Writing to fellow physicians: literary genres and medical questions in Louis Odier's (1748-1817) correspondence

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Abstract

Correspondance between physicians reveals much about their medical practices and the theoretical frame within which they evolve. Concentrating on a correspondance between Daniel De la Roche and Louis Odier, this chapter explores the uses these authors make of case histories and the different cultural genres to which they refer.

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Writing to fellow physicians: literary genres and medical questions in Louis Odier’s (1748-1817) correspondence

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The history of the clinic is one of the most compelling stories conveying meaning to the transition from traditional humoral medicine to today’s modern ‘scientific’ medicine.¹ The plot is well known. In the last years of the eighteenth and in the early nineteenth century, physicians in hospital wards began to systematically correlate symptoms with histological and organic deteriorations revealed by post-mortem examinations. Hence they initiated a new nosological system which enabled them to establish diagnoses with unprecedented precision. Michel Foucault has most clearly described the epistemological shift of the physician’s gaze which accompanied and stimulated the transition, heavily associating the innovation with the Paris medical school.² More recently, Othmar Keel has argued that the transition began earlier, namely in exchanges between the British and the French medical worlds, insisting that similar evolutions were in fact taking place all over Europe.³ Beyond the geographical debate, it appears that one of the conditions needed for the story to unfold was the primacy given by physicians to individual case histories. But what made Enlightenment physicians so interested in cases? What did they make of the cases they observed? Concentrating on letters exchanged by physicians active in the second half of the eighteenth century, the finality of this chapter is twofold. First, I would like to ascertain the meaning case histories had for young physicians and how their reading of medical histories could lead them to construe innovative medical knowledge. Second, I shall strive to link medical narratives with a larger cultural background, suggesting that emphasis on stories of individuals was a widespread cultural phenomenon in which case histories were just one example.

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² Michel Foucault, Naissance de la clinique (Paris, 1972).
³ Othmar Keel, L’Avènement de la médecine clinique moderne en Europe, 1750-1815: politiques, institutions et savoirs (Montreal, 2001).
Writing to a distant colleague was a means of finding an alter ego with whom to address problems encountered in medical practice, and, consequently, medical correspondence is today an extraordinary source for unravelling eighteenth-century medical considerations and a rare opportunity to assess the use medical correspondents made of case histories. The attitude of eighteenth-century physicians to knowledge was historically contingent. They espoused the traditional emblems of academic doctors since the Renaissance, based on intellectual and moral values and built their image on good advice fuelled by knowledge and judgement. The physician’s pragmatic ability to cure was less essential to his professional identity than his capacity to prognosticate, possibly because many competing healers based their claims on empirical success. That being said, case histories had long been important vehicles of medical knowledge, namely since the beginning of the early modern period, when their importance grew as historiae and they came to represent not knowledge itself, as Gianna Pomata has contended, but data from which knowledge was construed. Case histories were to be interpreted by the reader and no longer mirrored the traditional medieval concilia in which individual cases served to demonstrate theoretical frameworks. The new usage of case histories was catalysed by a novel approach to wonders which encouraged contemporary physicians to observe their natural environment. Both these evolutions encouraged the doctor to consider practical aspects of physic. Personal observations of patients came to play an essential role in the way medical cases were described and published.


5. In the first pages of his introduction to practice, for instance, William Cullen claimed that it ‘must depend [...] upon the extensive knowledge and judgement of the physician to discern the degree of probability in the several parts of medical doctrine, to admit those only, as a foundation of practice, which are simple, obvious, and certain’. William Cullen, First lines of the practice of physic, for the use of students in the University of Edinburgh (London and Edinburgh, J. Murray, 1777), p.3.

6. For a discussion of the training in Renaissance medicine, see Nancy G. Siraisi, Medieval and early Renaissance medicine: an introduction to knowledge and practice (Chicago, IL, 1990), p.48-77.

7. Traditional medieval concilia concerned individual cases which were set in a clear doctrinal framework giving meaning to diagnosis and therapy. Curatio and observatio published in the early modern period are detailed descriptions devoid of doctrinal interpretations. Gianna Pomata, ‘Praxis historialis: the uses of historia in early modern medicine’, in Historiae: empiricism and erudition in early modern Europe, ed. Gianna Pomata and Nancy G. Siraisi (Cambridge, MA, 2005), p.105-46 (131).

The effects of this change in perspective can be seen in long-term trends in medical training. Knowledge of bedside medicine was rarely required of medical students in the sixteenth century.\(^9\) When practical courses were introduced, they remained theoretical, the teacher describing cases he had himself encountered, but not presenting patients to students.\(^{10}\) Some initiatives did tend to institutionalise bedside teaching. In the 1540s, for instance, Giovanni Battista Da Monte innovated in the medical curriculum at Padua by taking students to patients' bedsides and in Paris, as from 1639, students who had passed their baccalaureate were expected to attend an outpatient clinic.\(^{11}\) The growth of the importance of practical knowledge was irregular. By the middle of the eighteenth century, Othmar Keel has argued, clinical teaching became widely recognised as an important aspect of medical training in Europe, both in military and in civil contexts, despite being largely on the margins of academic curricula.\(^{12}\) And yet serious clinical training was then available but in a handful of clinics. Consequently some young doctors encountered difficulties in obtaining licences to practise due to the theoretical nature of their training. In 1737, Jean-Jaques Manget (1716-1789) stood examination in order to qualify for a licence to practise in Geneva. He had left Geneva to study medicine less than two years earlier and held a doctoral title from Valence. Although he would have been considered sufficiently qualified less than a century earlier, in 1737 he was failed on the grounds that his knowledge was insufficient.\(^{13}\) Some European universities, namely Montpellier, Vienna, Edinburgh and Leyden, did attach clinical teaching to their courses. More commonly, students would walk the wards in hospitals, during or after their academic curriculum, for months or even years, before settling down to medical practice.\(^{14}\) This became almost systematic in the second half of the eighteenth century.\(^{15}\) Louis Odier (1748-1817) did not consider his three-year curriculum in Edinburgh sufficient prep-


\(^{10}\) Brockliss and Jones, The Medical world, p.167.


\(^{12}\) Keel, L'Avènement de la médecine clinique, p.91-106, 395-430.

\(^{13}\) Geneva, Archives d'Etat de Genève (henceforward AEG), Santé F1, p.58.

\(^{14}\) See for instance the training received by Samuel-Auguste Tissot (1728-1797) in Montpellier: Antoinette Emch-Deriaz, Tissot, physician of the Enlightenment (New York, 1992), p.16.

aration to set up a medical practice. As he prepared to take his medical
doctor’s degree in 1770, he wrote: ‘I know so little of practice that it
would be murder, or little better in me to go and attack our people.’

His remark echoes Thomas Platter’s (1574-1628) own evaluation of
students’ practice in the vicinity of Montpellier two centuries earlier,
but, whereas the young Platter proceeded, unsupervised, to practise
medicine in Uzès, Odier devoted three extra years to walking the wards
and following clinical courses given by the most eminent physicians of
his day in Edinburgh, London, Paris and Leyden. Thus, Odier and
students of his generation were intent on getting a solid clinical training.

What use did they make of the clinical cases they observed, reported and
discussed? Two series of letters will be discussed in the following pages.
Each one illustrates a distinct stage in Odier’s career. The first letters
cover the years of clinical training and were addressed by Odier to
Charles Blagden (1748-1830), then a young Edinburgh-trained physician.
The second series of letters was written during Odier’s years as a mature
physician, some two decades later, and is addressed to another doctor,
Daniel de La Roche (1743-1812).

Learning by cases

In the extant fourteen letters he wrote to Charles Blagden between 1769
and 1775, Louis Odier expressed an appetite for ‘interesting cases’. A
medical student since autumn 1767, he recognised Edinburgh as a source
of case histories. The university clinic of some thirty beds was then one of
Europe’s most prominent teaching clinics. Odier’s first contact with
practice was Francis Home’s Clinical lectures in summer 1769: ‘It was my
first engagement with the art, but I was astonished and almost disgusted
for ever at medicine. Would you believe that almost every one of his
patients had worms in his opinion.’ As he prepared his final academic
examination the following year, Odier expressed the desire to spend
another two years in Edinburgh, chiefly at the Royal Infirmary, despite
his low opinion of his first clinical teacher: ‘Tho’ the practice of Dr Home
is but very wretched, yet I take it that after the instructions of Dr Cullen, I
will profit as much by his perpetual blunders, as I would perhaps by a
better, but more uniform practice.’ He believed himself to be capable

16. Bibliothe`que de Gene`ve (henceforward BGE), MS fr. 1397, Louis Odier to Charles
Blagden, Edinburgh, 26 May 1770.
17. Brockliss and Jones, The Medical world, p.168; Philip Rieder, Anatomie d’une institution
18. G. B. Risse, Hospital life in Enlightenment Scotland: care and teaching at the Royal Infirmary of
of judging the success of ‘trials’ undertaken by Home: ‘It is enough to have eyes and a little common sense, to judge in a great measure of their success.’21 Was common sense sufficient to make sense of clinical observations? Francis Home himself took pains to construct knowledge by targeting particular medical issues. He encouraged young clinicians to multiply therapeutic experiments, arguing that one needed more than just a few observations in order to select the best therapy.22 The ‘trials’ which he undertook were controversial; his colleague James Gregory later condemned them and argued that only therapies tested in private practice should be used at the Royal Infirmary.23 Odier expressed no such concern and concentrated his attention on therapeutic results:

We had four or five Intermittents, in which the bark succeeded better after the fit than before. Four doses [...] were given before the fit at 1/2 hour’s distance of each other without effect, but the same quantity given after the next fit stopped the following ones. I own this staggered me a little about the doctrine of Cullen on the Bark.24

This was to be Home’s own conclusion in his published appraisal of fourteen cases in 1782;25 Odier’s common sense and Home’s focused empirical analysis led to the same conclusion! The ‘trial’ does highlight one of the main characteristics of clinical research then carried out: statistical proof was rare. Odier usually dealt with cases on a then-common trial-and-error basis.26 He practised ‘governing patients’ and looked out for treatments that worked and could prove useful for future practice, clearly using cases as indicators of the efficiency of remedies.27 In relating cases, he emphasised the quality of his observations and

21. Francis Home (1719-1813). Surgeon in the army and then medical doctor in Edinburgh (1750), Home was professor of materia medica at Edinburgh University (1758) and as such was responsible for a term of teaching at the university’s clinical ward. See W. E. Home, ‘Francis Home (1719-1813)’, Proceedings of the Royal Society of Medicine 21 (1928), p.1013-15. Geneva, BGE, MS fr. 1397, Louis Odier to Charles Blagden, Edinburgh, 26 May 1770.
23. James Gregory, Memorial to the managers of the Royal Infirmary (Edinburgh, 1800), p.141; J. Gregory, Additional memorial to the managers of the Royal Infirmary (Edinburgh, 1803), p.478-80. For background on this issue, see Risse, Hospital life in Enlightenment Scotland, p.251-52.
25. See Risse, Hospital life in Enlightenment Scotland, p.191.
26. For clinical teaching at the Infirmary, see Risse, Hospital life in Enlightenment Scotland, p.240-77.
27. This was a traditional approach. Pomata, ‘Praxis historialis’, p.123-25.
adopted the habit of referring to patients by the name of the disease from which they suffered. He refers to ‘intermittents’, ‘hydropics’, ‘tetanuses’, to a ‘nervous fever’ and a ‘pleurisy’. Among the first cases he directed himself, in May 1771, is a ‘very clear case’ of pleurisy. Two successive phlebotomies were deemed ineffective. Vinegar diluted in gruel water was then tried, and ‘it worked’. The patient ‘sweated abundantly during the night, and felt much better the following morning, notwithstanding the cough of which he complained a lot’. Odier then prescribed footbaths to help the patient sleep and some mucilaginous mixture ‘which calmed the cough and eased the expectoration’. ‘I ordered a vesicatory’ he then reported after having been told that the patient suffered from a pain in the groin. But the patient refused and the young physician offered an alternative solution: a flannel to cover the relevant body part. Odier finally states that the patient, although not yet quite well, was ‘much better’, he walked and worked with ease.28

Considering the variables one would expect Odier to have taken into consideration, it is surprising that he gave his correspondent little information about the patient’s age, constitution, lifestyle, place of origin and so on. His narratives are quite clearly not ‘reports’ as students were then taught to write them. Reports were rigorously organised day by day and included possible causes of disease, family history, age, way of life and so forth.29 The absence in case histories of possible causes is particularly surprising due to the attention attributed to causes by Cullen, Odier’s medical model. Moreover, an official clinical ‘report’ of the same case of pleurisy, written by Odier himself, gives little additional information beyond the patient’s name, Douglas Sanders, and his approximate age, between thirty and forty.30 The narrative Odier addressed to Blagden can be seen as a second analysis of the case. In his report, he had concluded that the cure was due to phlebotomy, a possibility he excluded in his letter to Blagden where he identified the successful healing agent to be gruel water. In his letters, Odier gives what appears to be a more personal account, an account which includes details left out of his official record such as, in this case, the patient’s refusal of a vesicatory.31 As in his relation of cases to Blagden, Odier’s clinical reports written in the Infirmary tend to concentrate on the

patient’s sojourn in the hospital and his or her complaints and symptoms. This limited perspective may reflect the policy of the Infirmary which aimed, to put it crudely, to cure symptoms and discharge patients. It confirms the known focus of the Infirmary on an immediate hands-on approach centred on the patient’s present circumstances.\(^{32}\) There are few exceptions. In a case related to Blagden, a ‘hydrothorax’, for instance, Odier suggests the cause: ‘heavy drinking’. All in all, it is tempting to conclude that anamnesis played but a small role in the hospital cures he undertook. Low emphasis on causes, importance given to observation and the habit of reducing patients to the names of their affections could be seen as steps towards considering diseases as ontological entities. And yet such an interpretation would be misleading. The focus of Odier’s attention is neither clearly on the disease nor, in fact, on the patient, but on the interaction between the physician and the sick person. This is confirmed by the very qualification of cases. The case of pleurisy is described as ‘a very clear case’, suggesting that there were less clear cases and thus difficulties in comparing cases. Furthermore, while the historian of medicine is keenly looking for traces of taxonomical insight or of diagnostic capacity, these skills awake little interest in the eighteenth-century medical student or in his prospective patients. There is no sign of diagnostic procedures or of any hesitation in giving patients labels. The young physician’s pride or reputation does not depend on his capacity to diagnose, but rather on his ability to prognosticate the evolution of individual cases. Odier’s fame grew considerably, he reported, when he predicted a ‘crisis’ on the eleventh day of a ‘nervous fever’, a crisis which was observed on the fourteenth day. The event, he reported, ‘increased much my reputation in the village, and procured me some patients more’.\(^{33}\) Confronting patients to medical theory and accumulating experience on how to deal with individual sick patients appear to be the main uses made by Odier of the cases he encountered during his student days.

**Case histories in established medical practice**

Odier remained at the forefront of medical knowledge throughout his life, notably thanks to a network of correspondents and his activity as medical editor of the *Bibliothe`que britannique*.\(^{34}\) Did his perspective on case histories evolve? Answers can be found in letters he sent to his friend and
colleague, Daniel de La Roche, between 1786 and 1812. Both physicians
set up practices in Geneva in the early 1770s and contrived an original
medical association, promising patients the benefit of two physicians for
the price of one.35 Geneva’s town library holds 135 letters written by
Odier to de La Roche after the former left Geneva in 1782 and estab-
lished himself in three successive European towns: Paris (1782), London
(1792) and Morges (1793). Odier’s apparently informal letters are remi-
niscent of a dialogue between friends and convey a realistic impression
of his activities as a physician. He often wrote in the evening.36 One letter
states: ‘J’avais deux heures à moi quand j’ai commencé cette lettre. Il y en
a déjà une d’écoulée et je me vois obligé d’employer l’autre à aller chez
Madame Barde à Plainpalais qui vient de me faire demander.’ On his
return he resumed his letter: ‘J’ai été chez Madame Barde. C’est sa fille
qui a un peu de fièvre. J’espère que ce ne sera rien.’37 Pondering over his
medical practice after a day’s work, Odier related many case histories to
his distant colleague. The Barde case finally took much of his attention
during the following month. Odier qualifies the case as ‘une des plus
intéressantes et des plus instructives que j’aye encore vues’. His relation
takes the form of a play staging two actors: the illness (‘maladie’) and the
physician. Each act is a day and describes the state of the patient, the
reasons for trying each medicine and the observed effects. The child’s
state deteriorated rapidly after the first symptoms, a fever and some
meteorism, were acknowledged on 5 July 1786. ‘Le 13 le pouls était à 140.
L’état de la tête était le même [la malade délirait]. Le météorisme était
moindre. On lui appliqua deux sangsues aux tempes. Le soir, le pouls à
150. Le 14. La tête allait beaucoup mieux. Point de délire, mais le ventre
était plus tendu. On lui donna encore une once d’huile de ricin.’ Odier
explains, for instance, that after the patient had complained of the
discomfort caused by a vesicatory, it was dressed with innocuous oint-
ment (‘onguent anodin’). The three weeks leading to the death of the
patient take up an entire four-paged letter and yet Odier fails to explain
in what it was so interesting! After going into so much detail, he finds it
necessary to add a summary, a third-person narrative (‘on’). The process
of simplification emphasises his efforts to influence the course of the
disease and consequently highlights yet again the medical art of wrestling
with symptoms. Details such as the application of innocuous ointment
were edited out. The diagnosis, with which he concludes, ‘a hydrocepha-
lus’, is not corroborated by a post-mortem examination despite the fact

35. Louis Odier and Daniel de La Roche, Avis au public (Geneva, 1773).
36. For instance, Geneva, BGE, MS fr. 4158, Louis Odier to Daniel de La Roche, Geneva, 23
December 1788.
37. On the outcome of this case, see below, p.58. Geneva, BGE, MS fr. 4158, Louis Odier to
Daniel de La Roche, Geneva, 5 July 1786.
that the abdomen was dissected. ‘On n’a pas ouvert la tête. On a eu tort. On aurait trouvé un hydrocéphale.’

Summarising in a purposefully neutral fashion highlights one of the physician’s main activities: the art of conjuring symptoms as they appear. This, of course, is something Odier did every day and in this case not particularly successfully... His focal point lies elsewhere. The case tends to confirm his understanding of the disease history of hydrocephalus, as a close reading of his own article on the subject reveals. From the story of Barde’s illness, one can draw two conclusions. First that, despite the nature of the medical knowledge displayed, the result does not give information on the medical history of the family, past diseases and possible causes of the illness itself, data one would expect of a clinician of the period. Second, comparing cases to disease theory is a traditional usage of case histories and one that influences the physician’s convictions, but has little effect on medical knowledge.

That the patient’s past and background were in fact considered by Odier to be essential in order to evaluate patients’ conditions is quite clearly shown by an extraordinary summarising system he invented for an insurance company. The scheme was simple. Investors bought life annuities on selected young ladies. The choice of the girls was essential and Odier was paid to establish medical reports on eligible individuals. Defining three different states of health (1: below average, 2: average, 3: above average) and a fourth of death (0), he included in his appraisal the individual’s present health (A) and past health (B), her father’s present (C) and past (D) health, her mother’s present (E) and past (F) health, but also her paternal grandfather’s health (G), her paternal grandmother’s health (H), her maternal grandfather’s health (I), her maternal grandmother’s health (K), the present state of her father’s family including first cousins (L), the past health of the same family (M), the present state of her mother’s family (N) and the past health of the same family (O). Odier’s system enabled him to convey a report on the state of health of his own daughter, Amélie, as follows: A2-B2-C2-D2-E2-F3-G0-H0-I0-K2-L3-M3-N3-O2. The simplification of medical evaluations is innovative, but its heuristic potential is ignored by the physician who aims to use it for administrative concerns only in order to efficiently convey his appraisal of the girls’ health to the insurance company, his employer.

Odier made various uses of case histories: confronting them to medical theories, using them to evaluate the efficiency of his therapeutic strategy in particular cases and to establish lists of individuals with long life expectancies. In the latter case, his letters reveal that taking into account family medical background and the patient’s own history were clearly important elements in his evaluation of an individual patient’s state of health and future health. In fact the notions of individual temperament and constitution were routinely taken into account. He described, for instance, the delivery of his third child, insisting on the fact that he had had to convince the surgeon, Louis Jurine (1751-1819), to administer opium to his wife, on the grounds that, although opium rendered most women lethargic, it had a contrary effect on her.

Prompted by a family event, Odier stressed the subjective nature of bodies, one of the obvious characteristics of humoral medicine and a patent obstacle to the clinical gaze described by Foucault: if all bodies are different, there seems to be little point in studying diseases which could set off different symptoms in every individual body. Some of the more subjective and historic information may have been unnecessary in accounts sent to de La Roche, as the latter knew most of Odier’s patients personally, but the absence of more precise indications on possible causes of disease suggests that, in relating his medical experience, Odier is again focused on his own effort to extirpate symptoms. His case histories reveal that he is still following both the focus of the reports he wrote as a student and the hands-on approach learnt at Edinburgh, maintaining his attention on the patient’s present circumstances. Some differences are striking. In the first place, the identity of the patient is more important in Odier’s private practice and he refers more often than not to patients by name. The identity and the status of the patients themselves were important for the practitioner as they affected the physician’s reputation in corresponding social circles. It was common practice to treat the sick differently, depending on their social status and their capacity to pay for expensive services. Some information exchanged in Odier’s letters was destined to solve concrete problems encountered in practice. His practice did not enable him to give any advice regarding ‘constrictions organiques dans l’urètre’, he explained to de La Roche, as venereal patients avoided consulting him. It did lead

42. Geneva, BGE, MS fr. 4158, Louis Odier to Daniel de La Roche, 10 June 1786.
44. Odier’s letters sometimes contained samples of smallpox venom which he sent to de La Roche when they were lacking in Paris. Geneva, BGE, MS fr. 4158, Louis Odier to Daniel de La Roche, Geneva, 5 May 1794 and 25 April 1796.
him to recommend ‘le camphre et le miel mais à grandes doses, d’une ou deux livres par jour’, as remedies for asthmatic patients. As in the letters addressed some twenty years earlier to Blagden, Odier related stories which illustrated the success of specific therapies, sometimes suggesting new medicines, at other times proposing adaptations to traditional therapeutic patterns. His experience, he wrote, had led him to prescribe a dose of oil to be taken directly after his fern-based preparation against worms. In his letters to de La Roche, Odier also used stories to justify medical opinions and to expose medical knowledge. He declared that stramonium was effective for dilating the pupil and explained how he came by the information. M. Tronchin had had an accident while playing a game of bowls. Squashing some leaves between two bowls, ‘une goutte du suc lui sauta dans l’œil et à l’instant sa prunelle se dilate au point que l’iris ne paraissait plus qu’une ligne circulaire bleue.’ Accidents and unusual situations were the most common contexts in which Odier was able to learn something new. Despite his interest in ‘trials’ and the statistical competence he had gained in taking part in debates about inoculation, he rarely referred to more than a few cases at a time. Interestingly, the only occasion when he mentioned more cases was when inoculating smallpox. His personal observation of thirty cases had led him to establish a correlation between the slenderness of the inoculator’s incision and the violence of the convulsions later experienced by the patient. Observations are here empirical and not reinforced by a critical method. His demonstration is built loosely on personal experience and is not convincing.

Despite constant efforts to access and to share case studies, Odier did not try to repeat with his correspondents the systematic statistical accumulation of case histories famously carried out by James Jurin (1684-1750), at the beginning of the inoculation debate, in the 1720s. The most obvious explanation is the prevalent importance of the subjective nature of the illness experience. A particularly clear expression of...
This can be found in the considerations addressed to de La Roche about his correspondent’s health. De La Roche fell ill in 1792 on the ferry from Dieppe to Dover and dreaded a serious heart disease. He complained of an irregular pulse and of palpitations. Odier expressed great concern and wrote an entire letter considering the possible causes of his state. He finally concluded that de La Roche was suffering from a nervous condition and not from an organic heart disease. His main argument was based on the story of a man who, ‘en passant de Calais à Douvres fut si horriblement tourmenté du mal de mer qu’il sentit tout à coup un mouvement très extraordinaire dans sa poitrine et dès lors il eut toujours soit en repos soit en mouvement le pouls très irrégulier, très inégal, et très intermittent. La marche lui donnait des palpitations et de l’oppression.’ It is noteworthy that Odier found it necessary to find the case of a man who had suffered not only from similar symptoms, but whose symptoms had appeared on the very same trip, on a crossing from France to Britain. Odier thus assured his friend that he was not in danger of imminent death. Nonetheless, one can wonder at de La Roche’s reaction to the end of the story. After contracting the disease, the patient was vulnerable for some time, reported Odier. ‘Il aurait pu vivre longtemps si un rhume négligé ne l’avait enfin précipité dans une phtisie dont il est mort à Naples l’hiver dernier.’

The body beyond the case

The perspective adopted by Louis Odier on case histories was fundamentally based on the subjective nature of patients and of their illness. From his point of view, correlations between symptoms and lesions revealed by post-mortem examinations could seem futile. And yet post-mortem examinations were carried out. Clinicians such as Cullen explained that they enabled a physician to perceive his mistakes. Others contended that the abnormalities observed were not related to diseases, or, as one of Odier’s colleagues argued, ‘toutes les affections organiques qu’on rencontre par l’ouverture du cadavre n’ont été formées qu’à l’instant où elles se sont manifestées par quelques symptômes.’ Odier did not agree with this contention and the disagreement itself suggests that physicians had difficulties in deriving clear conclusions from body openings. As a student, he did mention the results of two or three post-mortems performed at the Infirmary, but examinations were partial and apparently conducted in order to ascertain the causes of death rather

than the effects disease had on internal organs. Physicians’ letters reveal that their authors harboured a sublimated notion of their own genteel status, which kept them at a safe distance from contact with bodies and bodily fluids. Dissecting and direct contact with bodies appear to have been left in the hands of those they considered to be subservient actors – surgeons. Indeed, Odier’s disregard for Home – who first trained as a surgeon – seems to stem from fact that he was not a gentleman but a ‘nasty man’ because he ‘stirred himself the stools with a spoon’. Such attitudes tended to fragment expertise and may be one of the reasons why post-mortem examinations were rarely conclusive. And yet the desire to understand the ‘precise’ causes of death was shared by physicians and the families of patients alike. Guenter Risse mentions some families who actually asked for their kin’s bodies to be opened. One may go one step further and state that, when considering family documents, private openings of deceased patients were relatively common in the second half of the eighteenth century. The demand reflects a widespread desire to make sense of death from a medical standpoint. It is therefore not surprising that Odier later reported a number of post-mortem investigations carried out in his practice. Although not always scientifically conclusive as in the case of the young Barde mentioned above, they were usually described as a source of relief. One of Odier’s young patients suffered from an accumulation of liquid. The surgeon wanted to carry out a puncture. An agreement could not be reached before the patient died, but the post-mortem examination convinced all concerned that the puncture would have been useless and thus enabled the physician to reassure the parents that nothing that he could have done would have saved the child. Physicians did not escape the phenomenon themselves. In March 1789, Odier struggled with grief after having lost his youngest son, Ami. He wrote about the dissection of his son’s body, 

ce qu’il y a de plus étonnant, de plus triste et de plus consolant à la fois [est que] tous les poumons [étaient] farcis en dehors et en dedans de petits tubercules mols blanchâtres et comme en efflorescence. Il serait donc devenu phtisique, lui qui avait la voix si bonne, qui n’avait jamais eu d’oppression, et jamais de toux que les trois derniers jours de sa vie.

54. For instance BGE, MS fr. 1397, Louis Odier to Charles Blagden, Edinburgh, 5 February 1770. Dissections were rare at the Infirmary. Of fifty-seven recorded deaths at the Infirmary, barely half (thirty) were autopsied. Students could have expected to partake in only one or two during their studies, but Odier stayed on longer. Risse, Hospital life in Enlightenment Scotland, p.262-66.
55. BGE, MS fr. 1397, Louis Odier to Charles Blagden, Edinburgh, 5 February 1770.
56. This supports Toby Gelfand’s contention that the role of surgery was in fact important in the early history of the clinic. Toby Gelfand, ‘Gestation of the clinic’, Medical history (1981), p.169-80.
57. BGE, MS fr. 4158, Louis Odier to Daniel de La Roche, Geneva, 14 March 1789.
Storytelling and case histories

Observing cases enabled Odier and his correspondents to accumulate and share empirical medical knowledge and bedside skills, two essential elements for physicians of their generation. What they were intent on doing, following illness as it evolved in subjective bodies, appears to have had little effect on their knowledge of diseases. Why were they so keen on case histories? The pragmatic answer is of course that they strove to erect the direction of individual patients into a precise art. That said, it is interesting to reconsider their particular practices in the perspective of wider cultural processes. Physicians were then foremost men of letters and our correspondents had read contemporary novels such as *La Nouvelle Héloïse, Sir Charles Grandison* and *Clarissa Harlowe*. As a student in Edinburgh, Odier actually started a translation of Laurence Sterne’s *Sentimental journey*. Sterne’s autobiographical novel on a trip as a dying phthisic patient through France and Italy depicts an idiosyncratic individual, following no apparent aim beyond enjoying emotions and following his own whims. It is one example taken from a growing corpus of stories characterised by a renewed interest in everyday realities and in individual destinies and bodies, a phenomenon which was coined the ‘humanitarian narrative’ by Thomas Laqueur.\(^{58}\) The effect of such readings on physicians’ letters is difficult to ascertain. Ideal humanitarian, social and romantic values are present both in contemporary novels and in vocational statements inserted in physicians’ letters. Characters such as Saint-Preux, Julie, Humphry Clinker, Roderick Random and so forth are omnipresent in allusions and sometimes direct references. Odier, for instance, clearly conceived his relationship with women through the characters he had found in such books. He referred explicitly to Julie as a model in his letters to his future wife.\(^{59}\) In a letter to Louis Odier, Charles Blagden reported an enthusiastic reading of *Humphry Clinker*, ‘the best’ of all the novels he had read ‘these many years’. ‘His partiality is excessive, but does not disgust me, and the characters are drawn with a degree of precision which satisfies, and of force which enraptures me.’\(^{60}\) Beyond the novelist’s partiality which effectively highlighted ordinary individuals’ everyday tribulations, Blagden would have found in the novel Jery Melford’s letters to another former student (Sir Watkin Phillips), a possible model for the letters he himself sent to his former fellow

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60. Geneva, BGE, MS fr. 4160, Charles Blagden to Louis Odier, Gloucester, 26 March 1771.
students. Letters exchanged by students and young physicians express nostalgia for past companionship, desires to pursue commerce by letter and titbits of news concerning common friends in a fashion reminiscent of letters signed by Smollett’s character. Thus, whereas for authors such as Samuel Richardson, writing conduct literature could lead to conceiving a novel, for young physicians, reading novels could affect both their perception of social relationships and the content of their letters. The correlation between writing case histories and stories told in novels is not explicit, but appositional. Blagden’s correspondent reported the success of Humphry Clinker in Scotland before continuing to relate the medical cases he had encountered since his last letter. Reading may have affected the way they acted as physicians. Odier’s professed attitude, for instance, of treating the poor with charity and condescension is possibly one indirect sign of the type of regard and values the humanitarian narrative could instil in reading practitioners. Interest in individual medical histories mirrored the fascination reported by contemporary readers for ordinary people’s destinies. In the same way the reader was led by the author to discover extraordinary characters and picaresque adventures through a complex and ever-changing world, the young physicians strove to make sense of idiosyncratic disease patterns against an extremely flexible medical paradigm.

Were there more direct links between literary endeavours and medical practices? The question leads to no simple answer and, at this stage, one is reduced to suggesting parallels and discussing hypothesis. A first point to be made is that the plot of case histories is similar to those of episodes described in novels. An unexpected (rarely unidentified) event renders the subject ill. The ill state is socially recognised (admission into hospital). Medical authorities offer counsel and treatment. The state of the ill person evolves in response to successive medical interventions leading either to a recovery (the patient leaves the hospital) or to death. In novels, such narratives appear as subplots. At the very beginning of Humphry Clinker, for instance, Lydia Melford falls ill after having been violently separated from Wilson, her lover. She is carried to Bath where a Dr Rigge tends her and guides her back to good health. In her case the medicines used are not reported, but other examples include details on the nature of the therapy undertaken. Such subplots are common in Smollett’s and Richardson’s novels, as health was one of the preoccupations of the day and therefore one of the necessary themes for narrators in search of verisimilitude. As in case histories, the accent

was on ordinary life and human suffering. Case histories thus express not only medical preoccupations but also a wider cultural interest in individual human destinies. Moreover, when accumulating case histories the physician is not as culturally isolated as he may appear. Tragic and heroic stories related in novels circulated freely, as did dramatic and heroic stories of health. Anecdotes concerning individual case histories were relayed among the lay public and contributed to fashion lay medical culture. Correspondents exchanged stories on individuals of the same sex, in similar situations and suffering from comparable complaints as themselves, their acquaintances and addressees. Even medical eminences such as Cullen occasionally resorted to such stories. When presenting the use of alcalines in treating a case of ‘suppressed urine’, for instance, he referred to the case of Sir Robert Walpole to illustrate the pain they incurred, without feeling compelled to describe the case. It was obvious to Cullen that his audience had heard the story. The medical cases of celebrities were common medical knowledge. This is obvious when analysing eighteenth-century recipe books and large numbers of private letters. The case histories of famous political or literary figures were widely spread and discussed in family circles. In 1746, for instance, Marie Charlotte Lullin, having heard of the Dauphine’s death in childbirth after a phlebotomy, was careful to plan her own delivery and insisted on being bled before the delivery itself. The presence of sick figures in society was observed and discussed. Comparisons were made. Jean-Jacques Rousseau, for instance, was sceptical of M. Deschamps’s illness, ‘un hydropique prétendu’. ‘Quoiqu’il consulta beaucoup de gens, fit beaucoup de drogues, et qu’il m’eut consulté moi-même comme si j’eusse été médecin’, Rousseau considered Deschamps to be a cheat and sent him away curtly. He only changed his opinion after having visited the patient and personally observed his symptoms. The proximity of both practices and observations in lay and medical contexts

69. On Rousseau’s claim to be able to establish a diagnosis, in competition with medical doctors, see Rudy Le Mentheour’s article in this volume, ‘Melancholy vaporised: self-narration and counter-diagnosis in Rousseau’s work’, p.111.
corroborates the notion that medicine and medical history must be considered within a wide social and cultural setting.

Conclusion

Reading medical correspondences helps to suggest and sometimes establish links between both academic and clinical preoccupations and contemporary cultural issues. Direct influences are difficult to reconstruct with any certainty, and yet the proximity of medical cases presented by the physician and disease stories related by the lay public and novelists suggests that the physician was himself well embedded in lay medical culture. Literary and medical activities interweave around case stories to form a thriving cultural net from which the clinical gaze would later emerge. Were not the endeavours of nineteenth-century physicians and surgeons driven by a larger cultural fascination for the internal body and the need to understand the biological causes of disease?

Medical culture in the eighteenth century tended to emphasise the originality of the individual, stressing particular traits, and yet the hero of the stories told in physicians’ letters was neither the patient nor the disease, but the physician. The overall picture remains that of a physician concerned with subjective bodies and not with coherent groups of diseases. Empirical and practical data, however, did carry professional connotations. Accumulated by physicians, such knowledge was an important asset in medical practice. Systematically recording data relevant to individual patients, classifying patients following Cullen’s nosological system and listing series of symptoms were clearly essential to Odier’s medical methodology, a practice continued during his long career, attesting to the lasting influence of his training at the Infirmary on his medical practice. The empirical data he derived was often surprisingly difficult to accumulate and compare, and insufficiently focused for Odier to pretend to build consequent ‘objective’ knowledge. Case histories as they were exchanged in private correspondence did respond to the medical formats of the day, but they were also affected by the freer format of the letter and therefore convey more information on the perspective and intent of their author. Although one could relegate these stories to the sole field of medical knowledge, considering them as narratives in themselves and in a wider cultural context suggests that medical discourse was not strictly confined within scientific boundaries.