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The non-patient's view*

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Roy Porter's article 'The Patient's View' stimulated a major change in medical history. In many ways it defined the new social history of medicine, which since the 1970s had been challenging doctor-centred histories and opening new approaches and topics. Many historians took up Porter's invitation to rewrite medicine's past 'from below', but I argue in this chapter that they have not been radical enough and have missed one of his major challenges. The overlooked item is the last on his agenda for future research:

We should stop seeing the doctor as the agent of primary care. People took care before they took physick. What we habitually call primary care is in fact secondary care, once the sufferer has become a patient, [and] has entered the medical arena.¹

Porter is pointing to the importance of self-diagnosis and self-treatment – the beliefs, behaviours and actions of sick people who did not go to the doctor and remained 'non-patients'. In time and if symptoms persisted, they might have seen a medical practitioner. Though not addressed in this chapter, an important question therefore is what it took, in terms of beliefs, symptoms, opportunities and resources, for a person to move from being a 'non-patient' to a patient. This issue has become an important policy issue in the early twenty-first century, in terms of demand on health services.

Exploring this new area of ignorance requires historians to explore familiar sources in new ways and to find new sources, many of which have previously been regarded as non-medical. Historians of

medicine have been quite presentist in only rarely exploring prayer as an aid to healing, which was and remains a common response to illness. It also requires the creative reading of absences. For example, 'doing nothing' about an illness should be approached, not as passive or negative, but as a positive action, based on knowledge, opportunity and experience.

One indication of the scale and importance of the 'non-patient' for medical history is suggested by contemporary sociological studies of the so-called 'symptom iceberg': 'the phenomenon that most symptoms are managed in the community without people seeking professional healthcare'.² The 'iceberg of illness' had been identified as early as 1949 by Percy Stocks and then by John and Elizabeth Horder in 1954.³ In 1972, Karen Dunnell and Ann Cartwright published a study of medicine-taking in Britain, based on surveys over a two-week period.⁴ The context was concern that people were not going to the doctor, rather preferring to take the growing range of proprietary medicine. They found 91 per cent of those questioned reported 'abnormal symptoms' in the previous fortnight, with just 16 per cent consulting a doctor.⁵ More detailed studies were undertaken in the 2000s. The most comprehensive study sent questionnaires to 8,000 randomly chosen adults aged eighteen to sixty.⁶ Of these, 33.2 per cent returned a completed questionnaire, describing a total of 7,994 symptoms. Their actions – which are not mutually exclusive – are summarised in Table 1.1 and illustrated in Figure 1.1.

The key finding of the study was that only 8.3 per cent of symptom episodes led to the sufferer seeing their GP, with a further 3.1 per cent seeing another type of orthodox practitioner (e.g. nurse or pharmacist) or proxy (e.g. NHS24/NHS Direct). A further 11.1 per cent were already 'patients' and took a prescribed medicine. Thus, around 80 per cent of people in the sample with symptoms can be regarded as 'non-patients'. The survey focused on responses to symptoms not illnesses per se, though this was allowed for by ranking the seriousness of symptoms defining specific illnesses. The four most serious (and corresponding percentages of respondents seeing the GP) were shortness of breath (18.2 per cent), blood in stool (23.1 per cent), unintentional weight loss (27 per cent) and chest pain (15.7 per cent).⁷

Thus, in the early twenty-first century, in a country where access to care through the National Health Service (NHS) is free at the

Table 1.1 Actions taken by survey participants for each symptom experienced in the preceding two weeks

Action	%
Did nothing at all	48.6
Looked for information	2.6
Discussed with family and friends	9.8
Took over-the-counter medicines	25.0
Phoned NHS24/NHS Direct	0.5
Consulted nurse	0.8
Consulted pharmacist	1.8
Consulted complementary therapist	1.8
Consulted GP (on phone or in person)	8.3
Took prescribed medicines	11.1



1.1 Graphic representing the 'symptom iceberg'

point of delivery, and after a century of great advances when public confidence in medicine's ability to cure is very high, only one in five symptom episodes involves the sufferer becoming a patient. The obvious question for historians is, what would the proportion have been before the introduction of the NHS and the 'therapeutic revolution' of the twentieth century? The answer in all probability is a very much lower percentage.⁸ Also, the proportions were likely to have differed between men, women and children. Where and when medical treatment was seen to be more effective, priority would have been given to men as the main breadwinner and to children.⁹ Anne Hanley's chapter in this volume points to other ways responses were patterned.¹⁰ The stigma of venereal infection meant that self-treatment was tried for longer, and with gonorrhoea, there was the belief that the infection was like a head cold's runny nose 'down there' and would be self-limiting.

In this chapter, I make the case for historians to give greater attention to the 'non-patient's view' and especially to their actions. While records of their views are likely to be scarce, those of their actions, such as buying products and literature for self-treatment, should be less so. My focus is on Britain in the century before the establishment of the NHS. I begin with a brief review of where I have explored this topic in my own work, which was largely framed as the 'public's view', now changed in this chapter to 'non-patient's view'. I then deal in turn with the main categories of action from the 'symptom iceberg' study: doing nothing; looking for information; discussing with family and friends; and taking over-the-counter medicines. I finish with a discussion of sources as this is a major challenge for the approach and subject matter I am advocating. In the conclusion I discuss briefly the policy implications for healthcare in the twenty-first century. The advice to 'Not see the doctor' was advocated directly in the winter of 2017–18 and again in the early months of the COVID-19 pandemic in 2020 to help ease demand on the NHS. More positively, the Self Care Forum, founded in 2011, has been lobbying for greater investment and education for 'empowering people with the confidence and information to look after themselves when they can'.¹¹

My time frame means that I will not be exploring historical antecedents, nor parallels with the extension of the late twentieth-century doctor's gaze on the 'potential patient', as defined by their

risk factors.¹² And although I discuss only physical illnesses in this chapter, it will be clear that the same arguments and wider historical lenses are needed for mental illnesses. I also see this chapter as a contribution to the new interest in ‘Medicine in the Household’, which was the subject of a special issue of *Social History of Medicine* in 2016 in which its editors explored more imaginatively what counted as ‘medical’ in history.¹³ There are also possible links to work on the ‘patient-consumer’. Alex Mold’s review of the uses of the term in Britain shows that it has been framed, no doubt because of the NHS, largely in terms of consuming state medical services.¹⁴ However, Nancy Tomes’s work on patient-consumers in the United States necessarily has a wider focus given the country’s different history of healthcare infrastructure and can be read as a study of the transition from ‘non-patient’ to patient.¹⁵

The public’s view

I was a ready subscriber to Porter’s manifesto for ‘The Patient’s View’ and first attempted to capture what I now term the ‘non-patient’s view’ in an article published in 1994, co-authored with Michael Sigsworth, on ‘The Public’s View of Public Health’ based on a study of Yorkshire towns.¹⁶ We explored the public’s view of early nineteenth-century sanitary reform. Our main point was that ‘the Great Unwashed’ had different ideas and priorities to sanitary reformers, and that these were more economic than environmental, and based on different ideas of the nature and causes of disease. For example, the working class in Leeds wanted decent wages to buy the food that would build strong, disease-resistant bodily ‘frames’, ahead of clean water. Improved wages would additionally allow them immediate escape from overcrowding in slum dwellings by moving to the healthier streets that they recognised only too well. However, in their new dwellings they would still want to keep pigs, which far from being filthy sources of disease, were valuable scavengers that cleared up and recycled waste, provided manure to sell or fertilise land, and a good Christmas dinner in mid-winter. Second, in the 2007 book on rabies in Victorian Britain, co-authored with Neil Pemberton, we considered the responses of victims and their families to dog bites, and the calculations they made about the risks

and benefits of different actions.¹⁷ The options ranged widely. Assuming that the dog was unlikely to be rabid or that a harmless amount of poison had been inoculated, many chose to wait and see. Others employed a range of preventives and curatives, from applying the hair of the dog to the wound, hand-me-down herbal potions and patent medicines, and vapour baths to sweat out the poison, to the medical option of cauterisation or excision of wound tissue. Doctors at the time were clear that the chance of any biting dog having rabies was very small, hence their frustration over lay beliefs that almost all remedies ‘worked’ most of the time. Finally, in the 2013 book on fungal diseases, co-authored with Aya Homei, we discussed responses to infections like athlete’s foot, which caused irritation rather than illness: from accepting irritation and trusting to the healing power of nature, through applying patent ointments (what one doctor termed ‘the unbelievable chemical abuse’ of the nation’s feet).¹⁸

Also interesting for the argument advanced in this chapter is the doctoral thesis of Rachael Russell on nausea and vomiting in nineteenth-century Britain.¹⁹ The most severe forms of nausea and sickness, seasickness and morning sickness, were temporary and therefore mostly endured with stoicism and the knowledge of eventual certain relief. However, many precautions and remedies were proposed, from mental disciplines to medicinal compounds, patent and prescription. Most episodes of vomiting were transient, usually explained by something eaten, over-indulgence, something catching, or as ancillary to another illness. The very nature of the symptoms meant that taking something by mouth was largely redundant, hence, wait-and-see was the commonest action. With nausea, measures taken, if any, depended on many things: past experiences, the duration and intensity of symptoms, the frequency of fainting, associations with pain and other signs. Russell’s thesis shows that throughout the nineteenth century and across social classes, people had highly developed understandings of their body’s normal and abnormal functioning, and of likely linkages between prognoses and various remedial measures. These were drawn from experience, knowledge and help drawn from social networks, and from a variety of information sources.

In the following sections of this chapter, I discuss in turn the four ‘non-patient’ responses identified in ‘symptom iceberg’ studies:

doing nothing; looking for information; family and friends; taking over-the-counter medicines; and then ending with a discussion of sources.

Doing nothing at all

For the most serious symptoms in the 'symptom iceberg' survey, the percentages for 'doing nothing at all' were shortness of breath (47.2 per cent), blood in stool (57.7 per cent), unintentional weight loss (59.9 per cent) and chest pain (52 per cent). What do we make of these surprising figures? Surely, it is that 'doing nothing at all' does not capture people's responses, as it implies passivity or fatalism. Put another way, it makes 'doing nothing at all' a residual. It assumes a 'deficit model' where medical intervention is normal and necessary and that anything less is considered to be negligent. I argue that 'doing nothing at all' is (and was) an active and informed choice, based on experience, lay understandings of the meaning of symptoms and likely prognoses. More simply, 'doing nothing at all' is doing something. Wait-and-see shows faith in the healing powers of nature and points to the issue of the threshold for the move from 'non-patient' to patient. In his 1977 essay on 'The Therapeutic Revolution in Nineteenth-Century America', Charles Rosenberg suggests that this move became easier from the late nineteenth century, due to changed social, economic and cultural factors, and also because doctors and the public increasingly shared the same view of the body and had growing confidence in medicine's powers.²⁰

The 'symptom iceberg' survey was thoroughly materialist. It only asked about physical, material and social responses to illness, not spiritual and psychological ones. Yet there is evidence that prayer is a very common response to symptoms and illness. In the early twenty-first century church attendances in Britain are low. None the less, a survey of 2,069 people, across all ages in 2017, found that 51 per cent still prayed; indeed, a fifth of non-believers prayed.²¹ Among those who prayed in a group that included non-believers, 40 per cent did so for healing, with the figure similar across all religions.²² If these levels are found today, it is almost certain they would have been higher historically when religious observance and belief were the norm.

Such is the implicit materialism of medical historians today, that very few have even considered prayer as a rational, let alone possibly effective, response to symptoms. One exception is Joanna Bourke in her book *The Story of Pain: From Prayer to Painkillers*.²³ While the subtitle might be teleological, carrying the implication of progress from faith in God to effective pharmaceuticals, the narrative shows the changing religious meanings given to pain. If it was a punishment, then perhaps relief should not be sought, but if it was due to malign forces then prayer was legitimate. Bourke's narrative shows the complexities of responses to pain, lay and medical, with spiritual, psychological, material and social actions combined and intertwined. An important point is that many prayers would have been social as well as private, and offered solace and hope, with shared meanings and experiences. Lastly, and perhaps most importantly, prayers would have been experienced to 'work'. The great majority of symptoms and illnesses are self-limiting, with individual experience unable to distinguish whether the association between prayer and their recovery was cause and effect, or coincidence.

Evidence for the role of prayer in responses to illness are to be found in private diaries, but there were also public demonstrations of prayer and its success in healing. Historians have been interested in the seeming increase in public acts of worship in response to crises in Victorian Britain.²⁴ With regard to disease and medicine, these studies have been mostly framed in terms of changing relations between science and religion, yet, the efficacy of prayer was the immediate issue.²⁵ The most celebrated instance was in the winter of 1871, prompted by the Prince of Wales suffering from suspected typhoid fever. Government ministers and church leaders organised national prayer days for his return to health, and when this was successful, arranged nationwide services of thanksgiving. There had been no large-scale public turn to prayer ten years earlier, when the Prince's father died of the same disease, but during the 1860s prayers came into favour for relief from disease. Frank Turner's discussion of the episode is in terms of the struggle for cultural authority between scientists and the clergy, with the latter winning when the Prince recovered four days after prayers were read out in churches across the nation.²⁶ Turner quotes a letter to *The Guardian* from a vicar who wrote that 'The wonderful change in the condition of the Prince of Wales will surely impress many hitherto doubtful of the efficacy of prayer'.²⁷ To rub salt in the wound of the medical

profession, there were three further religious observances of thanksgiving for divine intervention with the Prince's illness. Reports on the episode in *The Guardian* spoke of 'the direct and personal working of the Hand of God', and that the Prince's recovery 'was not by some abstract "Law of Health", not merely by human skill and tenderness, but by the mercy of God who hears and answers prayers'.²⁸

Turner shows that the reaction of the medical profession was to argue that religion and science were complementary. An editorial in the *Lancet* recognised 'the hand of Providence', but also contended that modern medical science had 'signally won fresh laurels in the recovery of the Prince of Wales'.²⁹ For nineteenth-century America, Rosenberg makes the same point, observing that for most doctors and patients, 'There was no inconsistency between [the medical] world of rationalistic explanation and traditional spiritual values.'³⁰ However, some scientists were less accommodating. Indeed, Francis Galton was moved to undertake statistical analyses on the efficacy of prayer, finding that 'sick persons who pray, or are prayed for, on the average' did not recover more quickly.³¹ Given the power of churches in Victorian Britain, if calls to prayers for recovery from illness and questions about its efficacy were so public, then in private it is almost certain that prayers for the recovery of the sick were pervasive across society.³² Indeed, every hospital had a chaplain and while their formal role was to serve the spiritual rather than the material needs of patients, prayers for divine intervention to aid recoveries were customary.³³ The chapters in this volume by Hanley and Houston both discuss the notion that patients' engagement with doctors was a type of 'lay confession', where they might acknowledge how their behaviour contributed to their condition. Regular evening prayers on wards fostered a spiritual ambience, which was manifest in some institutions by the religious affiliation of nursing orders. The only conflict evident in the medical press was of doctors' complaints that chaplains were paid more, enjoyed better conditions, and were, perhaps, more valued.³⁴

Looking for information

Medicine Without Doctors was a pioneering collection of essays published in 1977, edited by Guenther Risse, Ronald Numbers and Judith Leavitt.³⁵ In many ways it anticipated Porter's 'patient's view'

manifesto. Like Porter, Risse's 'Introduction' observes that the importance of 'do-it-yourself healing' was not reflected in medical historiography and argues that those taking up its investigation should be open to the varieties and eclecticism of self-care and self-treatment. He set out an agenda that emphasised the need to consider prevention, as well as diagnosis and treatment: to look at physical and mental problems; to recognise that actions were shaped by the traditions and experiences of family, friends and wider groups; to take cognisance of the healing powers of nature in resolving many illnesses; and to not forget the placebo effect. However, most of the contributors to *Medicine Without Doctors* wrote on 'alternative' healthcare systems and the information they provided for self-help. They tended to assume a version of the 'deficit model', where orthodox medicine was unavailable or spurned, with the gap filled by movements, such as Thomsonianism and homeopathy, or by patent medicines and quackery. Much of the work promoted by Porter's 1985 essay on British healthcare has been on similar topics.³⁶ One wonders if the link between the patient's view and 'medicine' is ingrained to such an extent that historians could only think in terms of systems: orthodox or non-orthodox alternative?

Two essays in *Medicine Without Doctors* do go beyond medical systems and quackery to consider self-reliant responses to illness. Risse highlights the importance of the sick person's knowledge and experience of their own body, its past illnesses, how responses were shaped by religious beliefs and practices, and a commitment to self-reliance. James Harvey Young shows the need for relativism in considering what 'worked', be that treatments or 'wait-and-see'. He also stresses the importance of emotion and feelings, concluding with a nod to the healing powers of nature and the placebo effect that, 'Self-help, of course, has a high enough percentage of success to build confidence in the means of employed', and any measure might help 'by furnishing a sense of relief through the sheer act of doing something, by encouraging mood'.³⁷

Family and friends³⁸

The 'Introduction' to *Medicine Without Doctors* did look beyond systems to 'orally transmitted folk traditions', but these mostly

remained tied to systems.³⁹ British historians and social scientists have followed the same trajectory, taking folk medicine to be ‘all those practices which lie outside the “normal” sphere of operations of orthodox western medical practice’; in other words, quacks, alternative, complementary and fringe medicine.⁴⁰ Such studies, which were presented as a radical turn, still neglected ‘non-patient’ health-care. None the less, I want to take the notion of ‘orally transmitted folk traditions’ and develop it differently. My suggestion is to take the ‘folk’ in folk medicine in the colloquial sense of ‘folks’ and specifically the ideas and practices that circulated in families, neighbourhoods and communities.⁴¹ Dunnell’s and Cartwright’s study of medicine-taking in Britain in the early 1970s found that ‘only a small proportion, a tenth, of the non-prescribed medicines taken by adults had been first suggested by a doctor; most were the suggestions of parents, friends, neighbours, husbands or wives or other relatives’.⁴²

For the same period in Britain, there is one seminal study of folk medicine, namely Cecil Helman’s “‘Feed a Cold, Starve a Fever’”.⁴³ Helman was a general practitioner, who also qualified in anthropology and combined the two disciplines in a study of the belief systems and practices of his patients regarding the causes and cures of colds and fevers. Over four years, he undertook interviews with selected patients from his practice in the West London suburb of Stanmore. The prime puzzle he sought to solve was the persistence of humoral ideas about colds and fevers in the age of modern biomedicine and particularly bacterial and viral explanations of infection. He showed that patients and, importantly, doctors too, worked across the two seemingly contradictory registers of humoral and infective models of disease causation and treatment. Sometimes they were in conflict, but more often they were found in parallel, or in innovative, *ad hoc* syntheses. His findings echoed those of anthropologists’ studies on non-Western cultures, where the norm was so-called medical pluralism.⁴⁴

Helman acknowledged one important weakness in his study: ‘Only those cases of illness brought to the GP’s attention could be included.’⁴⁵ Thus, he ignored illnesses that were self-treated or untreated. Nonetheless, his findings offer valuable insights into the ideas and actions of ‘non-patients’. Helman paid particular attention to coughs, then the most commonly complained of symptom in general practice. In fact, after aspirin and similar analgesics, the combination of

prescribed and over-the-counter cough remedies constituted the second most common class of medicines consumed in the country.⁴⁶ He concluded that the use of over-the-counter medicines, in the face of medical evidence that these mixtures had no value in treating infection, ‘can be explained (if only in part) by the patients’ need to “make sense” of treatment for their illness in terms of their indigenous medical system’.⁴⁷ It is interesting that he posits that his patients in Stanmore had ‘indigenous medical systems’ in the same manner as anthropologists had talked about the beliefs and practices of groups in non-Western cultures. However, in West London and as often elsewhere ‘indigenous medical systems’ had been infected with orthodox, Western medicine. Thus, Helman found that humoral notions of removing excess fluid and ‘muck’ from the lungs and chest had been combined with germ theories of infection, to make sufferers seek to expel or kill invading agents and their poisons.

One disease for which ‘folk medicine’ in my familial sense has been explored is whooping cough (pertussis), a childhood infection characterised by severe (whooping) coughing fits. Its distinctive symptoms meant it was defined as a specific disease from the early modern period, with many remedies tried by parents, following family traditions, or the advice of neighbours and friends. Those remedies common in Britain, according to Samuel Radbill’s quarrying of the folklore literature, included tying a spider or wood louse in a bag for the sufferer to wear round their neck or nearby; wearing red or blue cloth; three-times protocols (drinking milk stood for three hours, three times for three mornings, and wearing a string with nine knots); crawling under a bramble bush; and passing children through a tunnel or similar hollow.⁴⁸ Donkeys and other animals were variously used in passing, seemingly hoping that passage under their body would allow the disease to be passed to the animal. Remedies were also combined. Thus, children were passed under a donkey or ass three times, or taken for a ride, preferably to a crossroads and back, and the hair of a donkey eaten or worn round the neck.⁴⁹ Many concoctions were made with parts of animals, such as frogs in the hope that croaking would be passed on, or that the smell of sheep and donkey dung would break the cycle of paroxysmal coughing. Whooping cough had a relatively low mortality rate in children over a year old. Therefore, for most sufferers most of the time, these treatments worked.⁵⁰

In a survey of late nineteenth- and early twentieth-century cough remedies, Radbill found that a change of air was often recommended to 'break the cough'. In Hull, parents took their children across the Humber and in Scotland to distilleries and gasworks. Taking children to gasworks grew in popularity with germ theories of infection and the profile given to carbolic acid in antiseptic and antigerm measures after 1870.⁵¹ This is another example of Helman's point about the synthesis of 'indigenous' and orthodox medical cultures, seen in the practice of families taking sufferers to inhale presumed chemicals antidotes – the waste gases released by factories and works. This practice was tried during cholera outbreaks in Leeds and more widely for pulmonary tuberculosis, with children taking the air by playing near creosoting or tarmacking gangs.⁵² With whooping cough, one practice was to take the sick child 'for a walk round the gasworks every day for a week, and he'll be as right as rain in a very short time'.⁵³ During the outbreak of the disease in the winter of 1925–26, the South Suburban Gas Co., Ltd., whose chief engineer and manager George Livesey was an active philanthropist, made their works in Lower Sydenham available to local families. The company turned its 'pump-room into a clinic, where children could go and "take the smells"'.⁵⁴ The 'smells' were 'ammonia, sulphuretted hydrogen – that obnoxious gas which makes one think of rotten eggs – naphthaline [sic] and tar'.⁵⁵ Ammonia and tar were said to be the key agents: 'It is more or less a case of killing to cure, for in most instances the fumes from the gas liquor bring on violent fits of coughing. But the trouble in the throat, which causes the whoop, is often removed in this manner.'⁵⁶ This rationale combines humoral notions of clearing phlegm, with modern ideas of chemical disinfection.

Taking over-the-counter medicines

A common assumption in most historical studies of over-the-counter or patent medicines is that their sellers made exaggerated, even fraudulent, claims about their effectiveness; put simply, they did not 'work'. This view is most evident in studies by pharmacist-historians, who have been fascinated by the ingredients of patent remedies and the seeming gullibility of the people who bought and took them.⁵⁷ However, they also recognise that these medicines often contained

substances like opium, alcohol, emetics and purgatives. Thus, they would, if taken in large enough doses, have produced physiological changes and altered symptoms. Yet, the charge remains that manufacturers and sellers were wrong to claim that their medicines ‘worked’, hence, they were and are appropriately labelled quackery. Such claims are based on modern pharmacology’s ability to demonstrate that the component compounds of patent medicines could not have altered the underlying pathology and in many cases had side-effects that were deleterious to health.

I argue, as with prayers, the case for being relativistic about what ‘worked’ and developing a fuller, more nuanced understanding of the experiences of health and illness. Consider the experience of a nineteenth-century consumer of Holloway’s Pills, the most popular patent remedy by market share.⁵⁸ Pharmacist-historians have followed the lead of the British Medical Association’s (BMA) exposés of ‘Secret Remedies’ in the 1900s, in disparaging the man and his medicines. The pills were revealed to be mostly composed of ineffectual ingredients: aloes, powdered ginger and soap.⁵⁹ Edwardian doctors often wrote of public gullibility in repeat purchases of such concoctions, though as Harvey Young presumed, much of their efficacy and market success must be due to placebo effects.⁶⁰

The fortunes built by entrepreneurs such as Thomas Holloway and Thomas Beecham indicate that customers felt that they were getting value for money, so it is worth looking beyond any presumed placebo effect.⁶¹ One typical advertisement for ‘Holloways Pills and Ointment’ in 1869 recommended they be taken for the following conditions:

Bad legs, Bad breasts, Burns, Bunions, Bite of Mosquitoes and sandflies, Coco-bay, Chicago-foot, Chilblains, Chapped Hands, Corns(soft), Cancers, Contracted and stiff joints, Elephantiasis, Fistulas, Gout, Glandular Swellings, Lumbago, Rheumatism, Scalds, Sore Nipples, Sore-throats, Skin Diseases, Scurvy, Tumours, Ulcers, Wounds, Yaws, &c., &c., &c.⁶²

Lists such as these were often printed in small type and would have been hard to read given the state of indoor lighting and contemporary optometry. None the less, it is interesting to speculate on the meanings that customers would have taken from the marketing. First, the listing gained authority in mixing medical and lay terms, while its

length and indication of multi-valency could have indicated the pills' potency. Second, Holloway's Pills and Ointment were promoted as both a specific and general remedy. Their action was described in humoral terms that were congruent with popular understandings of the body: 'A course of this admirable medicine clears *the blood* of impurities and improves its quality. The *whole system* is thus benefited through the usual *channels* without reduction of strength, shock to the *nerves*, or any other inconvenience.'⁶³ Third, many of the conditions would have been self-limiting, resolved by what contemporaries would have described as the healing powers of nature, nowadays expressed as immune responses, anti-inflammatory mechanisms, physiological adaptations and, perhaps, behavioural changes induced by symptoms. For example, lumbago, if the demands of work permitted, would have led sufferers to try and change their behaviour, seek rest, or find new ways of coping. Fourth, customers were encouraged to use the medicines for prevention as well as cures, hence, not suffering from any of the complaints listed would have been seen as the pills 'working'. All four considerations were congruent with popular understandings of the body that was part humoral, part physiological and part anatomical, and the experience of those taking the pills was that more often than not they were effective. One imaginative use of this source is to speculate on whether those taking Holloway's Pills regarded themselves as patients, their own doctor, or more likely both. The next step is to consider what might have happened if their illness persisted or worsened and when to seek a second opinion, to become what should rightly be called 'a medical patient'?

Such remedies seem to have been no less popular a half-century on in the years immediately before the NHS. For this later period we no longer have to rely on proxies and speculation as this was the era of new types of social surveys.⁶⁴ In 1944, Jack Davies, then in the Physiology Department at the University of Bristol, published the results of a survey of 'the medicines not taken under medical advice', by participants of the Medical Research Council's haemoglobin survey.⁶⁵ This was a nominally healthy group of 277 people (149 male and 128 female), aged 15 to 45+ years and from a variety of occupations. The headline finding was that 75 per cent (71 per cent males and 83 per cent female) were taking non-prescribed medicines, the commonest were laxatives (saline and vegetable) and

aspirin. Davies was disappointed that ‘after the propaganda of the last few years’, few people were taking iron, vitamins and other preventives proven by science to be effective. However, his conclusions were mixed. On the one hand he was pleased that Victorian patent medicines, described as ‘the most extravagant and exotic remedies’, were no longer widely used and that ‘there was a widespread desire for information among those questioned’. Tellingly, he observed of his survey group that:

They desired good health, and many quite sincerely thought that they were ensuring it by taking these medicines. The majority of those surveyed were ostensibly healthy people, and when the high proportion taking drugs is noted we may well wonder at the probable extent of self-medication among the sick folk.⁶⁶

On the other hand, Davies was sure that, though consumers benefited from ‘the therapeutic powers of hope and faith’, they were swindled. He was doubtful that education was the answer and worried that advertisers were becoming more sophisticated and effective; hence, his conclusion was that ‘to prevent much public exploitation and ill-health, restrictive legislation is imperative’.⁶⁷ My argument is that the public were not being exploited through ignorance, but rather were making informed decisions based on experience as much as manufacturers claims, and shaped by the healthcare options available, economics and cultural values. Needless to say, Britain, the landscape in which Davies set his views, was about to change radically with the establishment of the NHS.

Sources

How do historians recover the views and actions of ‘non-patients’? Information on most short-term, self-limiting and resolved symptom episodes will not have been recorded, let alone kept. Yet there are sources that can be tapped. The first thing to say is, if I am correct about the scale and prevalence of the sick remaining ‘non-patients’, then there is potentially an awful lot of self-help healthcare to look for. In seeking the ‘patient’s view’, historians have necessarily been led to look at ‘medical records’ in the broadest sense. These have been read in patient-centred ways, but they remain ‘medical’; recorded

by doctors and other medical actors. For example, the many studies based on patient letters to doctors in the eighteenth century are, by definition, from people who became 'patients', though teleology can be avoided by looking at the early stages of a correspondence to recover the 'pre-patient's' view. What actions did they take as 'non-patients' and what led them to become patients? In this chapter, I have given other examples of how well-known and well-hewn sources can be interrogated in new ways.

One source that can be looked at again is diaries. Emma Griffin has recently used working-class diaries and what they say about diets to look again at debates over the standard of living.⁶⁸ Similar studies could be made for illness and healthcare. There is much on healthcare and medicines in the working autobiographies collected by John Burnett, David Mayall and David Vincent.⁶⁹ The reminiscences of Mary Jones tell of her sister reacting badly to smallpox vaccination. As her condition worsened, the doctor reportedly gave up hope, stating that, 'if she lived, she would be either a cripple or an imbecile'. However, her mother Elizabeth did not give up and nursed her back to health with an eclectic mix of measures:

She went to the farmer to get milk twice a day from one cow, his healthiest, she got the butcher (?) send a small amount of fresh blood each day She went to the builder yard for a piece of rock lime which she (?) daily, she got cod liver oil and oranges. these she administered in very small doses (?) large amounts of love, her little limbs were (?) with olive oil and she carried the baby lying on a pillow for small doses of sunshine into the garden.⁷⁰

Perhaps there is another type of 'non-patient' to explore: the 'post-patient' who is no longer under medical supervision. Indeed, this group is likely to have been larger historically, when recoveries were likely to have taken longer and been based largely on constitutional support, perhaps a change of air and often long periods of convalescence. Medical historians have begun to examine convalescence and the proliferation of medical advice and convalescent homes.⁷¹ The corollary from the argument of this chapter is that most 'getting better' was self-managed and in circumstances that likely did not have exemption from family and work. Moreover, 'post-patients' would not only have been recovering physically, but also mentally with continued anxiety about their future.⁷²

For Britain in the twentieth century, there is the rich material collected by Mass Observation (MO). The diaries, survey reports and other material collected are an excellent resource: practically because many records have been digitised and are searchable, and empirically because they capture health and illness in the context of everyday life, not medical ideas and actions. On ‘non-patients’, particularly instructive is the 1943 *Report on Taking Medicines in War-Time* for what it says about MO’s interest in public morale. Were more medicines being sold and, if so, was this due to poor dietary, anxiety, or both.⁷³ The main finding, based on self-reporting, was that there had been no increase in the number or quantity of non-prescription medicines being taken. Incidentally, the report’s narrative reveals the reasons people gave for their consumption of medicines. One person in seven was taking something regularly as a preventative. Those people taking a prescribed medicine were often also taking a non-prescribed medicine in addition. In 1943, one respondent wrote:

Last winter and this I have taken iodine solution internally as a cure for chilblains, and this winter I have taken matetone [a tonic] for a few days at a time when I have been feeling run down or tired. Last winter I had injections to keep me free from colds, but I am one of the unfortunate beings with whom this method is of no use. Having heard very good reports from two friends of Serocalcin as a preventative of colds, I have tried that this winter and it seems to have been fairly successful so far.⁷⁴

Oral vaccines for the common cold were controversial and expensive, as with ‘Buccaline’, sold by Hayman and Freeman chemists of Piccadilly, London.⁷⁵ The other medicines being taken by those surveyed were: sedatives (Aspro, Aspirin, Veganin, Luminal), laxatives (Liver Salts including Andrew’s, Epsom’s, Eno’s, Paraffin, Taxol, Senna Pods, All Bran) and digestives (McLean’s Stomach Powder, Milk of Magnesia). The number of popular brands is an indication of the size of the market.

In August 1943, the journal the *Manufacturing Chemist and Manufacturing Perfumer*, published a report by MO’s National Panel of Voluntary Informants titled ‘What the Consumer Thinks of Self-Medication’.⁷⁶ Its subtitle set out that it was ‘the middle-class reaction’, later qualified by the authors to be that of the ‘more than average’

ARE YOU FIGHTING a cold?

YOU may be the type of person in whom a cold is of short duration but severe in character, or you may suffer from an "everlasting" cold—one which returns over and over again. In both cases the ultimate defeat of the attack depends upon the natural defence powers of the body. SEROCALCIN is successful in dealing with colds because it stimulates these natural powers of resistance.

A SIMPLE TREATMENT

SEROCALCIN is taken in tablet form and the dosage for treating an existing cold is 3 tablets three times daily. It contains no "drugs" and gives excellent results with children.

FOR PREVENTION, TOO

An immunising course of SEROCALCIN gives complete protection against colds for 3 to 4 months in 80% of cases. For this purpose, 60 tablets are taken at the rate of 2 daily.

A booklet "Immunity from Colds" will gladly be sent to doctors, nurses and interested members of the public on receipt of 1d. stamp (as required by Control of Paper Order).

SUPPLIES AND PRICES

War Factories, Hospitals, Schools and Export have priority claims on the supply of SEROCALCIN (Registered Trade Mark) but it is now obtainable from most Chemists. The cost is:—

20 Tablets 3/4—*for intensive treatment of an existing cold.*

60 Tablets 8/5—*the immunising course for preventing colds.*

Prices include Purchase Tax.

SEROCALCIN DEFEATS COLDS

HARWOODS LABORATORIES LTD., RICKMANSWORTH ROAD, WATFORD, HERTS.

1.2 Advertisement from the *Yorkshire Post* (13 February 1943)

informed and thoughtful section of the community'. The enquiry was also to look at 'the patent medicine trade', where both the terms 'patent' and 'trade' would have been pejorative.⁷⁷ Among those consulted, 70 per cent said they were opposed to the patent trade, though it is clear from this and other surveys that many of these were taking patent medicines.⁷⁸ One complicating factor was

the public were uncertain over what was and was not a patent medicine, because of the convergence in styles of packaging and marketing across the pharmaceutical industry.⁷⁹ Most prejudice was against the heavily advertised, high-priced remedies that made bold, curative claims. Cheaper patent medicines were more acceptable if thought to be ‘harmless’, or as only offering ‘psychological cures’. In other words, placebo effects.

Conclusions

On 29 December 2017 the Royal College of General Practitioners (RCGP) issued a statement urging the British public ‘Not to call the doctor’. There was a specific context: the long Christmas break, but more significant were the longer-term pressures on the NHS’s frontline services due to funding not keeping up with inflation, increased demand and the specific pressure of winter illnesses.⁸⁰ The RCGP urged people to think ‘3 before GP’.⁸¹ The RCGP produced a poster for display in surgery waiting rooms. It was, needless to say, too late to change patients’ behaviour, so it was presumably aimed at encouraging those attending to remain ‘non-patients’ in the future. There was a similar appeal to adopt self-care in the early stages of the COVID-19 pandemic.

The RCGP advice was, first, to see if the illness could be dealt with by self-care; second, to seek help from reputable online resources; and third, to consult a pharmacist. It is not clear how successful this attempt to manage demand was, but what is certain is that it was unnecessary. The leaders of the RCGP were apparently unaware of the published work on the ‘symptom iceberg’. Nor, from their own practice experience, had GP leaders seemingly thought about the actions people had taken before arriving at their surgery for an appointment, though determining previous self-care measures is an important element in patient history taking. Questions about self-care are, of course, routine. Doctors need to know what, if any, medications have been taken as these could affect the presentation of signs and symptoms.

In the context of the problems in the NHS and the likely waiting time for a GP appointment, it is likely that self-care had been extensive. Interestingly, the RCGP has run an e-learning course, available to GPs

and the public, on 'Self Care for Minor Ailments'.⁸² The course is run in partnership with the Self Care Forum, a campaign and lobby group that 'aims to further the reach of self-care and embed it into everyday life'. Self-Care is defined as 'the actions that individuals take for themselves, on behalf of and with others to develop, protect, maintain and improve their health, wellbeing or wellness'. Their approach is framed as the self-care continuum, from 'pure self-care', with the individual responsible at one pole (essentially 'non-patient' actions), to 'pure medical care' and professional responsibility at the other.⁸³ There was a similar injunction to self-care in the early stages of the COVID-19 pandemic in the spring of 2020. People who believed they had the infection but with mild symptoms, were told to stay at home and manage their condition with antipyretics and rest. The aim was two-fold: to isolate the infected to prevent the spread of the disease; and to ease demand on health services.

There are important policy issues at stake if the RCGP, and the NHS more widely, is trying to change the terms of when, if indeed at all, people should see the doctor. And confusion too, because with cancers, mental illness and other conditions, people are told not to delay, as this makes the disease more difficult to treat. Clearly, those working in the health professions and its policy-makers, as well as medical historians, need to know more about the 'non-patient', their views and their actions, and the transition from 'non-patient' to patient. Such analyses ought to be informing initiatives such as the NHS 10-year plan announced at the beginning of 2019, a principal aim of which is making people healthier, more self-reliant for their healthcare, and not have to see their GP.⁸⁴

In this chapter I have argued that historians writing the 'medical history from below' need to be more radical and widen their gaze to consider self-care and self-treatment. Moreover, they should not regard this teleologically as a precursor to becoming a patient, but as an end in itself. One question raised in this chapter, and again which has been strangely neglected by historians of medicine, is the timing of the decision to seek a medical encounter and become a patient. That said, becoming a patient has been (and remains) a small part of the everyday experience of ill health. Nearly half-a-century on from Porter's manifesto, historians of medicine are still writing 'doctors' histories', in the sense that they use sources that focus on the interactions of a specific group of sick people – patients – with

the medical profession and its institutions. This approach misses over 80 per cent of healthcare today and no doubt a higher percentage historically. Furthermore, historians have tended to study the diseases that medicine prioritises. Histories are biased in favour of mortality over morbidity, acute over chronic disease, and serious over slight complaints. With each of these pairs, the latter was and is overwhelmingly the lived experience of illness and disease.

It would help too if there were more historical studies of minor and chronic diseases, far and away the common experience of illness, and fewer on serious, acute diseases. With the latter, medical sources and perspectives are almost always bound to predominate, while the view from below will necessarily be that of patients. If there were more studies of minor and chronic illnesses, as in this volume in the chapters by Georgia McWhinney and Coreen McGuire, Jaipreet Virdi and Jenny Hutton, there would be more opportunity to explore non-patient views and actions. As I have shown, the typical experience of minor illnesses is not to see the doctor. But that might still be considered a ‘deficit model’ framing. It would be more useful and accurate to say the experience of minor illness was (and remains) self-diagnosis and self-management, then perhaps self-treatment, and in one-in-twelve instances to see the doctor. The management of chronic conditions, where the notion of the ‘post-patient’ might be useful, is care as much, if not more than, treatment. With minor illnesses and chronic conditions there are opportunities for a new social history of medicine, where the ‘social’ is about the ‘parents, friends, neighbours, husbands or wives or other relatives’.

Notes

- * I would like to thank the editors of this volume, Anne Hanley and Jessica Meyer, for their comments on this chapter and for bringing the collection together. The discussions of my work at two meetings were extremely helpful: ‘Patient Voices’ in Oxford, September 2017; and ‘Healthcare before the Welfare State’ in Prague, March 2018. Thank you also to Dr Pete Smith for his kind permission to reproduce a graphic representing the ‘symptom iceberg’. And, finally, I would like to thank the Wellcome Trust for their support (grant no. WT 092782).

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