemingly ignorant old women could interpret and signs as representing authoritative, precise knowledge printed in the Bills of Mortality.

Historians of the early modern patient have used case histories to access healers’ and patients’ cultural assumptions, power relations and perceptions of health. Many of these studies show that case histories, despite presenting the healer’s perspective, contain valuable information about patient concerns, symptoms and opinions. Even if surgeons presented cases that promoted their own skills or retrospectively described cases to support known outcomes, the case history remains an authentic representation of possible and reasonable interpretations of health, patient choices and treatment options. This article relies on vernacular medical texts, literature, diaries, as well as case histories, or ‘observations’, of bodily bumps in surgical and medical texts spanning the seventeenth century. While much of the history of the patient focuses on the eighteenth century, this time-frame provides a detailed examination of patient perceptions and

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10Pelling in Beier and Finlay (eds) 1985. See also Cavallo 2007a, ch. 2.
experiences before new theories of the chemical and mechanical body pervaded popular consciousness. Richard Wiseman’s 1676 *Severall Chirurgicall Treatises* serves as the central source for this article, as it is one of the few surgical texts in this period containing an extensive chapter on tumours that also includes observations of patients. Because Wiseman directed his text to the ‘young Chirurgeon’ learning the art, his cases represent more standard surgical ailments rather than rare and peculiar ones. The text’s multiple editions also reflect its popularity as a compilation of surgical theory and practice, thereby confirming that Wiseman offered a well-received approach to reading and treating the surgical body. After examining patients and surgeons separately, this article discusses patients and practitioners together at the moment of encounter in order to highlight the ways both parties’ observations and interpretations of the body shaped one another.

### Patients’ Interpretations

In November 1691, a Rye merchant named Samuel Jeake recorded a fever in his diary, after which ‘there bred upon me 3 or 4 sore boyls’. He noted their location under each armpit, their size (‘as big as walnuts’) and the duration of their irksome existence. Yet his jottings also reveal his judgement of the bumps and their implications for his health. His ability to dress and drain the boils without breaking them, for instance, was worthy of documentation and indicated that these types of bumps should not be disturbed. The appearance of smaller boils accompanied by itch compelled Jeake to self-prescribe and administer a ‘mercurial girdle’, which proved effective. Jeake’s response is representative of early modern men and women who read the size, location, colour and resulting pain of bumps in order to determine their nature and malignancy. Even popular medical texts, which rarely differentiated various bumps and often included treatments intended for ‘any Rising, Swelling, or Boyl in the Flesh’ or ‘all Imposthums and Swellings wheresoever’, assumed that anyone could recognise the most important features of bumps when necessary. For instance, some remedies were specified as softening agents for hard bumps, while others drew out poisonous matter or treated swellings that resulted from bruises and wounds. Nicholas Culpeper assigned coltsfoot to ‘Wheals, and small Pushes that arose through heat’, a bodily sensation that surely all early modern men and women could evaluate. A pauper who visited Somerset healer, John Westover, in 1690 could even discern the internal workings of a bump; Westover wrote that the patient ‘consaits [conceits] that he hath An Impostum broke in him’. While patients did not always define their bumps using the same terms as practitioners, they clearly relied on a range of sensory perceptions and observations to read and treat their bodily ailments. Examining patients’ initial responses to bumps, as well as the factors involved in their decisions to seek help from surgeons, offers a valuable view of early modern patients’ interpretations of the body.

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13 Wiseman 1676, sig. a2r.
14 *Severall Chirurgicall Treatises* was published in 1676, 1686 and 1692, and then again as *Eight Chirurgical Treatises* in 1696, 1697, 1705, 1719 and twice in 1734.
16 Tryon 1696, p. 6; Culpeper 1652, p. 32.
17 Culpeper 1652, p. 37.
18 Westover 1685–1700, Somerset Record Office, DD/X/HKN 1, f. 100v.
Accessing patients’ responses to and interpretations of bodily bumps requires examining behaviour and choices preceding the medical encounter. Patients often self-treated with topical remedies, such as plasters, poultices and ointments to disperse collected matter, soften tumours or ease pain. Samuel Pepys applied plasters and administered sweats to treat his bumps, while physician Théophile Bonet described a man who treated his own painful swelling with an ointment and cataplasm of linseed oil. Upon developing a swelling in his jaw in 1679, Samuel Jeake initially had a blister applied to his neck. When the tumour not only returned, but grew ‘more obstinate’, he had a second blister and a few days later took ‘Volatile Salt of Vipers to discuss it’s [sic] remaining hardness’. The bump returned once again and, in the end, Jeake decided that gargling brandy was the cheapest and most effective remedy.

Timing, of course, was an important factor when deciding to open bumps. In a 1657 letter to his daughter, George Weckherlin explained that his son-in-law’s boils ‘commonly carry away much ill homo’; and are best to preserve & prove Our health in the spring time; When Nature desires to bee discharged of ill homo⁹. While Weckherlin’s advice addressed the broader relationship between bodies and the environment, references to bodily bumps in dramatic literature demonstrate a common understanding of precisely when to open bumps for the best results. In The Spanish Bawd, Sempronio uses a lancing metaphor to describe his fear that staying with Calisto to comfort him will only increase his anger and worsen the situation: ‘For I haue heard say, that it is dangerous to lance or crush an Impostume before it bee ripe, for then it will fester the more.’ In The Virgin Widow, Comodus uses a similar metaphor when he implores Formidon to disclose why he is so sad: ‘Come, if the Bile be ripe ’Tis best to launce it: A revealed grief Invites to cure, lies open to relief.

Perhaps it is not surprising then that some patients cut open their own swellings—an act more often relegated to surgeons. William Salmon mentioned a smith who opened a tumour in his thigh using ‘a hot Iron’ and Richard Wiseman described a middle-aged gentleman who lanced a swelling on his face with a penknife. This particular gentleman was initially ‘vexed with a flushing heat all over his face, with some red Pimples considerable’. He self-administered remedies that Wiseman later believed were responsible for the development of a more serious species of bump: tubercles. The tubercles were of varying shapes and hardness and itched terribly, putting the man ‘upon a pinching of them, upon which they grew the bigger’. This compelled him to vent one using a penknife, only to have the bump swell again with matter. This chain of events traces a logical course of action a patient might take before visiting a surgeon: the use of remedies to disperse matter and ease pain followed by observations of the bump’s colour, size and hardness, and finally the decision to vent collected matter. Only when these steps...
failed and ultimately exacerbated the problem would patients turn to surgical practitioners.

As the above example illustrates, patients often decided to visit healers simply because they ‘tryed many things but all in vain’ or exhausted their domestic and local options.27 Although patients were equipped to read their own bodies, extended pain and signs of danger often drove them to seek help. When a man sent a messenger to fetch a plaster from Wiseman he demonstrated his ability to determine his own appropriate remedy; his bump was so readable it did not require a face-to-face encounter. Only upon increasing pain after six days did the man reassess his situation and decide to see Wiseman in person.28 Case histories often mentioned patients’ ‘intolerable pain’ or ‘Pain increasing beyond sufferance’ as reasons for seeking help.29 Thus, when a woman discovered a small bump on her nipple, the pain was so slight that ‘she would not suffer it to be meddled with’.30 Wiseman also acknowledged this trend when he complained that patients often waited until they were in extreme pain before consulting him, which resulted in bumps that were too mature to benefit from proper remedies.31 We cannot simply assume, however, that severe pain always necessitated medical intervention. Salmon mentioned, for instance, a woman whose lack of pain allowed her to shop around for ‘the opinions of many men’ before settling on Salmon.32 Additionally, patients sought out healers when they interpreted their situations as exceedingly dire. This is most evident in Paul Barbette’s case histories, which consistently noted patients’ concerns and how, following treatment, their anxieties were ‘presently removed’.33 Similarly, many of Wiseman’s patients came to him only after suspecting they suffered from the King’s Evil.34

Finally, the stigma of a marked body compelled men and women to consult practitioners. The moral significance of bumps was evident in the prevalence of metaphors in dramatic literature that relied on bodily swellings to describe dissolute characters and ominous signs: ‘Noble Gentleman? A tumor, an impostume hee is Madam’; ‘some hot vein’d letcher, whose prone lust Should feed the rank impostume of desires’; ‘I must forget you Clara, ’till I have Redeem’d my uncles [sic] blood, that brands my face Like a pestiferous Carbuncle.’35 Samuel Pepys documented two occasions when his wife, Elizabeth Pepys, suffered from abscesses. These episodes highlight anxieties about physical appearance, as well as the ways different readings of a bump could result in varied responses and choices. In May 1661, Elizabeth Pepys had ‘a very troublesome night’ and was in great pain from a swelling.36 This abscess was probably an instance of a recurring gynaecological ailment, which Pepys referred to as ‘her old...
payne. Perhaps because of its location, or because the bump was recurrent and familiar to them, the couple did not seem particularly concerned when the swelling broke; Pepys noted that his wife’s pain was eased and he applied a tent to the resulting ulcer. In December 1667, however, a second painful swelling led to a wholly different chain of events. The couple suspected that if this bump broke it would leave a scar and this interpretation led to increased anxiety and a disrupted daily routine. The fear was tangible in Pepys’ words: his wife’s cheek was so ‘miserably swelled, so I was frightned to see it’, and he made a point of ‘talking and reading and pitying her’. The Pepys’ interpretation of the swelling compelled them to call their surgeon, who confirmed the bump ‘may spoil her face if not timely cured’. Although surgical case histories that noted patient anxieties about scarring almost always involved women and bumps on the face, men were also threatened by the implications of bodily marks. With an inflamed body and a face ‘in a sad redness and swelling and pimples’, Pepys confined himself to bed for three days, ‘not only sick but ashamed of myself to see myself so changed in my countenance’. A nobleman with a bump in his groin ‘as big as a Child’s head’ told his healer he could not endure it any longer because his ailment rendered him ‘unfit for Arms or Wedlock’. In addition to being morally stigmatizing, bumps limited social roles.

Analysing patient responses to bumps and the factors involved in their decisions to visit surgeons show that sufferers were quite capable of reading and treating their own bodies. Only when they interpreted their ailments as increasingly painful, dangerous or threatening to their appearance did patients find it necessary to seek help. In many ways, this brief discussion of patient responses to bumps mirrors patients’ perceptions of sickness more generally. Just as early modern men and women relied on a complex sequence of varying environmental, biographical and incidental factors to make sense of illnesses, similar chains of causation appeared in surgical case histories. In addition, like other health issues, interpreting the external body was a collective task that often involved family and friends. Other people’s advice, views and negotiations with surgeons appeared frequently in case histories and often guided medical practice. A focus on bodily bumps thus enriches our understanding of early modern patient perceptions and knowledge and, as a result, offers new insight into the ways patients’ readings of the body shaped the medical encounter.

Surgeons’ Interpretations

According to surgeons, reading the early modern body to diagnose and treat bumps was a tricky business. To determine a prognosis, Wiseman instructed practitioners to consider the part afflicted; the cause of the bump; its size; accompanying accidents; and the ‘quality of the Humour that raiseth it’. He then listed five possible trajectories

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40 Bonet 1684, p. 592. See also Wiseman 1676, p. 140.

41 See Wiseman 1676, pp. 39, 69, 100, 108–9, 115, 119.

42 Wiseman 1676, p. 4.
of bumps and their accompanying signs. Dissolution of the tumour, known as ‘discussion’, was defined by relaxation, diminution and decreased pain. ‘Suppuration’ was associated with pain, pulsation and fever. Signs of corruption included ‘a livid or blackish colour’ and the sinking of the tumour. ‘Induration’ was marked by diminution, pain and increased hardness. Finally, ‘retraction’ involved the sudden disappearance of the bump without suppuration. Distincting between these paths clearly demanded a nuanced reading of the body. Similarly, choosing appropriate treatments required consideration of multiple factors, including whether the bump resulted from (to name a few possibilities): congestion; ‘fluxion’, or a sudden movement of humors; ‘attraction’, in which case the force of attraction must be removed; or ‘translation’, a type of fluxion in which disease preceded the development of the tumour. Prescribed readings of bodily bumps were quite complex and, not surprisingly, surgeons rarely adhered to prescription. For instance, while both ‘phytgethlon’ and ‘phyma’ were bumps located under the jaw often attributed to chafing head clothes, one was associated with the confluence of bile and the other phlegm. When discerning between these two bumps in case histories, however, practitioners relied on physical, external signifiers, such as the fact that a phytgethlon lies ‘round and flat as a Cake’. As opposed to examining prescribed readings of bodily signs, this section explores how healers interpreted bodily bumps in practice.

Case histories presented a number of signs that surgeons read in varying ways to make sense of bodily bumps. Rather than systematically assessing each factor, practitioners often relied on one or two in order to make a diagnosis. As Elizabeth Pepys’ reaction to an abscess on her cheek clearly demonstrates, a bump’s location could provoke anxieties and lead to choices that differed significantly from responses to the same bump on another part of the body. The varying semantics of bumps also reflects the significance of location for diagnosis. For example, bumps in the ear were usually called impostumes; cancers in women were almost always found on the breasts; while ‘parotis’ was a tumour on the parotid gland that lacked any defining characteristics other than its location.

Another telling sign was colour, especially when determining malignancy. Wiseman knew precisely when a boil would break because of its inflamed ‘livid colour’ and was able to diagnose a woman with erysipelas upon noting a ‘burning heat of palish yellow colour’ mixed with red, tense and shining skin on her arm where she recently had blood let. Additionally, the size of bumps was informative; practitioners described bumps as being as big as a child’s head, a fist and even a ‘rowl of White-bread’. Lastly, surgeons assessed the matter contained within bumps, including its movement, depth and quality (thick, runny, milky). ‘Epinyctis’ commonly emitted a thin pus, or sanies, followed by a bloody matter; bumps associated with herpes ‘weep a thin waterish Humour’;
whereas, the matter in boils was ‘clammy, and not unlike pith’. The significance of these many characteristics varied from case to case.

As discussed in fuller detail below, pain was central to diagnosis, prognosis and treatment by aiding surgeons’ and patients’ abilities to pinpoint the depth, location, movement and severity of bumps. Pain was so significant to diagnosis, it often outweighed other symptoms: Bonet explained that if a patient had localised pain and the surgeon suspected trapped matter, ‘you may certainly conclude that Matter is gathered in that part . . . though the colour of the Part be not changed’. Biographical information, including constitution, occupation, status and additional or previous bodily ailments and symptoms, were also central to surgeons’ readings of bumps and could easily override other symptoms when making a diagnosis. Several cases attributed bumps to immediate circumstances, such as the weather, chafing sutures, or riding a long way on an ‘uneasy saddle’. Despite the number of factors and symptoms William Salmon might have taken into account to explain the appearance of a bubo on his forehead immediately following the successful cure of an old one, he simply asserted that ‘by going a little too early in the cold, a Tumour was protruded again in the same place’. Another instance in which a bump resulted from weather was articulated in wholly humoral terms: a maid’s inflamed leg was linked to an abundance of humors ‘by reason of the change of Air’ after moving to the city. Bumps also arose from what we would call lifestyle choices. Perhaps it is not surprising that one practitioner attributed bumps on a lawyer of ‘very gross and ill habit of Body’ to the pox.

Sex-specific bumps associated with lying-in, breast-feeding and menses most clearly show how surgeons could value one factor over all others when reading bodily signs. Bumps associated with reproductive status also point to the important ways social factors such as gender might have influenced surgeons’ interpretations of the body. The impact of a woman’s reproductive status on diagnoses of bodily bumps is clearest in cases categorised as abscesses arising from distempers of the uterus. These cases all involved women who were pregnant or lying-in, but they rarely mentioned the uterus at all; in fact, these cases tended to describe bumps in body parts as far removed from the reproductive organs as possible, the explanation being that the uterus was so powerful it could cause bumps to erupt anywhere on the body. For instance, one woman in childbed had impacted matter in her foot and another woman felt pain from her thigh to her knee after giving birth; Wiseman categorized both cases as abscesses arising from distempers of the uterus.

Barbette described a pregnant woman with a bubo in

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47 Wiseman 1676, pp. 44, 78, 9.
49 Bonet 1684, p. 6.
50 Ryder 1689, p. 59. Some bumps, such as ‘pernio’, were directly linked to seasons and weather conditions.
51 Salmon 1687, p. 386.
52 Wiseman 1676, p. 23.
53 Ryder 1689, p. 51.
54 Wiseman 1676, pp. 30–1, 32.
her groin who had ‘scarcely any Fever; her Eyes look’d well, and her Tongue was moist, and she seem’d very heart-whole’. Yet Barbette read her premature delivery the following day as ‘a certain sign of Death’ overriding all these otherwise healthy bodily signs. Thus, a patient’s sex was often a key determinant of bumps, as reproductive status signified the cause and nature of bodily swellings the same way colour might characterise malignancy. Other sex-specific bumps included ‘milky’ tumours associated with breast-feeding and bumps linked to suppressed menses. One woman, ‘upon a suppression of the Menstrua’, was afflicted with ‘many angry Pustulae on her right hand’, while another woman’s menses was linked to ‘an itching on the right side of her Head above her Ear’. Likewise, the falling of the menses was a sure sign of a bump’s cure, a logical connection considering both involved the release of pent-up matter.

As previously mentioned, the physical appearance of a bump signified its nature; when Wiseman held a candle up to an abscess and found it appeared ‘splendent’, he clearly offered a careful reading of bodily signs. Assessing the physical appearance of bumps, however, was only one of many ways surgeons used their sensory observations to read the external body and infer its internal workings. Visual observations were often supplemented with touch. Wiseman’s diagnosis of a woman’s cancer changed after seeing her breast ‘very big and inflamed, and felt it all apostemated’, and in another case he described ‘handling’ a woman’s breast and feeling ‘hard Glands’. Surgeons also used touch to measure a range of factors, including heat; ripeness (by exerting pressure and observing the resulting impression); depth and consistency (by judging whether bumps felt solid or hollow); and movement. Wiseman gauged the nature of one bump by observing that the ‘[m]atter was felt to fluctuate in several parts’.

In addition to sight and touch, Wiseman used the ‘foetid smell’ of vented matter to posit that a swelling ‘seemed to have been long made’. Surgeons even listened to the body. In one case, Wiseman found all the characteristics of a flatulent tumour ‘except the Sound’. The multiple signs and observations healers used to read bodily bumps clearly required experiential knowledge; experience allowed surgeons to diagnose bumps with confidence and case histories provided a place to display their expertise. This reliance on sensory observations to decipher the body’s external signs and interpret its inner workings also shows that, long before the advent of physical diagnosis in the nineteenth century, seventeenth-century surgeons were prodding, pressing and manipulating patients’ bodies to determine the nature of bumps.

55 Barbette 1672, p. 41.
56 Wiseman 1676, pp. 79, 80.
57 For example, see Wiseman 1676, p. 50.
58 Wiseman 1676, p. 130.
59 Wiseman 1676, pp. 27, 108.
60 This quote is from Wiseman 1676, p. 32. On the use of touch to measure heat, see Wiseman 1676, p. 56. To assess whether a bump ‘yielded to the impression of my Fingers’, see Wiseman 1676, p. 83; also p. 143; ‘pressing it with my fingers found it hollow’, see Bonet 1684, p. 6.
61 Wiseman 1676, p. 24. Wiseman also punctured a tumour in a 30-year-old maid, discharging a ‘stinking Serum not unlike Horse-piss’ (p. 279).
62 Wiseman 1676, p. 88.
The Medical Encounter

When Wiseman informed a patient that she had a fever, she responded by explaining its origin: ‘it was for want of sleep occasioned by the intolerable Itch and soarness’.63 This sort of exchange often comprised medical encounters, in which patients’ and practitioners’ readings of the body created a patchwork of interpretations of health. Of course, assessing bodily bumps was open to interpretation for patients and healers alike. Wiseman’s assertion that a carbuncle was simply a hard tumour raised ‘somewhat like an angry Boil’ highlights how vague and problematic his categories were for making diagnoses.64 How did deciphering such ambiguous signs play out in medical encounters where patients’ and surgeons’ interpretations conflicted? Various readings of a single bump demonstrate the significant ways patients’ observations shaped healers’ interpretations of health. For instance, one of William Salmon’s patients claimed to suffer from St Anthony’s Fire, but Salmon diagnosed him with an ‘ominous Catarrh’ upon hearing the patient complain about difficulty swallowing, a persistent heat and thirst, and sensations in his back ‘as it were pricked with some sharp thing’.65 After briefly examining how patients and surgeons reconciled such conflicting interpretations, I focus on two specific ways patients shaped practitioners’ readings of the body: expressions of pain and anxieties about certain types of bodily signs. Because case histories were written from the practitioner’s perspective and provide only limited access to the patient’s voice, the discussion focuses on patients’ influences on surgeons’ interpretations of the body. Patient and healer narratives, however, clearly shaped one another in equally significant ways.

The ambiguity of bodily signs and extreme flexibility of humoral medicine facilitated practitioners’ tendencies to blame undesired outcomes on other people. Wiseman attributed gangrene to his patient’s decision to use a cataplasm made of white bread and milk, a proper treatment for alleviating pain but in this case responsible ‘for the influx and increase of the Tumour’.66 When patients’ and healers’ interpretations conflicted, healers obviously favoured their own readings of bumps; however, the patient’s narrative retained an important role in shaping those readings.

Physician Paul Barbette believed that a midwife’s trembling, unsteady behaviour represented a weakness or delirium, but he was unable to detect other symptoms to confirm this suspicion. Only after a lengthy inquiry did he learn that she had a ‘push’ on her thigh, and this information allowed all his suspicions about the woman’s ailment to fall into place. Upon inspection, he re-interpreted the midwife’s own reading of her body by defining the bump as a carbuncle. He then learned that she, too, had conjectured some sort of malignancy and was taking plague-water, although in very small doses. When Barbette asked if she had an additional bubo on her groin, she refused to let him look but insisted there was none, which he ‘doubted not of’.67 Barbette trusted her ability to discern different types of bumps and had learned

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63Wiseman 1676, p. 137.
64Wiseman 1676, p. 52.
65Salmon 1687, p. 382.
66Wiseman 1676, p. 21.
67Barbette 1672, p. 42.
enough to believe her claims that no bubo existed. Even though the patient and healer disagreed about the nature of the bump, it is clear that the patient had been thinking along the same lines as Barbette and in the end she retained some authority in her ability to read and interpret her own body. Of course, Barbette recounted the interaction in a way that left him with the upper hand, despite the fact that his diagnosis relied on a combination of the midwife’s and his own observations.

Patients’ responses and observations could also be misleading. In 1660, Bonet described a man who suffered from a boil on his back, which the patient believed developed after he ‘omitted one Autumn his accustomed bloud-letting’.68 Bonet noted that when he lanced the boil the ‘Patient felt it not’ and when he vented the trapped matter there was no accompanying fever, fainting ‘or any other grievous Symptome’.69 Bonet seemed to come to these conclusions not by interrogating the patient, but by observing the patient ‘on his legs, not dreaming in the least of his death’.70 When he described this cheery demeanor to the patient’s wife, he stated that, ‘she took me for mad’.71 Clearly Bonet was surprised to see the patient appear so healthy and the patient’s wife was so surprised she refused to believe it. This case is interesting because a patient provided input without necessarily speaking; it was his silence when the boil was lanced and his subsequent jolly and relaxed disposition that Bonet found most telling. Additionally, the patient’s behaviour contradicted both his wife’s and healer’s understanding of his ailment, and yet Bonet still granted the man’s odd response significance. In the end, the patient’s input, as demonstrated rather than verbally articulated, was indeed misleading; the boil proved to be fatal.

Practitioners’ reliance on patient narratives and self-observations are perhaps most evident when we focus on the crucial ways pain shaped surgical encounters. Wiseman described one 60-year-old man ‘of gross Body and highly scorbuticall’ who was seized with vomiting and a burning fever.72 Though hesitant to treat a patient suffering from no apparent surgical ailment, Wiseman eventually visited the man, prescribed remedies, let blood and ordered a clyster. Only as Wiseman was leaving did the patient ask the surgeon to look at his sore back. This request led Wiseman to the true source of the man’s malady: a dark red swelling the size of a chestnut surrounded by several small, white wheals. Yet even more significant than whether or where sufferers felt pain were the nuances of patients’ expressions of pain: pulsating pain was different from a steady pain; localised pain was telling; and a ‘pricking heat’ was distinctive from ‘itching pain’.73 Such articulations of pain not only influenced surgeons’ diagnoses of bodily bumps, but also marked trajectories of recovery. One of Wiseman’s patients noted that his ‘gnawing prickling’ pain became ‘a burning hot’, and the next day was a mere ‘comfortable heat’.74 The shifting nature of his pain signified the improving

68 Bonet 1684, p. 6.
69 Ibid.
70 Ibid.
71 Ibid.
72 Wiseman 1676, p. 53.
73 For pulsating heat and pain, see De La Vauguion 1699, p. 298; ‘pricking heat’, Wiseman 1676, p. 40; ‘itching pain’, Wiseman 1676, p. 62.
74 Wiseman 1676, p. 114.
condition of his bump. Wiseman described another man who developed a swelling after bruising his chin from slipping while stepping into his coach. The man’s report that the pain diminished quickly while the swelling remained allowed Wiseman to determine with confidence that the bump contained blood.75

Surgeons also evaluated verbal expressions of pain by manipulating patients’ bodies and assessing the ensuing responses—again illustrating an early form of physical diagnosis. For instance, surgeons pressed down on body parts to judge ‘the Patient’s sense of pain’ as a means of locating trapped matter.76 When one patient reported pain in the joint of her big toe and sole of her foot, Wiseman assumed she suffered from deeply embedded corns. Yet, even after a corn-cutter removed this potential source of affliction, she continued to suffer excruciating pain. Noting how, upon pressing with his fingers she ‘complains much’, Wiseman was able to re-interpret his diagnosis, despite finding no other signs of swelling, heat or disturbance.77 Similarly, Lazare Rivière surmised a young patient from Montpelier suffered from dropsy. However, when she refused to let him press down on her stomach he realised his initial assumption was incorrect. Rivière was able to pinpoint the size and location of an abscess in the young girl’s abdomen by noting where she allowed him to press and where she refused his touch. He then treated the area where she felt ‘a pricking pain’.78 Surgeons interacted both verbally and physically with patients to read the nuances of bodily pain.

Fear of pain and concerns about scarring clearly illustrate how anxieties influenced patients’ readings of the body and interactions with practitioners. Thus, the patchwork of patients’ and healers’ interpretations of health was built on each party’s observations and views, as well as their fears and concerns. Because plague sores were so ambiguous and interpreting them had such serious consequences for a patient’s status, cases of potential plague offer a clear site for assessing how patient concerns and anxieties shaped their own, as well as their surgeons’ readings of the body. Barbette described a bookseller who suffered from boils on his scrotum and then three months later, he diagnosed the same man with a pestilential bubo on his groin despite an absence of other symptoms. What led Barbette to read these two bumps in nearby body parts of the same man so differently? This case demonstrates the ramifications of diagnosing plague. After informing the bookseller and his wife that the bump was pestilential, Barbette noted, ‘it was strange to see what terror seized upon them both’.79 Yet the only difference between the two incidents was the patient’s own certainty of how to read his body. In the first case, there was no question about the nature of his boils and Barbette treated them accordingly. In the second case, perhaps because ‘[p]lague reaged here very much’, the patient was uncertain about his swelling and required Barbette to satisfy his and his wife’s curiosity.80 The man’s uncertainty about the nature of his bump in a

75Wiseman 1676, p. 68.
76Bonet 1684, p. 5.
77Wiseman 1676, p. 97.
78Rivière 1672, p. 53.
79Barbette 1672, p. 40.
80Ibid.
time of plague resulted in Barbette’s assessment of a pestilent bubo, despite the man’s otherwise healthy body.

There are also cases in which multiple signs pointed to plague and yet the medical encounter unfolded in such a way that plague was never diagnosed. Such cases again show how anxieties about bumps shaped patients’ conceptions and descriptions when interacting with healers. For instance, a man fleeing the city during the plague was careful to link his illness to riding too fast, which heated his body; this, in turn, compelled him to rest on some grass where he caught cold. Upon standing up, the man developed a pain in his right kidney and returned home very ill. Even after discovering a painful swelling in his groin, Wiseman never mentioned plague. He instead applied a series of treatments to the ‘more than ordinary fulness’ of the man’s leg, and when the patient complained of kidney pain, Wiseman posited: ‘the original Matter might arise from thence, and pass inwardly to the Groin and outwardly to the Hip’.81 The patient’s expression of pain and account of causation influenced Wiseman’s reading of the case and outweighed factors that seemingly pointed to plague—a painful swelling in the groin after riding too fast to escape the city during ‘the last great Sickness’ and resting on the grass because all the inns were subject to infection.82

Patients’ articulations of pain, concerns about scarring and anxieties about plague shaped the medical encounter not only by influencing healers’ interpretations of bumps but also by guiding treatment. Before exploring the specific ways patients’ expressions of pain and anxieties shaped medical practice, it is necessary to outline the available treatment options. Healers targeted harmful humors by prescribing specific diets, bleedings, purges and changes in air, while other treatments included topical plasters and poultices that ripened and softened bumps to either induce suppuration or disperse humors inwardly. Additional methods of suppuration were caustics, agents that burned or corroded the tissue surrounding swellings, and lancets to open and vent trapped matter. Treatments, such as blisters and frictions, shifted humors by creating bumps on other body parts. Finally, there were also magical cures. One healer described a woman who cured a bump on her finger by sticking the afflicted finger into the ear of a cat.83 Another man’s commonplace book included a sympathetic cure for wens: ‘let her take a dead man’s hand (if a man, then a woman’s). Stroke the wen with it, once, twice and thrice. As the hand rotteth in the grave, so will the wen rot on the living.’84 Combinations of these many treatment options varied according to a range of factors, including the nature, location and cause of bumps, as well as body types, responses, symptoms, incidents and types of pain.

As Bonet explained, a cautery was more convenient than a lancet because it ‘does not affright faint-hearted Patients nor is very painful’.85 In many cases, patients’ fears or expressions of pain directly determined treatment, while some remedies solely served

81Wiseman 1676, p. 24.
82Wiseman 1676, p. 23.
83‘The Animal was in such extreme Torment, that two Men could scarce hold it’ (De La Vauguion 1699, p. 298).
84Oglander 1936, p. 220.
85Bonet 1684, p. 4.
to ease pain rather than directly target the offending bumps. For a woman with corrosive ulcers, Wiseman claimed, ‘[o]ur whole endeavours... were, how to contrive Pillows to give her ease.’ 86 Similarly, plasters and poultices were often prescribed or continued in response to patients’ increased or sustained pain. Although one woman complained ‘exceedingly’ of pain in her finger, Wiseman examined it and found ‘nothing of Swelling whereby I could judge it so ill’. Only when the woman ‘seemed ready to swoond with the pain’ did he take action and make an incision.87 Conversely, patients’ abilities to endure severe pain determined possible treatment options. When clergyman James Clegg suffered from a ‘Bastard Quinzey’ in 1695, his surgeon feared he might hit a jugular artery while lancing the throat swelling. Clegg explained, ‘I bore it well and beg[ge]d he would go deeper which he did and it succeeded well.’ 88 Similarly, a man with a cancer in his mouth asked Wiseman, ‘what way we had designed to cure him’.89 Wiseman admitted he had no such designs since he assumed the case was fatal; attempts to cure his ailment were ‘alwaies unsuccessfull and extream painfull’. The patient replied: ‘God’s will be done. I pray goe and consider the way’.90 In response to the patient’s demand, Wiseman operated and the patient survived.

Patient concerns and anxieties most clearly shaped treatment when there was fear that a swelling might leave a mark. Wiseman carefully chose treatments for a little girl with a painfully swelled cheek because her mother was extremely concerned about scarring. After an initial topical treatment failed, the mother grew impatient and threatened to take her daughter to another practitioner in Gloucestershire. Wiseman then considered alternative remedies, deciding against one in particular when a colleague asserted that ‘the very mention of it would fright them out of Town’.91 Wiseman eventually proposed a caustic and the mother assented. Thus, the surgeon did not choose a remedy according to his own judgement of the child’s bump, but rather in consideration of the mother’s demands and fears. Although in this particular case Wiseman was able to retain his client, case histories often mentioned patients who directly disobeyed surgeons’ advice or chose to seek help elsewhere in pursuit of more agreeable treatments.92 Sufferers resorted to this sort of behaviour when they desired less painful treatment, but also when they wanted to avoid travelling far from home or simply found a practitioner who would comply with their demands. The ways in which patients’ expressions of pain and anxieties both shaped healers’ interpretations of bodily bumps and guided treatment supports the theory that patients wielded considerable leverage in the early modern medical marketplace.93 While James Clegg demanded that his surgeon cut deeper,

86Wiseman 1676, p. 33. See also pp. 17, 24.
87Wiseman 1676, p. 56.
88Clegg 1981, p. 911. Quinsy was an abscess on or surrounding the tonsils.
89Wiseman 1676, p. 113. A cancer was a type of tumour that spread indefinitely, often returning after attempts to remove it: ‘it eats away or corrodes the part in which it is situated, and generally ends in death’ (OED, 2nd edn, 1989).
90Wiseman 1676, p. 113.
91Wiseman 1676, p. 119. Also see discussion of this particular case in Wear 2000, pp. 243–4.
92For example, see Wiseman 1676, pp. 32, 40, 43, 61, 100, 106, 108, 109, 130.
93Jewson 1974; Foucault 1994; Fissell 1991a.
despite the excruciating pain, Hugh Ryder was unable to perform a much-needed incision on one of his patient’s bumps: ‘he (being timorous) would not permit me’.  

Conclusion

Patients’ and surgeons’ interpretations of bumps relied on similar readings of external signs, as well as conceptions of the body. Bumps were not isolated events, but often resulted from or led to other ailments, such as agues and asthmas. When gentlewoman Sarah Cowper’s boil broke naturally, for instance, she hoped ‘it may benefit my almost Blind Eie’. Similarly, Wiseman described a long inflamed streak stretching from a bump on a woman’s knuckle to an issue in her arm—a certain sign of ‘communication from one to the other’. Such readings of bumps also reflect a common conception of a mutable early modern body in constant flux. Swellings often moved or dropped, and the goal of many treatments was to shift collections of humors. Wiseman described one man’s swelling which ‘shifted from one part to another in and about his Face’ and in a different case he had trouble extracting matter from a woman’s foot because it always ‘sunk lower, and put me upon the necessity of intercepting its farther descent to the Heel by applying another Caustick’. Along the same lines, bumps were often responsible for the cause or cure of other bumps. An apothecary’s treatment for a woman’s swelled breast created a fluxion of humors to another part of the body, resulting in new abscesses; oppositely, venting trapped matter in one swelling might cause others to become ‘more governable’. While these bodily perceptions corroborate previous studies, such as Barbara Duden’s work on eighteenth-century German women, a focus on bumps reveals how this fluctuating, holistic, mutable system was not only internally perceived, but read on to external bodily signs.

In addition to deepening our understanding of seventeenth-century patients’ and healers’ conceptions of the body and health, this article points to the ways early modern medical encounters were informed by a patchwork of interpretations between patients and practitioners. Patients’ concerns with appearance, pain and the consequences of bodily signs influenced the ways they understood and described their bumps. Surgeons’ interpretations were shaped by patients’ accounts and expressions of pain, as well as their own concerns with maintaining clientele and their own observations based on amassed experience. Additionally, a focus on bumps in surgical case histories reveals that bodies were often key components of medical encounters. Healers did not only listen to patients’ accounts, but observed and touched people’s bodies. The medical encounter was shaped by a collaborative interpretation of health based on patients’ as well as practitioners’ readings, sensations and observations of bodily signs.

94Ryder 1689, p. 52.
95Cowper 1701–2, p. 206.
96Wiseman 1676, p. 45.
97Wiseman 1676, pp. 41, 31.
98Wiseman 1676, pp. 28, 24.
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