

“No Small Uncertainty”: Eye Treatments in Eighteenth-Century England and France

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In 1755, Mary Smaldrige, wife of a Plymouth mariner, consulted a local surgeon Edward Spry about her “morbid eye”. The violent pains failed to respond to the surgeon’s blistering, collyriums and calomel, and she turned to another physician with no better success, “her pain increasing rather than diminishing”. Spry then tried some drastic purges, he tells us: “but these disagreeing very much I was forced to return to my former method. I then cut a seton in her neck, which run very much; but all to no purpose and she became still more miserable.” After some months: “I judged her disease to be a Carcinoma, and therefore proposed cutting out the whole eye as the only remedy.” Having consulted several colleagues, Spry removed the eye and Mary experienced no further pain.¹ At least five medical opinions had been sought in this unfortunate case. Treatment was lengthy, debilitating and uncompromising in its conclusion. We do not know whether Mary shared the surgeon’s verdict on its eventual success, or how far she directed the course of her treatment, but we can glimpse her pain, anxiety and persistence.

Eye ailments are a common theme in early modern accounts of illness.² Oculists were among the first practitioners to be called upon by English parish overseers, and eye complaints make regular appearances in Poor Law records.³ French medical and charitable writings point to a similar concern with eye disease in France, and its potentially devastating effect on people’s lives. This article offers a preliminary exploration of eye disease and treatment in eighteenth-century England and France. It examines people’s expectations and experiences of treatments, and the context of their choice of practitioners. In particular, it emphasizes the risks surrounding eye disease which patients and practitioners alike had to negotiate.

Sources

Eye disease attracted considerable attention in England and France during the eighteenth century, stimulated by two developments. The first of these was the debate over

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¹ Royal Society, *Philos. Trans.*, 1755–6, 49: 18–21.

² Lucinda Beier, *Sufferers and healers: the experience of illness in seventeenth-century England*,

London, Routledge & Kegan Paul, 1987, p. 140; R C Latham and W Matthews (eds), *The diary of Samuel Pepys*, 11 vols, London, Bell, 1970–83, vol. 9, pp. 247, 252, 556, 564–5.

³ Joan Lane, ‘The provincial practitioner and his services to the poor, 1750–1800’, *Soc. social Hist. Med. Bull.*, 1981, no. 28, pp. 10–14; Margaret Pelling, ‘Healing the sick poor: social policy and disability in Norwich 1550–1640’, *Med. Hist.*, 1985, 29: 115–37; E G Thomas, ‘The Old Poor Law and medicine’, *Med. Hist.*, 1980, 24: 1–19, on p. 2.

the “Molyneux Problem”, inspired by Locke’s *Essay concerning human understanding* of 1690.⁴ Its question—whether a man born blind would be able to see instantly if his blindness were cured—aroused curiosity beyond the world of sensualist philosophy in both England and France. The London surgeon William Cheselden’s pioneering artificial pupil operation of 1728 offered just such a case of sight restored, and became an important reference point for eighteenth-century ophthalmic writings. Numerous surgeons and oculists were keen to present their own “Molyneux” cases, sometimes with full rehearsal of the philosophical arguments. These cases offered surgeons not only the opportunity for public demonstration of their ultimate ophthalmic skill—giving sight to the blind—but also for direct contribution to a high-profile intellectual debate.⁵ Lively surgical debate was also inspired by Jacques Daviel’s proposal of cataract extraction as an alternative to the traditional couching treatment, which he reported to the Académie Royale de Chirurgie in 1753.⁶ Ophthalmic writings during the second half of the century gave detailed attention to cataracts, weighing up the arguments for and against extraction and offering refinements of operating techniques and instruments, as well as advice on handling complications.⁷ Much of the discussion came from France, perhaps reflecting the initial interest taken by the Académie Royale de Chirurgie.⁸ As with the “Molyneux Problem” though, the debate crossed the Channel freely. London surgeons such as Samuel Sharp in the middle of the century, and later James Ware, were keen contributors.⁹ The ophthalmic treatises give a prominence to major surgical operations in their case histories which was unlikely to reflect the profile of average provincial practice.¹⁰ On the other hand, there is no evidence that the leading surgeons operated within a different therapeutic framework: humoral interpretations encountered little challenge, and maintained a common basis of medical understanding throughout the century.

⁴ John Locke, *Essay concerning human understanding*, 1690, London, Dent, 1993, pp. 80–1; William R Paulson, *Enlightenment, romanticism, and the blind in France*, Princeton University Press, 1987, pp. 21–4.

⁵ William Cheselden, ‘An account of some observations made by a young gentleman, who was born blind, or lost his sight so early, that he had no remembrance of ever having seen, and was couch’d between 13 and 14 years of age’, *Philos. Trans.*, 1727–8, 35: 447–52; Jean Janin, *Mémoires et observations anatomiques, physiologiques et physiques sur l’oeil, et sur les maladies qui affectent cet organe*, Lyons, chez les frères Perisse, 1772, pp. 213–24; James Ware, *Observations on the cataract and gutta serena*, 3rd ed., London, J Mawman, et al., 1812, pp. 337–50. The case was read before the Royal Society in 1801.

⁶ Couching involved lowering the lens from the line of vision, using a needle. Extraction removed the lens, via an incision in the cornea. Jacques Daviel, ‘Sur une nouvelle méthode de guérir la cataracte par l’extraction du cristallin’, *Mémoires de l’Académie Royale de Chirurgie*, 1753, 2: 337–54.

⁷ Louis Florent Deshais Gendron, *Traité des*

maladies des yeux, Paris, Claude J B Herissant, 1770, vol. 2, pp. 288–301; Pierre Guérin, *Traité sur les maladies des yeux*, Lyons, Widow of Reguilliat, 1769; Janin, op. cit., note above 5 pp. 266–7; Ware, op. cit., note 5 above, pp. 263–4, 353–4.

⁸ M La Faye, ‘Mémoire pour perfectionner la nouvelle méthode de faire l’opération de la cataracte’, *Mémoires de l’Académie Royale de Chirurgie*, 1753, 2: 563–72; Morand and Verdier, ‘Rapport des opérations de la cataracte par l’extraction du cristallin’, *ibid.*, pp. 578–83.

⁹ ‘Extracts of two letters of Thomas Hope MD to John Clephane, MD FRS concerning Monsieur Daviel’s method of couching a cataract’, *Philos. Trans.*, 1751–2, 47: 530–3; Samuel Sharp, ‘A description of a new method of opening the cornea in order to extract the crystalline humour’, *ibid.*, 1753, 48: 161–3; Ware, op. cit., note 5 above, pp. 263–5.

¹⁰ Irvine Loudon, ‘The nature of provincial medical practice in eighteenth-century England’, *Med. Hist.*, 1985, 29: 1–32; Toby Gelfand, ‘Deux cultures, une profession: les chirurgiens français au XVIIIe siècle’, *Rev. Hist. Mod. Contemp.*, 1980, 28: 468–84.

The possibility of curing blindness also featured in more anecdotal news writing. Daviel's extraction technique, for example, found its way into the *Gentleman's Magazine*, alongside accounts of more esoteric ailments such as colour blindness, and night blindness.¹¹ These accounts belong to the broadening range of scientific and humanitarian discussion disseminated to the reading public.¹² Like the medical sources, accounts may manipulate the patient's experience for specific purposes—whether to emphasize a philosophical point or medical success, or to recount an interesting news item. But they occasionally reveal the more immediate dynamics of illness and treatment.

Turning to the incidence of eye disease, the institutions for the blind offer useful, if limited, evidence. During the 1790s blind schools were established in Liverpool, Bristol, Edinburgh and London, following the creation of Valentin Haüy's pioneering Institution des Jeunes Aveugles in Paris in 1784.¹³ Paris also had the medieval Quinze-Vingts asylum for the blind, and Zina Weygand's study of medical records for the early nineteenth century provides a valuable survey of eye disease and treatments there.¹⁴ None of these institutions had medical priorities and evidence is patchy. It is also confined to the 1790s and 1800s, though there is no reason to believe that the causes of blindness had changed significantly from earlier in the century. These sources provide a valuable counterbalance to the medical writings: if the latter are more inclined to present success stories, the blind applicants to the institutions bore witness to medicine's limitations.

Profile of Eye Disease

A limited core of major eye diseases emerges, the commonest being cataracts, ophthalmia, gutta serena, and fistula lachrymalis.¹⁵ Cataracts affected old and young alike.¹⁶ We find numerous childhood cataracts among the case histories and at the blind schools, and their significance is acknowledged in medical debate, particularly later in the century, over the best approach to treatment.¹⁷ At the other end of the life-cycle, Paris surgeons found a ready source of cataract practice among the elderly soldiers of Les Invalides, and the ophthalmic case histories also suggest a high proportion of middle-aged and elderly cataract sufferers.¹⁸

¹¹ *Gentleman's Magazine*, 1763, 33: 438; 1779, 49: 554; 1787, 57: 1098; 1792, 62: 608.

¹² Jeremy Black, *The English press in the eighteenth century*, London, Croom Helm, 1987, p. 266; Daniel Roche, *Les républicains des lettres, gens de culture et lumières au XVIIIe siècle*, Paris, Fayard, 1988, pp. 205–16; Roy Porter, 'Lay medical knowledge in the eighteenth century: the evidence of the *Gentleman's Magazine*', *Med. Hist.*, 1985, 29: 138–68.

¹³ For this article, I have drawn upon the early records of the London School for the Indigent Blind, comparing findings with Michael Royden's bicentenary monograph on the Liverpool School: London School for the Indigent Blind, St George's Southwark, *Minute book 1800–1809*; Michael W Royden, *Pioneers and perseverance. A history of the Royal School for the Blind, Liverpool, 1791–1991*,

Birkenhead, Countywise, 1991.

¹⁴ Zina Weygand, *Les causes de la cécité et les soins oculaires en France au début du XIXe siècle, 1800–1815*, Vanves, CTNERHI, 1989.

¹⁵ Royden, op. cit., note 13 above, p. 272; Weygand, op. cit., note 14 above, pp. 90–1, 144–5, 70–1.

¹⁶ La Faye, op. cit., note 8 above, pp. 563–72; Morand and Verdier, op. cit., note 8 above, pp. 578–83; Royden, op. cit., note 13 above, p. 272; Weygand, op. cit., note 14 above, pp. 77–90.

¹⁷ Noel S C Rice, 'John Cunningham Saunders (1773–1810): his contribution to the surgery of congenital cataracts', *Hist. Ophthalm.*, 1992, 5: 43–8; Ware, op. cit., note 5 above, pp. 353–4.

¹⁸ M La Faye, op. cit., note 8 above, pp. 563–72; Morand and Verdier, op. cit., note 8 above, pp. 578–83; Weygand, op. cit., note 14 above, pp. 90–2.

Ophthalmia was a general category, covering most inflammations of the eye, and surgeons made sophisticated distinctions between different types, as they did for cataracts.¹⁹ Ophthalmia could arise either in isolation, or through diseases such as syphilis. Occasionally it struck in epidemic form, the most dramatic example being the Egyptian Ophthalmia, which beset the French and British forces during Napoleon's Egyptian campaign (1798–1802), ultimately leaving many thousands blind across Britain and Europe.²⁰ Lower-key outbreaks of ophthalmia were a chronic problem, especially at sea.²¹

As with cataracts, children were vulnerable to ophthalmia, both from congenital venereal infections and through the classic childhood illnesses such as measles, scarlatina and scarlet fever.²² These causes were seldom identified by sufferers and their families; instead we hear accounts from the blind school applicants of "fevers" and convulsions.²³ Still more devastating was smallpox, which, despite inoculation and later vaccination, remained a major cause of childhood blindness into the early nineteenth century.²⁴ The numerous cases for which we have details support the contemporary view that blindness was linked to contracting the disease at a very early age.²⁵ Others, though not blinded, were left with severe ophthalmia, abscesses or corneal scars.²⁶

Gutta serena denoted any blindness which left the appearance of the eye unaffected, and was attributed to various causes, including palsy of the optic nerve and venereal disease.²⁷ The modern glaucoma probably also came into this category.²⁸ Fistula lachrymalis was specifically a sinuous ulcer of the lachrymal sac or duct, but the term was more broadly applied to any obstruction of the tear duct.²⁹ It was another frequent after-effect of smallpox. To this main set of ailments should be added numerous common accidental eye injuries, through falls, knocks, burns or sharp instruments.

¹⁹ See for example, Charles de Saint-Yves, *Nouveau traité des maladies des yeux*, Amsterdam, chez François l'Honoré, 1736, pp. 132–65 (first published in 1722). Deshais Gendron, *op. cit.*, note 7 above, vol. 2, pp. 2–36; Robert Morris, James Kendrick, *et al.* (eds), *Edinburgh medical and physical dictionary*, Edinburgh, Bell and Bradfute, 1807, Cataract.

²⁰ G Cornand and J P Renard, 'L'Ophtalmie des armées au XIXe siècle', *L'Ophtalmologie des origines à nos jours*, 1979, 2: 110–24; François Natali, 'Les affections oculaires à la succursale des Invalides d'Avignon au début du XIXe siècle', *ibid.*, pp. 91–4.

²¹ *Gentleman's Magazine*, 1772, 42: 89; Larry Stewart, 'The edge of utility: slaves and smallpox in the early eighteenth century', *Med. Hist.*, 1985, 29: 54–70, p. 64; Royden, *op. cit.*, note 13 above, p. 28; J P Bailliant, 'Autour d'une conjonctivite épidémique en 1819—une conception originale de la médecine expérimentale', *L'Ophtalmologie des origines à nos jours*, 1979, 2: 95–7.

²² Weygand, *op. cit.*, note 14 above, p. 123.

²³ London School, *op. cit.*, note 13 above, p. 50.

²⁴ Royden, *op. cit.*, note 13 above, pp. 272–3;

Pierre Darmon, *La longue traque de la variole*, Paris, 1986, pp. 40–9, 57–61.

²⁵ Berthold Lowenfeld, *The changing status of the blind: from separation to integration*, Springfield, IL, Charles C Thomas, 1975, pp. 49–61; London School, *op. cit.*, note 13 above, pp. 53–4, 66; Weygand, *op. cit.*, note 14 above, pp. 108–9.

²⁶ Deshais Gendron, *op. cit.*, note 7 above, vol. 2, p. 8; Jean-Louis Petit, *Traité des maladies chirurgicales*, 1790, in *Oeuvres complètes*, Paris, 'Dans toutes les librairies médicales', 1837, p. 479; Jean-François Gleize, *Règlement de vie*, Orléans, Jacob l'aîné, 1787, p. 90; James Ware, *Remarks on the fistula lachrymalis*, London, printed for Charles Dilly, *et al.*, 1798, pp. 50, 53.

²⁷ Morris, Kendrick, *et al.*, *op. cit.*, note 19 above, Amaurosis.

²⁸ Though the older use of the term glaucoma for certain types of cataract was virtually obsolete, glaucoma had not yet acquired the modern medical meaning.

²⁹ Samuel Sharp, *A treatise on the operations of surgery*, 6th ed., London, printed for J & R Tonson and S Draper, 1751, p. 174; Morris, Kendrick, *et al.*, *op. cit.*, note 19 above, Fistula Lachrymalis.

The social profile of eye disease is not easy to establish. Applicants to the Quinze-Vingts and the English blind schools were by definition indigent, and there are clearly difficulties in making any quantitative assessment based on the ophthalmic case histories. Smallpox certainly had a broad social impact, but with many of the childhood illnesses, as with ophthalmia more generally, crowded living conditions and poor diet probably made the poor vulnerable.³⁰ On the other hand, the growing number of medical treatises on the eye in the eighteenth century, and the profile of eye care in court circles, suggest that the privileged as well as the poor felt themselves at risk. Oculists held royal appointments at the English court from the Restoration onwards, and French surgeons were equally keen to develop their aristocratic connections.³¹

The Search for Cure

The eye, as an external organ, fell within the surgeon's province, though patients might turn first to an apothecary for a collyrium or topical treatment, and there is occasional evidence for physicians involving themselves in eye treatment.³² Patients could also resort to itinerant oculists, particularly for cataract couching, which held a significant place in itinerant practice throughout the early modern period.³³ The prominence of itinerants is acknowledged in the complaints of surgeons, particularly earlier in the century, that eye surgery had fallen into the hands of "charlatan oculists".³⁴ In France the surgical establishment fought hard to reclaim this ground, and ocular surgery achieved some official recognition in 1765, with the creation of a chair at Saint-Côme. Matthew Ramsey suggests that this did not succeed in regularizing provincial practice, and the itinerant market certainly continued to thrive.³⁵ The more famous (or notorious) of the itinerants, such as John Taylor, travelled widely and provided another level of cross-channel interchange in ophthalmic practice.³⁶

Less apparent from the medical sources is the range of preliminary or complementary "self-help" approaches which people might adopt. Certainly collyriums and similar treatments for ophthalmia are found in contemporary household receipt books alongside

³⁰ See for example, Ruth McClure, *Coram's children: the London Foundling Hospital in the eighteenth century*, New York and London, Yale University Press, 1981, p. 210.

³¹ Eric Jameson, *The natural history of quackery*, London, Michael Joseph, 1961, pp. 79–80; P Bec, Ph Grosset, J L Arrie, 'Dominique Anel, ophtalmologiste et chirurgien Toulousain', *L'Ophtalmologie des origines à nos jours*, 1981, 3: 125–9.

³² For example, the Paris physician Antoine Petit included lectures on eye diseases among his Jardin du Roy courses: Antoine Petit, *Cours de maladies internes, traitées par M^{re} Petit, Docteur & Professeur de Médecine au Jardin du Roy*, student lecture notes by Poinsot, Wellcome Institute Library, Western Manuscript, 3844, Paris, vol. V, 1768–9; Janin, *op. cit.*, note 5 above, pp. 295–8.

³³ Arnold Sorsby, 'Richard Banister and the

beginnings of English ophthalmology', in E Ashworth Underwood (ed.), *Science, medicine and history: essays on the evolution of scientific thought and medical practice written in honour of Charles Singer*, 2 vols, London, Oxford University Press, 1953, vol. 2, pp. 42–55, on pp. 51–4; Roy Porter, *Health for sale. Quackery in England 1660–1850*, Manchester University Press, 1989, pp. 65–6; Matthew Ramsey, *Professional and popular medicine in France, 1770–1830*, Cambridge University Press, 1988, pp. 25–6.

³⁴ Sharp, *op. cit.*, note 29 above, p. 167; Saint-Yves, *op. cit.*, note 19 above, p. 5.

³⁵ Ramsey, *op. cit.*, note 33 above, p. 25.

³⁶ See for example, R Dupont-Barron, 'L'Ophtalmologie en Franche-Comté au XVIIIe siècle', *L'Ophtalmologie des origines à nos jours*, 1979, 2: 83–9.

other home remedies.³⁷ For France, other sources hint at the persistence of religious healing. Holy springs and special stones were used to cure eye disorders, and a number of saints (the Saint Lucies and Saint Claires in particular) had special associations with healing the eye.³⁸ Though religious healing is less evident for England, Mary Fissell and Michael MacDonald suggest that some spiritual healing traditions lingered, particularly among the poor and in evangelical communities.³⁹

Given this range of therapeutic options, and the lesser visibility of some to the historian, we should be wary of mistaking the view which ophthalmic case histories offer for the whole picture. However, they do allow a tentative assessment of the way people used formal treatment. The stories are long and often harrowing. The *Philosophical Transactions* for 1757 reported the case of thirteen-year-old John Law, of Fenny-Stanton, “a strong and robust lad”. When he suffered a sudden violent pain in his eye at Easter 1756, while beating dung, his widowed mother “followed the direction which she received, without the least benefit to her child, after having, besides other expenses, been defrauded by a quack of two guineas, a great sum for a poor cottager.” Having heard of a cure in another local case, she took her son to Huntingdon to consult a surgeon, who advised that “immediate extirpation” of the eye was necessary. Two further surgeons were consulted before the drastic solution was agreed. Further treatments were then sought for complications—“fungous excrescences” and “an intermittent fever”. Here was a “poor cottager” prepared to seek multiple medical opinions for her son and agreeing eventually to drastic, and presumably costly, treatment.⁴⁰

The treatment of an elderly patient of Jean Janin, a Lyons surgeon, though less drastic in its outcome, was equally uncertain in its course. M. Sautou, father of a Carcassonne leather dresser, suffered a cataract in his early sixties, and was successfully couched in 1751:

The following year, bending down to pick up his handkerchief, this man found himself suddenly deprived of sight, by the cataract rising. He hastened at once to the surgeon-oculist who had already operated on him, who proceeded to do a second couching, with the needle, which was as successful as the first time. In the space of a year and a half, this cataract rose again on two different occasions, which necessitated two new operations, which were carried out in the same way. This man then enjoyed his sight until March 1760, when he fell off his horse. As his head struck the ground in this rapid fall, it created such a strong disturbance in the eye, that the cataract, which had been lodged for more than six years in the front of the posterior chamber, rose again, passed through the pupil, and lodged in the anterior chamber, where it occupied most of the space.

Now aged seventy-two, the man was brought by his son to Janin, who performed a successful extraction, which “left the patient the certain hope of recovery of the sight, of which he had so often been deprived by the rising of this altered lens.”⁴¹

³⁷ See for example, *English receipt book of Elizabeth Smith*, c.1700, Wellcome Institute Library, Western Manuscript, 6956, p. 51.

³⁸ François Lebrun, *Se soigner autrefois. Médecins, saints et sorciers au XVIIe et XVIIIe siècles*, Paris, Temps Actuels, 1983, pp. 80–2, pp. 110–14; Jean Ladame, *Les saints de la piété populaire*, Paris, 1985, pp. 226–8; Michel H Faure et G Girard, ‘Quelques éléments de l’ophtalmologie traditionnelle en Savoie au cours des siècles’, *L’Ophtalmologie des origines à nos jours*, 1983, 4: 155–61.

³⁹ Michael MacDonald, ‘Religion, social change, and psychological healing in England, 1600–1800’, in W J Shields (ed.), *The church and healing*, Oxford, published for the Ecclesiastical History Society by Basil Blackwell, 1982, pp. 101–25; Mary Fissell, *Patients, power, and the poor in eighteenth-century Bristol*, Cambridge University Press, 1991, pp. 171–82.

⁴⁰ *Philos. Trans.*, 1757–8, 50: 747–52.

⁴¹ Janin, op. cit., note 5 above, pp. 266–7.

These cases highlight several recurring themes. Multiple consultations, either at the same time or successively, were common, as was the patient's story which stretched back over a number of years, perhaps with intermittent "cures". Underlying this is the sense of the patient's vulnerability in facing the hazards of daily living. These and other cases indicate that the surgeons treated patients from a broad social spectrum: merchants, artisans, aristocrats, servants. It is admittedly fairly rare to encounter French cases relating to peasants, though not all patients are described by their status or occupation.

For England, other evidence also suggests a strong response to eye afflictions and a ready resort to formal medical aid.⁴² It is tempting to attribute this to the eighteenth century's growing concern with health,⁴³ but the widespread use of oculists claims earlier roots. Margaret Pelling notes that the oculist Richard Banister was one of the first practitioners to be used by the Norwich city authorities at the turn of the seventeenth century.⁴⁴ Arnold Sorsby's analysis of Banister's ophthalmic contemporaries shows that he was by no means an isolated case: there were numerous other itinerants couching cataracts.⁴⁵ Nor does it seem appropriate to interpret the extensive use of formal eye care as a response to medical "progress": it was not until the second half of the century that the new techniques of extraction and iridectomy were being adopted, and even then they met with mixed success.⁴⁶

The persistent searches for eye remedies were more closely linked to patients' anxieties than to developments in medical practice. Fear of the loss of sight seems to have outweighed any underlying fatalism or doubts concerning medical capabilities. The stories of successions of fruitless treatments tell of a need to hold on to even the faintest hope. Popular wisdom might mock the squinting and the one-eyed, but blindness was seldom a subject of levity: "Bigne, borgne, bossu, boîteux" (squinting, one-eyed, hump-backed, lame) formed a popular group in French proverbs of denigration and mistrust, but "He who loses his eyes, loses all", "Better to be a half-wit than blind".⁴⁷ The high proportion of surgeons' case histories relating to children, with their poignant hints of parents' anxiety, provides a further indication of the fears which eye disease aroused.

Harder to assess is the extent of people's fear of disfigurement, though there is suggestive indirect evidence. Hogarth, like the French proverbs, gives us the popular image of the one-eyed or squinting as villain. Physiognomy too, even in its shift towards countenance as its interpretative basis, confirmed the social importance of the sound eye.⁴⁸ Cultural representation is difficult to relate to people's direct experience of illness,

⁴² Thomas, *op. cit.*, note 3 above, p. 2; Lane, *op. cit.*, note 3 above, pp. 10–14.

⁴³ C J Lawrence, 'William Buchan: medicine laid open', *Med. Hist.* 1975, 19: 20–35; Roy Porter and Dorothy Porter, *In sickness and in health: the English experience 1650–1850*, London, Fourth Estate, 1988, pp. 21–42.

⁴⁴ Pelling, *op. cit.*, note 3 above, p. 121.

⁴⁵ Sorsby, *op. cit.*, note 33 above, pp. 51–4.

⁴⁶ Morris, Kendrick, *et. al.*, *op. cit.*, note 19 above, Cataract.

⁴⁷ Françoise Loux and Philippe Richard, *Sagesse du corps: la santé et la maladie dans les proverbes français*, Paris, G-P Maisonneuve et Larose, 1978, p. 312.

⁴⁸ See Hogarth's Bridewell scene of *The harlot's progress* (c.1732), *The rake's progress* (c.1735), plate 5, and *Industry and idleness* (c.1749), plates 9 and 10, in Joseph Burke and Colin Caldwell (eds), *Hogarth: the complete engravings*, London, Thames and Hudson, 1968, plates 137, 156, 211 and 212; Jean-Jacques Courtine and Claudine Haroche, *Histoire du visage: exprimer et taire ses émotions, XVIe—début XIXe siècle*, Paris, Rivages, 1988, pp. 118–19, 140–1; Yves-Marie Bercé, *Le chaudron et la lancette: croyances populaires et médecine préventive, 1798–1830*, Paris, Presses de la Renaissance, 1984, p. 102.

but there are occasional reminders of its social impact. The Paris surgeon Bordenave describes his treatment in 1764 of a 21-year-old man for a severely deformed eye-lid, noting that the young man had been refused admittance to holy orders because of his condition.⁴⁹ The aristocratic interest shown in Dominique Anel's new fistula lachrymalis treatment at the beginning of the century may also reflect concerns regarding disfigurement.⁵⁰

Constraints and Choices

It is likely that many patients' choice of treatment was influenced by practical or financial constraints, but poverty did not always preclude access to expensive medical care. Warwickshire parishes in the later eighteenth century not only paid for treatment for their ophthalmic cases at Banbury and Coventry, but also for the patients' board and lodging while there.⁵¹ The *hôtels-Dieu* in France or the English local hospitals, where these were in place, provided further opportunity for the poor to obtain medical attention. Despite significant local variations, the English poor were more likely to obtain support for their eye treatments than their French counterparts, who often seem to have been wretchedly impoverished by their outlays before any charitable assistance became available. Auguste Dupeigne, a former soldier applying to the *Quinze-Vingts* after ineffectual treatments, had been forced to sacrifice "all his remaining savings and even his furniture for his treatment", and he was by no means an isolated example.⁵² Janin treated a young Languedoc peasant in 1768 who had been blinded in one eye at the age of six, and in the other four years later through an accidental blow while playing. The resulting ophthalmia had been left untreated "through want of resources" and it was not until he was seventeen that treatment was sought for him.⁵³ The Fulham overseers, on the other hand, paid seven shillings in relief to a couple in 1776 "while under the care of Baron de Wenzell for the eyes".⁵⁴ De Wenzell was the royal oculist.

The access of people on poor relief to the royal oculist is not as bizarre as it first appears. Professional interests and philanthropic concerns found useful common ground here. De Wenzell had a reputation for his readiness to treat the poor, and a generation later James Ware gave his time and medical expertise to the London School for the Indigent Blind.⁵⁵ In France, Daviel also had a reputation for treating "malades indigents".⁵⁶ For an ambitious surgeon or oculist, a good reputation depended on attracting patients with a high social profile, but this in turn required underlying credibility and proof of experience. Itinerant practitioners, sensitive to the charges which itinerancy attracted, justified it

⁴⁹ Bordenave, 'Mémoire dans lequel on propose un nouveau procédé pour traiter le renversement des paupières', *Mémoires de l'Académie Royale de Chirurgie*, 1774, 5: 97–128, on p. 106.

⁵⁰ Bec, Grosset, Arne, op. cit., note 31 above, pp. 125–9.

⁵¹ Lane, op. cit., note 3 above, pp. 10–14.

⁵² Weygand, op. cit., note 14 above, p. 296. However, petitioners may well have dramatized their predicament, to present a more persuasive case for admission.

⁵³ Janin, op. cit., note 5 above, p. 200.

⁵⁴ A L Wyman, 'Baron de Wenzell, oculist to King George III: his impact on British ophthalmologists', *Med. Hist.*, 1991, 35: 78–88, on p. 87.

⁵⁵ London School, op. cit., note 13 above, p. 68; R Rutson James, *Studies in the history of ophthalmology in England prior to the year 1800*, Cambridge University Press, published for the *British Journal of Ophthalmology*, 1933, pp. 104–6.

⁵⁶ Denis Diderot, *Additions à la lettre sur les aveugles*, c. 1782, in *Oeuvres complètes*, Paris, Pléiade, 1969, vol. 2, pp. 223–4.

explicitly in terms of the breadth of experience which it offered. Here is the maverick “Chevalier” John Taylor:

... I must beg leave to observe thus much in my Favour, that the late tedious Progress I have taken, which I find has given to some a Cause of Objection, has been the only Means and Foundation of my knowledge and Improvement, as it has furnish'd me with an Opportunity of making my Remarks upon a greater number of subjects, in a few Years, than the whole Series of my life, in a Settled Way, could possibly have afforded me.⁵⁷

Poor patients thus had an ambivalent relationship with their surgeons or oculists: on the one hand they might receive free or bargain treatment through charitable or practical motives, but they could also find themselves in the hands of an inexperienced practitioner in search of practice.

The sheer variety of eighteenth-century practitioners offering eye care suggests that the style of treatment must have influenced the patient's choice. Handbills of many itinerants promised dramatic cures, based on their wealth of experience, “true” knowledge, and the profile of their satisfied clients.⁵⁸ The developing provincial press provided a channel for advance publicity, whilst on arrival elaborate attempts were made to attract public attention.⁵⁹ More sober practitioners hit out hard against this style of practice, and the reaction of the medical and surgical establishments to fringe practitioners in both England and France has been well documented.⁶⁰ Behind the claims of wonder cures, critics exposed tricks, incompetence and the rapid exit before failures were exposed (a recurring charge against itinerants). The Lyons surgeon Pierre Guérin described the conclusion of a typical Taylor treatment: “. . . he would exult; he would proclaim a miracle; he plugged the eye with firm recommendation not to uncover it until after five or six days, and he left on the fourth, after having exploited the victims of his bad faith.”⁶¹ Yet people from a wide social spectrum continued to turn to the itinerant oculists, and towns continued cautiously to permit their visits.⁶² To some extent their popularity may simply reflect the inability of regular surgeons to satisfy the demand for eye treatments, particularly couching. But the interpretation of beliefs and expectations is complex. If some were attracted by the itinerants' exotic appeals, buying the service was not necessarily accepting all the claims. In a sense, the oculist's sales talk belonged to the market-place and was perhaps no more or less heeded than anybody else's.

Roy Porter's study of quackery shows the inadequacy of interpreting itinerant practice with yet another differentiation of “good” and “bad”, the bona fide and the out-and-out charlatan.⁶³ Taylor's ambivalent reputation illustrates the problem. Guérin waxed lyrical about the tricks “cet homme rusé” used on poor unsuspecting patients to feign cures.⁶⁴ The Edinburgh medical establishment was equally trenchant in its criticism.⁶⁵ On the other hand, Taylor had trained at St Thomas's with Cheselden, demonstrated a fair anatomical

⁵⁷ John Taylor, *A new treatise on the diseases of the crystalline humour of a human eye*, London, printed for James Roberts, 1736, pp. ij–ijj.

⁵⁸ Jameson, *op. cit.*, note 31 above, p. 80; Dupont-Barron, *op. cit.*, note 36 above, p. 87.

⁵⁹ Dupont-Barron, *op. cit.*, note 36 above, p. 85; Jameson, *op. cit.*, note 31 above, pp. 84–5.

⁶⁰ J-P Goubert, ‘L'art de guérir: médecine savante et médecine populaire dans la France de 1790’,

Annales ESC, 1977, 22, pt 2: 908–26, on p. 916; Porter, *op. cit.*, note 33 above, pp. 2–17.

⁶¹ Guérin, *op. cit.*, note 7 above, p. 276.

⁶² Ramsey, *op. cit.*, note 33 above, pp. 25–6; Lebrun, *op. cit.*, note 38 above, p. 101.

⁶³ Porter, *op. cit.*, note 33 above, pp. 1–18, 69–71.

⁶⁴ Guérin, *op. cit.*, note 7 above, p. 276.

⁶⁵ Jameson, *op. cit.*, note 31 above, p. 88.

knowledge of the eye, and is credited with initiating successful surgical treatment of squinting. One French surgeon reckoned his “hand was as light as it was sure” in operations.⁶⁶ If some of the criticisms of Taylor reflected distaste for a flamboyant personality, the less extravagant Baron de Wenzell, Taylor’s successor at court, attracted similar criticisms of incompetence and secrecy, albeit less forcefully.⁶⁷

The contradictions within these men’s reputations reflected a fundamental problem with eye treatment, which itinerant couching exemplifies. As a precise, self-contained, surgical skill, with high potential value for patients, couching held an understandably important place in itinerant practice. But its uneasy combination of dramatic potential and patient anonymity reflected the difficulty inherent in the relationship between oculist and patient. The risk of blindness, whether sight lost through treatment, or simply not regained, meant that the stakes were high. The dilemma for patients and oculists alike was that while cure was sometimes possible, as the case histories show, it was never a foregone conclusion. The buffer of distance, both personally and physically from the patient, was probably a prudent survival technique for practitioners operating in this sensitive field.

Disappointed hopes and the desperate prospect of blindness turned the miracle-working oculist into the demon predator: “At last, the mask falls, the man is left and the hero vanishes”, the surgeon at Les Invalides at Avignon noted cynically, in his description of another renowned itinerant, Joseph Forlenze, in action.⁶⁸ Thus we are presented with the satirical picture of Taylor standing over his patient in devilish pleasure as he undertakes the cure of: “all weak and tender eyes that cannot bear the light . . . so that in a few days a great light shall not affect them . . .”.⁶⁹ Other types of “quack” attracted satire, but with the oculist it was particularly highly charged.⁷⁰

Negotiating the Risks

Itinerant oculists were condemned by the surgical establishment for their specialization, which ran counter to humoral therapeutics. But more astute surgeons recognized that to some extent they had only themselves to blame for the itinerants’ prominent position. Here is a French medical student, Poincot, recording the Parisian physician Antoine Petit’s eye lectures in 1768:

The [eye] maladies are currently treated by charlatans who are called oculists; doctors have doubtless abandoned this area because they have been alarmed by the considerable number of ailments, the difficulty of recognising and verifying them, and by the inevitability of some of them.⁷¹

Earlier in the century Charles de Saint-Yves had protested against this neglect of eye disease by surgeons, making a plea for specialization:

⁶⁶ G Bonneval, ‘La strabologie à travers les âges’, *L’Ophthalmologie des origines à nos jours*, 1981, 3: 87–90, on p. 89; Loudon, *op. cit.*, note 10 above, pp. 2–3; Jameson, *op. cit.*, note 31 above, pp. 89, 93, quotation p. 89; Porter, *op. cit.*, note 33 above, pp. 66–82.

⁶⁷ Wyman, *op. cit.*, note 54 above, pp. 81, 84, 87.

⁶⁸ Weygand, *op. cit.*, note 14 above, p. 276; Porter, *op. cit.*, note 33 above, p. 69.

⁶⁹ Jameson, *op. cit.*, note 31 above, p. 87.

⁷⁰ William Paulson has analysed the appeal of this ambivalence to the literary imagination: Paulson, *op. cit.*, note 4 above, pp. 73–89.

⁷¹ Petit, *op. cit.*, note 32 above.

for to consider the great number of diseases which attack the eye, and the delicate operations which their cures demand, it seems that in view of the difficulty of this science, it is doing little to devote oneself to it entirely.⁷²

Samuel Sharp recognized more explicitly, in his discussion of cataract couching, that fear of complications, together with “the uncertainty there always is of Success after the Operation, have deterr’d most surgeons from undertaking it, and ’till lately from studying the nature of the disease” though he was hopeful that the situation was improving:

but I fancy the Operation will come into greater Repute when more generally practis’d by Men of good Character; for it is less the Difficulty, than the Abuse of it by Pretenders, which has brought it into Discredit.⁷³

The length and complexity of many of the ophthalmic cases which surgeons recount highlight the uncertainty which both patient and practitioner had to negotiate. Above all the cases show the fine line between minor and major illness. Ophthalmia could be a minor self-limiting eye inflammation, or it could leave the sufferer permanently blind; fistula lachrymalis could be a simple blocked tear duct, or the start of a major abscess which lasted months or even years, leading to blindness or permanent disfigurement. Surgeons acknowledged these risks in their emphasis on vigilant monitoring of symptoms, to identify and alert the patient to potential complications. They also stressed the exactitude needed in preparing and managing the patient. Saint-Yves again:

The Operation of the cataract is far from indifferent because of its unfortunate consequences. Its success depends no less on the dexterity of the operator than on an intire state of mind and body in the patient; he must be prepared well before the operation, by bleeding, bathing, cooling broths, and light purges.⁷⁴

Most ophthalmic writers made similar recommendations, with detailed directions down to the preferred time of year (spring) and weather (fine and dry) for eye surgery. Care following the operation was also based on a strict regimen, and typically lasted several weeks or longer.

This intricate, finely-tuned treatment (if in practice fairly standardized) provided an opportunity for the practitioner to transfer some of the risk back to the patient, through shared responsibility. Its interpretative basis recognized the precarious balance of patients within their environment, and perhaps helped to prepare both parties for the consequences of accidents and inadvertence which frequently dogged treatments. Patients recovering from eye surgery faced many hazards—falls, windows left accidentally open, a glancing blow to the head while dressing—any of which could set off a chain of complications, often with dire consequences. Sometimes the patient was directly responsible, as in this tragic Orphean tale from Jean Janin. In 1757 he operated on Simon, a stonemason, who had had cataracts in both eyes for ten years. All went well until the sixth day:

This man, impatient to see his wife and children, opened his eyes, and, despite the strength of the sunlight which he felt on his eyes, he continued to look at everyone who came for nearly an hour. Pains in the eyes and head were the result of this imprudence. This caused swelling of the eyes and eye-lids, insomnia, and finally fever; such a disorder established itself in the organ, that suppuration

⁷² Saint-Yves, *op. cit.*, note 19 above, preface p. 5.

⁷⁴ Saint-Yves, *op. cit.*, note 19 above, p. 218.

⁷³ Sharp, *op. cit.*, note 29 above, p. 167.

beset both globes. Nevertheless, I did not neglect to employ blisters, bleedings, diet and anodyne and revulsive collyriums. But all these aids were in vain; the blow had been dealt, and the ill consequence was irreparable.⁷⁵

The need for cataract patients to wait until the cataract was ripe before seeking treatment could cause additional stress, and with children there was a general reluctance to operate until they were in their teens and more likely to keep still.⁷⁶ Waiting could be difficult, and Saint-Yves notes that unscrupulous operators were only too ready to exploit the patient's understandable impatience to see:

They flatter the poor patients to restore their sight speedily; these are easily seduced by the pleasing bait; and the Desire of gain ensures that the operator, for fear of losing his present practice, hazards a doubtful operation, less concerned for his future reputation than his current interest.⁷⁷

Anxious parents seeking cures for their children's eye complaints seem also to have offered a tempting target. This teenage boy's case of trichiasis,⁷⁸ reported to James Ware by a colleague, suggests that having better means and access to treatment was perhaps not an unqualified advantage:

After a variety of treatment, as bleeding, purging, blistering, setons, bark, alteratives, and the use of every other method, which the most eminent practitioners, both in physic and surgery, could think of; recourse was had to eye-waters and salves, and the Panaceae of the most celebrated empirics of the time: but all proved ineffectual, and the young Gentleman became totally blind.⁷⁹

But if some patients found their hopes and anxieties manipulated, accounts of treatments reveal a more subtle balance of power. Despite the sense of desperation in some of the cases, there is evidence that patients chose their practitioners with care, seeking out those with a good reputation, perhaps by word of mouth, or through the advice of another practitioner.⁸⁰ They followed recommendations cautiously and sought the reassurance of consensus, particularly where drastic measures were being proposed or where the treatment involved the expense of a trip to Paris or London.⁸¹ Surgeons clearly felt that they could not afford to ignore patients' therapeutic preferences and aversions. Though there is little evidence of opposition to humoral treatments *per se* (apart perhaps from the French peasant⁸²), specific practices encountered considerable resistance. A common medical recommendation for ophthalmia was a programme of evacuation for plethora, including the application of a seton at the back of the neck, but as the French surgeon Jourdan remarked, "very few patients agree to undergo it". Similarly patients balked at the idea of applying a leech to the eye-lid (even if it was only a little one). "Few patients have enough courage to submit to it", commented the royal physician Joseph Lieutaud in 1771.⁸³ Scarification of

⁷⁵ Janin, *op. cit.*, note 5 above, pp. 273–4.

⁷⁶ Deshais Gendron, *op. cit.*, note 7 above, vol. 2, p. 260; Saint-Yves, *op. cit.*, note 19 above, p. 217; Ware, *op. cit.*, note 5 above, pp. 353–4.

⁷⁷ Saint-Yves, *op. cit.*, note 19 above, pp. 217–18.

⁷⁸ Trichiasis is a diseased condition of the eye-lids, often resulting from inflammation, causing in-growing eye-lashes.

⁷⁹ James Ware, *Remarks on the ophthalmia*, London, Charles Dilly, 1787, p. 95.

⁸⁰ Ware, *op. cit.*, note 26 above, pp. 50, 59;

Philos. Trans., 1757–8, 50: 748.

⁸¹ Janin, *op. cit.*, note 5 above, pp. 295–6; Ware, *op. cit.*, note 26 above, p. 57.

⁸² Ramsey, *op. cit.*, note 33 above, pp. 67–8.

⁸³ Weygand, *op. cit.*, note 14 above, p. 256; Jules Legrand, 'Comment sous Louis XVI guérir une ophtalmie', *L'Ophthalmologie des origines à nos jours*, 1992, 7: 87–90, on p. 89; cf. Antoine-Pierre Demours, *Traité des maladies des yeux*, Paris, chez l'Auteur, 1818, pp. 234, 263–4.

the eye to relieve ophthalmia was equally unpopular. While surgeons debated the comparative merits of barley beads or knives and needles for this, patients appear to have voted with their feet: Guenter Risse found in half the cases recorded at the Edinburgh Infirmary that those scheduled to undergo the treatment had simply refused.⁸⁴ Pain was certainly recognized as an important issue in surgeons' assessments of treatments, though the verdicts were often ambiguous. The proponents of extraction and couching each claimed that their method was the less painful.⁸⁵ The need to adopt acceptable treatments was a practical one, as it was virtually impossible to operate upon the eye of a reluctant patient—even a willing one had to be carefully restrained, as surgeons' descriptions of the cataract operations show, and the surgeon had to monitor the patient's eye movements constantly.⁸⁶

Consensus between surgeon and patient was also important at a more fundamental level, in ensuring that their respective expectations of the treatment were aligned. Where opinions diverged, it was not only the patients who felt vulnerable. Saint-Yves recounts a treatment of one M. Vihaude, who had been couched unsuccessfully by John Woolhouse, the exiled Jacobite oculist:

The patient came afterwards to consult me; but, having noticed that the cataract was complicated with a gutta serena, I assured him the operation would be of no service to him. Still he persisted to engage me to undertake it. As I was certain of its small chance of success, I would not perform it, but in presence of an oculist. M. Bailly, the father, was called; he, deferring to the patient, told him that if the operation did not restore his sight, it would not injure his eye.

He duly performed the operation with Bailly present, and as anticipated it did not restore the patient's sight; but Saint-Yves had evidently obtained the reassurance he needed.⁸⁷ On closer examination, the presence of fellow practitioners at operations seems often to reflect this need for professional solidarity. Almost invariably where action as drastic as extirpation of the eye was proposed, multiple views were sought, as often on the initiative of the surgeon as of the patient.⁸⁸ This caution is understandable given the length and ambiguity of many treatments. Unlike the itinerant, the establishment surgeon treating a cataract or ophthalmia was embarking on a relationship with the patient which lasted weeks or months, and a treatment whose unpredictable developments unfolded daily, to be interpreted by both parties. Occasionally we glimpse the intensity of the relationship and the emotional pressure it could place on the surgeon as well as the patient. Bordenave's trichiasis case (the young man who had been refused admission to holy orders) provides one such example. Bordenave undertook two operations to cut the eyelid, without any success:

I would have despaired of curing this patient, for whom I had employed with every rigour the normal and known procedures, if his courage and the desire which he had to be cured had not in some way forced me to try a different treatment.⁸⁹

⁸⁴ Guenter Risse, *Hospital life in enlightenment Scotland: care and teaching at the Royal Infirmary, Edinburgh*, Cambridge University Press, 1986, p. 218.

⁸⁵ Morris, Kendrick, *et al.*, *op. cit.*, note 19 above, Cataract; Ware, *op. cit.*, note 5 above, p. 21.

⁸⁶ Deshais Gendron, *op. cit.*, note 7 above, vol. 2,

pp. 279–81; Saint-Yves, *op. cit.*, note 19 above, pp. 229–30, 236.

⁸⁷ Saint-Yves, *op. cit.*, note 19 above, pp. 189–90.

⁸⁸ *Ibid.*, pp. 110, 113; *Philos. Trans.*, 1755–6, 49: 18–21.

⁸⁹ Bordenave, *op. cit.*, note 49 above, pp. 106–7.

Even a cataract couching, one of the few treatments with at least a reasonable hope of success, could become a nightmare ordeal. Cataracts could never be relied upon to cooperate: they might be too hard or too soft, disintegrate, elude the needle or need to be dispersed, any of which involved a painful and protracted fishing round inside the eye. Once over, the operation was seldom an immediate unveiling of the blinded eye. Often it produced an indecisive result and initial appearances of success might be followed by complications.⁹⁰ Prudent surgeons were well aware of this unpredictability and tried to manage expectations. The French military surgeon Edmé Protat put the ethical issue explicitly, in 1800:

In all cases of cataracts, whatever the hopes of success, the man of the art, jealous of the esteem of his colleagues and of the public, must never promise it definitely. This claim, I warrant, is normally the refuge of ignorance and of bad faith; in medicine there are so many risks to be run that one can never answer for anything.⁹¹

James Ware was similarly cautious in his prognosis on children at the London blind school.⁹² But however well prepared patients were for failure or complications, the uncertainty cannot have been easy, particularly when an operation offered a ray of hope which then faded fast.

It is perhaps not surprising, given the difficulties of many courses of treatment, that establishment surgeons were as anxious as their itinerant counterparts to draw attention to their successes, and to make use of the publicity vehicle offered by the “Molyneux Problem”. Like Cheselden earlier in the century, Janin and Ware were keen to capture the immediacy and excitement of their “Molyneux” cases. Ware’s patient was an eight-year-old boy:

On the 31st., as soon as I entered his chamber, the mother, with much joy, informed me that her child could see. About an hour before my visit, he was standing near the fire, with a handkerchief tied loosely over his eyes, when he told her that under the handkerchief, which had slipped upward, he could distinguish that table by the side of which she was sitting . . .⁹³

The humanitarian interest of these cases helped to keep the patient at the centre of the story. The cases also serve as a reminder that ultimately the success of eye surgery had to be articulated by the patient: until the bandage was removed from an operated eye, both parties waited in suspense.

New Hopes and Fears

There is a growing sense of confidence in the ophthalmic writings later in the century. Janin, writing in 1772, notes the progress made in the surgical knowledge of the eye over the previous fifty years, starting with Michel Brisseau’s and Antoine Maître-Jean’s confirmation of the lens as the seat of the cataract. Eye surgery was beginning to assemble its hall of fame, with Daviel in pride of place.⁹⁴ At the same time, the defensive attitude

⁹⁰ Ware, op. cit., note 5 above, pp. 13–24 (translation of treatise by De Wenzell [son]); Deshais Gendron, op. cit., note 7 above, pp. 265–7.

⁹¹ Dupont-Barron, op. cit., note 36 above, p. 89.

⁹² London School, op. cit., note 13 above, p. 133.

⁹³ Ware, op. cit., note 5 above, p. 343; Janin, op. cit., note 5 above, pp. 215–17; *Philos. Trans.*, 1727–8, 35: 448.

⁹⁴ Janin, op. cit., note 5 above, pp. 33–4; Demours, op. cit., note 83 above, pp. 131–43, 496–510.

towards specialization in eye care is far less evident. If itinerant practice remained important in both countries even at the end of the century, the new surgical techniques—more complex and less readily accessible to fringe practitioners than couching—were providing establishment surgeons with the opportunity to assert their position in the field. While this did not receive the formal recognition in England that it did in France, James Ware and others show that *de facto* specialization in eye treatment was well accepted by the end of the century.

It is less clear what impact these developments had on the patients' chances and expectations of cure. For cataract sufferers who had undergone multiple couchings and years of intermittent sight, extraction offered important new hope.⁹⁵ But opening up the eye brought new risks, as surgeons acknowledged, notably the danger of damage to the iris or pupil, or loss of the vitreous humour.⁹⁶ Extraction was not necessarily a successful conclusion of treatment; it could mark the beginning of a chain of further surgical intervention. Iridectomy was equally variable, as Janin's cases show. Complications in his operation on a young Languedoc peasant resulted in his making the artificial pupil too big, and he had then to construct cardboard glasses for his patient to restrict the light.⁹⁷ The smallpox victim with corneal scars (albugo) might now regain sight, but in some cases iridectomy was in effect a last resort when other surgery such as extraction had left the eye severely scarred.⁹⁸

On the other hand, less dramatic techniques could offer considerable benefit to patients. Having explored the Anel technique for treating fistula lachrymalis with a probe and syringe, Ware developed his own approach of inserting a small style into the tear duct to help it to clear, and he described a number of successful cases he carried out in the 1790s. These were all young girls who had suffered from watery or discharging eyes following smallpox in infancy. Here there were important cosmetic as well as medical benefits, and the *Edinburgh Medical Dictionary* commented on Ware's particular attention to appearance, in blackening the flat head of the style with sealing-wax, so that it would look like a small patch.⁹⁹

Improvements were not without their cost to patients. Extraction and iridectomy were both intricate and precise operations, with little room for error. Samuel Sharp presented the Royal Society with an account of his early extraction attempts in 1755, noting candidly:

I might here take notice, with regard to the case of AB, that the ill success was partly owing to the imperfection of my instrument; a disadvantage, that must frequently attend on the execution of new attempts.¹⁰⁰

The Académie Royale de Chirurgie encouraged an immediate trial of extraction on receipt of Daviel's report, having the advantage of a ready supply of cataract patients from Les Invalides, where their secretary Morand was Chirurgien Major. Results were reported carefully in the Académie's *Mémoires* for 1753. Some of these old soldiers (several of

⁹⁵ Janin, *op. cit.*, note 5 above, pp. 266–7.

⁹⁶ Ware, *op. cit.*, note 5 above, pp. 263–5; Deshais Gendron, *op. cit.*, note 7 above, pp. 306–7.

⁹⁷ Janin, *op. cit.*, note 5 above, pp. 200–2.

⁹⁸ *Ibid.*, pp. 186–92, 197–9.

⁹⁹ Ware, *op. cit.*, note 26 above, pp. 50–9; Morris,

Kendrick, *et al.*, *op. cit.*, note 19 above, Lachrymalis Fistula.

¹⁰⁰ Samuel Sharp, 'A second account of the new method of opening the cornea for taking away the cataract', *Philos. Trans.*, 1753, 48: 324.

whom had had a different surgeon doing each eye to enable results to be compared) had been successfully operated; but other operations were recorded as failures, either because of problems of technique or instruments, or through complications. Almost as many again were indecisive.¹⁰¹

Surgeons later in the century reiterated the need for practice and observation. As Ware commented, it was as important to learn from mistakes as from successes, and French surgeons such as Pierre Guérin in Lyons stressed the central importance of hospital experience, with its “rich harvest” of observations, in this process.¹⁰² If this is in line with the more general preoccupation of the surgical establishments,¹⁰³ eye disease raised the issue of experimental failure in a particularly acute form. Awareness of this tension between professional needs and those of the patient probably influenced the reactions of the London and Liverpool blind schools to offers which they received from surgeons and other practitioners in their early years. Both schools felt themselves to be well provided with the medical men already committed to the establishments and were wary about letting unknown outsiders loose on the children. (Presumably there was an element of medical defence of territory here too.) Similar opposition was expressed by Bélivier, the surgeon at the Quinze-Vingts.¹⁰⁴ Even with this degree of protection, the parents and friends of children at the London and Liverpool blind schools were not always ready to consent to treatment.¹⁰⁵ For the lifelong blind the terrifying prospect of surgery could be far more immediate than the potential benefit of gaining sight. De Wenzell had offered to operate on cataract cases at the Foundling Hospital, but the refusal of young John Printer, one of the foundlings, was respected.¹⁰⁶ Jean Janin had to resort to bribes to persuade his “Molyneux” peasant girl to agree to the operation, and even with this inducement: “One can well understand that the indifference which this young person had towards receiving a new sense increased further at the approach of the instruments . . .”¹⁰⁷

Finally, it is difficult to assess how widely the new treatments were available, even to those who wanted to make use of them. French writers at the end of the century assert confidently that extraction was now the standard practice, with couching used only for cataracts where extraction was inappropriate.¹⁰⁸ De Wenzell (son) and Ware shared this view.¹⁰⁹ But it is clear that there were still some strong supporters of couching in both France and Britain, and even if extraction had won the intellectual debate, it is unlikely that all or even most surgeons possessed the necessary skills to perform it.¹¹⁰ Other

¹⁰¹ La Faye, op. cit., note 8 above, pp. 563–72; Morand and Verdier, op. cit., note 8 above, pp. 578–83.

¹⁰² Ware, op. cit., note 5 above, p. v; Guérin, op. cit., note 7 above, p. ix.

¹⁰³ Susan C Lawrence, *Charitable knowledge: hospital pupils and practitioners in eighteenth-century London*, Cambridge University Press, 1996, p. 21; Michel Foucault, *The birth of the clinic*, trans. A M Sheridan, London, Routledge, 1989, pp. 54–85.

¹⁰⁴ Royden, op. cit., note 13 above, pp. 96–7; London School, op. cit., note 13 above, pp. 68–9; Weygand, op. cit., note 14 above, p. 275.

¹⁰⁵ Royden, op. cit., note 13 above, pp. 94–6.

¹⁰⁶ McClure, op. cit., note 30 above, p. 211.

¹⁰⁷ Janin, op. cit., note 5 above, p. 214.

¹⁰⁸ Deshais Gendron, op. cit., note 7 above, vol. 2, p. 273; Demours, op. cit., note 83 above, pp. 499–505.

¹⁰⁹ Ware, op. cit. note 5 above, pp. 17, 263–5.

¹¹⁰ Morris, Kendrick, *et al.*, op. cit., note 19 above, *Cataract*. French ophthalmic writings emphasized the central role of the *hôtel-Dieu* for learning and exercising these skills, yet throughout the century the *hôtel-Dieu* remained confined to urban areas, and unevenly distributed across the country. See Muriel Jeorger, ‘La structure hospitalière de la France sous l’Ancien Régime’, *Annales ESC*, 1977, 22, pt 2: 1025–51, pp. 1031, 1041–2.

evidence also warns against equating medical potential too readily with actual treatments. For example, alongside the smallpox victims who received successful treatments for their eyes, we have the reminder that smallpox remained one of the major causes of blindness among the inmates of the English and French blind institutions well into the nineteenth century, vaccination notwithstanding.¹¹¹ Does this simply reflect cases where the eye damage was irreversible, or does it also indicate that not everybody was aware of the possibility of cure, or had access to the necessary surgical expertise?

Conclusions

An analysis based mainly on formal medical sources has inevitable limitations as a guide to patients' experiences. In this study it also has implications for the comparative perspective. The French and English ophthalmic writings suggest a seamlessness in debates and concerns across the surgical elites of the two countries and emphasize the common therapeutic ground. However, differences both in the structure of the English and French medical professions and in the financial support available to patients become more material in assessing access to treatment. It has only been possible here to suggest at a broad level the likely impact of social policy on treatments, and no attempt has been made, for example, to consider the impact of the Revolution on both surgical practice and access to treatment in France.

The ophthalmic writings provide only a partial picture of treatments and conceal a range of alternative responses and experiences, but they suggest that in both England and France, people of a wide social spectrum sought cures for their eye ailments with a marked determination and persistence. On one level this supports the more general view of a varied and active eighteenth-century medical market in both countries.¹¹² It also highlights the important role of the itinerants, and the difficulty of evaluating their competence and use by patients. But the nature of eye disease brought a particular tension to the relationship between patient and practitioner. What was at stake in an ophthalmic infection, a cataract, or a festering eye wound was the patient's sight, and with it his or her future livelihood and wellbeing. The effect of this on the relationship between patients and surgeons or oculists was double-edged. Desperate patients could be gullible victims, ready to put themselves into the hands of anybody who offered hope. But they could also be exacting and vociferous, conscious of their purses draining with little to show for their expense. Definitions of success and failure did not lie entirely in the surgeon's hands.

Practitioners responded by managing risks and expectations in different ways. For the itinerant this was often a matter of keeping a step ahead of the game—moving on quickly when trouble loomed, and concealing failures behind larger-than-life success stories. For the establishment surgeons, it involved managing a contradictory professional identity. They were naturally eager to publicize their more spectacular successes—the “inestimable cure” of giving sight to the blind. But there is also a significant lower-key theme in

¹¹¹ Royden, *op. cit.*, note 13 above, pp. 272–3; Weygand, *op. cit.*, note 14 above, pp. 27, 97–100. For an example of successful treatment of smallpox albugo by iridectomy, see Janin, *op. cit.*, note 5 above, pp. 197–8.

¹¹² Dorothy Porter and Roy Porter, *Patient's progress: doctors and doctoring in eighteenth-century England*, Oxford, Polity Press in association with Blackwell, 1989, pp. 70–114; Ramsey, *op. cit.*, note 33 above, pp. 18–25.

medical writing which equates medical professionalism with a cautious, measured approach: avoiding unrealistic promises, and working carefully with emotionally and pathologically volatile patients. The case studies hint at the difficulty of maintaining cool-headed clinical detachment. In trying to restore sight to a blind child, for example, surgeons can reveal their own emotional engagement—disappointment at discouraging outcomes, delight at the child's first experience of sight.¹¹³ It is perhaps this personal interest, as well as the more public interest in eye cures, which helped retain for eye patients a central place in their medical stories.¹¹⁴

Finally, the whole concept of curing blindness underlines the shifting uncertainties which characterized many people's experiences. Eye afflictions were often gradual and unpredictable in their course, and the anxiety underlying patients' responses must be viewed in this context. A minor accident or unsuccessful treatment could be the prelude to years of complications and misery. A condition's incurability emerged through the experience of treatment, as patient and practitioner interpreted the outcome; it was not necessarily presumed at the outset. In the second half of the century surgeons were becoming more confident in claiming success for their new techniques. But while these offered important new options in treatment, they removed none of the risks and uncertainty. Patients and surgeons alike continued to wrestle with the volatility of eye afflictions and their cures, and with the consequences of failure.

¹¹³ Ware, *op. cit.*, note 5 above, pp. 337–46.

¹¹⁴ This contrasts with the more general trend in case histories away from personal detail to greater

focus on disease entities. See for example: Fissell, *op. cit.*, note 39 above, pp. 152–3; Lawrence, *op. cit.*, note 103 above, pp. 21–2.