

# *Medical Professionals and Charlatans.*

## *The Comité de Salubrité enquête of 1790-91\**

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Much has been written about medical charlatans, but seldom has the phenomenon of charlatanism been analysed in systematic fashion. Unlike its supposed antithesis, professionalism, the world of those who practiced medicine without academic or guild credentials, either outside the law or in its often-wide interstices, remains a shadowy realm, a subject for impressionistic study and colorful anecdote. This is unfortunate, for the two species of practitioner, whatever their differences, usually shared common objects and objectives — the sick person and his care and cure. Better knowledge of the charlatan would illuminate his professional counterpart and the society in which both functioned.

Reasons for an underdeveloped social history of charlatanism are not far to seek. On methodological and substantive grounds, they stem from some of the distinctions usually drawn between charlatans and professionals. The medical professional in the 18th century, as now, could be defined in terms of his technical training, legal certification, and subsequent membership in an organized community of fellow practitioners. Charlatans escaped such institutional categories. They apparently neither completed a formal period of training, nor practiced legally, and they lacked internal organization. In short, other than in negative terms charlatans appear notoriously difficult to define as a group.

The difficulty is compounded by a contrast between professional and non-professional discourse. The former includes theoretical elements: rational explanations of physiological and pathological events, as well as other ideological and programmatic statements on such matters as ethics, education, and public health. Taken together this literature reinforces professional coherence and cohesion. The 18th century situation may serve as illustration. Medical professionals exhibited wide divergence and disagreement over specific theoretical constructs: "systems" of iatromechanism according to Boerhaave, vitalism following Bordeu and the Montpellier school, Hallerian "irritability," and Hippocratic humouralism competed and, on occasion, complemented each other depending on the process involved or the persuasion of an individual medical man.<sup>1</sup> Yet professional

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<sup>1</sup> See L. KING, *The Medical World of the Eighteenth Century* (Chicago, 1958).

consensus existed on two fundamental issues: first, that medical theory was capable of causal explanations, and second, that natural philosophy, in particular anatomy and chemistry, underlay the complex phenomena of health and disease.

Charlatans were not necessarily inarticulate as a group. Yet their discourse, dealing mostly with therapeutic claims and particular cures for particular ailments, had little to tie it together beyond an implicit empiricism. Again, charlatanism is defined by what it lacks, in this case, theory. If non-professional medical literature of the 18th century sometimes broached theoretical concerns — Mesmerism in France, being a famous instance — the distinction between professional and non-professional discourse (and its respective advocates) became much more problematic.<sup>2</sup> Conversely, the case can be made that professional medicine at the level of therapeutic discourse, not to mention actual practice, tended to converge with the empiricism of the non-professional.

Defining the non-professional healer of the 18th century becomes increasingly difficult when one investigates how such persons actually functioned. Too often the problem of an operational definition or even a description is obscured by normative assumptions. The non-professional is labelled a charlatan, a quack, taken to be ignorant and incompetent. Motivated by greed he seeks to deceive his gullible patient-victim with fake, usually "secret", remedies and grandiose claims. On the other side, the medical professional is also stereotyped: knowledgeable, prudent, honest, concerned primarily with the patient's welfare, and, if not always effective, certainly more successful than the charlatan.

Through such a prism of values, charlatans and professionals may be distinguished. Yet the judgment often depends more upon presentist criteria disguised as "timeless" values than searching examination of the alleged charlatan or charlatans situated in historical time and space.<sup>3</sup> Another problem with normative categories is that genuine-fake and altruistic-greedy dichotomies have a peculiarly dubious status when medical services are involved. Effective results, if measured in terms of the patient's recovery from illness may have little to do with the biochemical action of a specific drug and less with the healer's motivations. One need only cite the unquestioned efficacy of pharmaceutically inactive substances or placebos administered by modern physicians and of "fake" remedies employed by shamanistic healers. In both instances the therapist introduces an element of duplicity into the doctor-patient relationship. Not only are these forms of practice generally considered legitimate, but the practi-

<sup>2</sup> See R. DARNTON, *Mesmerism and the End of the Enlightenment in France* (New York, 1970). C.C. Gillispie has a perceptive discussion of charlatanism and science in late 18th-century France in his *Science and Polity in France at the End of the Old Régime*. (In Press, Princeton University Press). I thank Professor Gillispie for permitting me to read his manuscript.

<sup>3</sup> Paracelsus, for example, has been castigated as a charlatan by some and lauded as a scientific genius by others, a judgment varying with the judges' special concerns, the values of their own epoch, and the tradition of their mother country.

tioners rightly expect substantial rewards for their services. Indeed, pecuniary or status rewards may be dominant incentives for successful healers whom no one thinks of as charlatans.

The present paper seeks to avoid normative distinctions between charlatans<sup>4</sup> and professionals. Our goal is to analyse medical charlatanism at a particular historical moment — an eventful one in the history of medicine as in history generally — the first years of the French Revolution. Evidence will be presented on the prevalence of charlatans, where they practiced, who they were, and the kinds of services they provided. We seek to determine the structure and function of charlatanism in the context of a larger medical professional economy; specifically, how did the practice of charlatans intersect that of professionals, how was it perceived by the latter and by public officials, and how did it respond to medical needs?

#### THE COMITÉ DE SALUBRITÉ ENQUÊTE OF 1790-91

Our study is possible because of the partial survival of a remarkably extensive survey questionnaire prepared and distributed by the *Comité de Salubrité* in the late autumn of 1790. Founded within the Constituent Assembly on 12 September 1790, the *Comité de Salubrité* took as its mandate the preparation of a national code for “that which relates to the teaching and practice of the healing arts, medical institutions, and the public health.” A more specific working agenda listed the “police of the healing art” as a priority; under this rubric, “the abolition of charlatanism” was an explicit goal.<sup>5</sup>

The physicians who composed and controlled the *Comité de Salubrité* worked on two levels. Firstly there were regular bi-weekly meetings in which physician and lay committee members, assisted by a panel of leading Paris medical men and scientists, developed and voted on articles for a new “medical constitution”. Secondly information was solicited in the form of correspondence from medical professionals and other interested parties throughout France. The *Comité's* minutes listed numerous replies at the beginning of each session.

This second approach — the *enquête* by correspondence — clearly reflected Revolutionary sentiment, already epitomized by the *cahiers de doléances* of 1789, to involve the people as much as possible in the decision-making process. At the same time, medical *enquêtes* drew upon specific precedents of the Old Régime. During the reign of Louis XVI, the

<sup>4</sup> Perhaps our goal would be better served by using a non-pejorative term such as “healer” or “folk practitioner”. We have conserved “charlatan”; i.e., the commonest descriptive label of our sources, in order to emphasize the inevitable subjectivity of these sources. Secondly, “charlatan” as commonly used, did not refer to overtly magical-religious types of practitioners. It thus has a greater specificity than “healer”.

<sup>5</sup> Archives Nationales AF I 23 “Procès verbaux par séances du Comité de Salubrité” (12 septembre, 2 novembre 1790). See H. INGRAND, *Le Comité de Salubrité de l'Assemblée Nationale Constituante (1790-91)*, *Thèse de médecine* (Paris, 1934).

royal government had attempted to survey the medical problems and resources of the kingdom. Especially noteworthy was the effort which Turgot's administration launched against epizootic and epidemic diseases in the middle and late 1770s and which led to the establishment of the *Société Royale de Médecine* (1776). As an institution for the regular collection of medical information, the *Société* perforce was at Paris, but it extended into the provinces through a correspondence network of some 150 doctors and surgeons. At monthly intervals for more than a decade the provincial correspondents produced a steady flow of reports on climate and local diseases in response to request forms sent out from the Paris headquarters.<sup>6</sup> The *Société's* permanent secretary, Vicq d'Azyr, looking back over his institution's accomplishments, considered the *enquête* method vital for the collective research he had coordinated over the previous fourteen years.<sup>7</sup> In 1786 the *Société* working with the Calonne government and the intendant-subdelegate system initiated another kind of *enquête* which aimed at preparing inventories of physicians, surgeons, midwives, and the most troublesome disease conditions in each region.<sup>8</sup>

Such surveys, imbued with a pragmatic and Physiocratic confidence in the power of simple statistics to bring order, if not solutions, to medical problems, directly influenced the approach of the *Comité de Salubrité*. To a large extent, the medical professionals of the *Comité* simply continued within a new political context the unfinished business of their colleagues at the *Société de Médecine*.<sup>9</sup>

During its brief existence of less than one year, the *Comité de Salubrité* conducted three *enquêtes*. At the first meeting on 4 October 1790, Joseph-Ignace Guillotin, the *Comité's* president, announced the project of a questionnaire to be circulated among "all colleges and faculties of medicine, colleges and communities of surgery and pharmacy and all academic and literary societies occupied with the healing art". The initial *enquête* invited recipients to "...cooperate in the regeneration of such a vital art [by sending] their views and observations on the present condition of practice..." and their ideas for reforms.<sup>10</sup> A broad appeal to a professional community eager to participate in the design of a new "medical constitution for France", the *Comité's* letter elicited a huge and diverse response. Individuals as well as professional medical communities inundat-

<sup>6</sup> J.P. PETER, *Revue Historique*, 499 (1971), 13-38; *ibid.*, "Disease and the Sick at the End of the Eighteenth Century," trans. E. FORSTER, in *Biology of Man in History*, ed. R. Forster and O. Ranum (Baltimore, 1975): 81-124.

<sup>7</sup> Académie de Médecine de Paris, Archives de l'Académie de Chirurgie, Carton #4, Undated letter by Vicq d'Azyr to [members of Comité de Salubrité?] Probably written in 1790.

<sup>8</sup> J.-P. Goubert, and F. Lebrun, "Médecins et chirurgiens dans la Société Française du XVIII<sup>e</sup> siècle," *Annales Cispalines d'histoire sociale* (1973): 119-136.

<sup>9</sup> The tight connections between the *Société* and the *Comité* are seen in their reciprocal correspondence, much of which is preserved in Carton #4 Archives de l'Académie de Chirurgie. See above note 7. D.B. WEINER, "Le droit de l'homme à la santé — une belle idée devant l'Assemblée Constituante: 1790-1791," *Clio Medica*, 5 (1970): 209-223.

<sup>10</sup> "Procès verbaux... du Comité de Salubrité" (12 septembre 1790).

ed the *Comité* with hundreds of projects on subjects ranging from the entire reformation of medical teaching and practice to personal requests for endorsement of medical competence and remedies.<sup>11</sup> Taken as a whole, the responses, most of which survive only as titles in the *Comité's* minutes, indicate considerable enthusiasm and optimism for medical reform on the part of professional practitioners, while saying little about actual conditions of practice.

In January 1791 the *Comité* launched a second *enquête* seeking more specific information. Here the objective, like the earlier Calonne-*Société Royale de Médecine* effort, was to quantify the medical resources, human and institutional of the realm. Addressed to the directories of the 83 newly-created *départements*, the *enquête* requested a listing by name of all medical personnel (physicians, surgeons, pharmacists, midwives) in each region and a complete list of medical institutions, their functions, and personnel. The *Comité* also asked whether local administrators favored an increase or a reduction in numbers of health personnel; distribution of the latter in the countryside was of special interest.<sup>12</sup>

Unfortunately nearly all the responses to the January 1791 *enquête*, if they ever existed, have since disappeared. The few which we have recovered indicate that the *départements* were not capable of responding, but had to transmit the *enquête* to administrative subdivisions (districts) and to local medical professional communities. Even the latter could not furnish all the information requested.<sup>13</sup>

The third *enquête* — the one with which we shall be concerned in the rest of this paper — was the most precise as well as the narrowest in its objectives. Sent out from Paris on 24 November 1790, the *enquête* consisted of fourteen questions on the practice of surgery and midwifery. It was addressed to surgical communities throughout the kingdom.<sup>14</sup>

The first five questions asked about the legal status and organization of the surgical community, modes of certification of master surgeons and whether exceptions to the regulations occurred. How many surgeons were

<sup>11</sup> A few examples representative of projects and requests sent to the *Comité* and entered in the *procès-verbaux* were: a new hospital (surgeons of Marans, Charente-Inférieure, 21 December); a remedy against scrofula (surgeon at Montluel en Bresse, 13 January 1791); a public course of accouchements (surgeon at Boulogne-sur-Mer, 13 January); creation of a medical school (directory of the Côte d'Or, 18 January); a pension for medical services rendered (surgeon at bourg of Montmort 18 January); free diagnostic centers for venereal disease (Master surgeon of Paris, 5 February).

<sup>12</sup> *Ibid.*, (7-11 January 1791).

<sup>13</sup> Between 20 January and 12 March 1791, 19 *départements* and one district acknowledged receipt of the *enquête*. Only three responses have been found: Angers (AD Maine-et-Loire 1L 934-2, prepared by district of Angers); Nîmes (AD Gard L 1310, prepared by College of Medicine); Charpey (Drôme AN F 17 2276; doss. 2, pièce 358, prepared by town).

<sup>14</sup> A printed copy of the *enquête* is in the Bibliothèque Nationale, T 11 9; 93 responses are in the Archives Nationales, F 17 2276, doss. 2, pièces 260-359, 12 responses in F 15 2281, 2282. A copy of the response from the Le Puy surgical community is in AD Haute-Loire L 861.

there in the jurisdiction (*arrondissement*) of the community's leader, the lieutenant of the king's *premier* surgeon? How many had been received since 1770? Questions #6 — 11 concerned accouchements: numbers of midwives, their training, examinations, and the involvement of surgeons as accoucheurs. Question #12 inquired after other kinds of surgical practitioners who worked as "experts" in one particular branch of the art; #13 sought the number of lieutenants within the administrative "district". Finally, #14 asked: "Are charlatans, empirics, and persons with [medical] secrets very prevalent in your *arrondissement*? What degree of tolerance are they given?"

Replies to the final question constitute the essential data base for our analysis. However, the answers to the other questions, excluding those on midwifery, have also been examined, since they characterize the responding surgical community. The questions on exceptions to regular certification and on "experts" relate directly to our primary object of inquiry, charlatanism.

The historical value of the 20 November 1790 *enquête* derives from the size and quality of the response. Replies began to arrive in Paris on 29 November; the great bulk were in before the end of January 1791. By early April, when the last stragglers were heard from, the *Comité de Salubrité* probably had several hundred replies to its questionnaire, of which slightly more than 100 survive today. How many were originally distributed or returned is not known. In principle the *enquête* was sent to all communities of master surgeons in France, a total of nearly 400. Evidently a majority of surgical communities either did not respond or their responses have been lost.<sup>15</sup> Despite this large gap, the volume of replies remains sufficiently impressive to try to determine whether they may be representative of surgical opinion in France as a whole,<sup>16</sup> and, in any case, to analyse on their own.

<sup>15</sup> Non-response is a plausible explanation for the absence of some large communities such as Bordeaux, Rouen, Nantes, and Nancy, all of whom had already answered the *Comité's* initial *enquête* of September 1790. But it appears likely that several hundred replies were lost after their reception in Paris. None survive for the reception period 5 to 27 December 1790, and the *Comité's* numbering system shows a gap between #13 and #259 inclusive. An extensive search in the Archives Nationales and in *départemental* archives has yielded only the copy of the Le Puy reply. See Appendix 1 for alphabetical listing and other data on respondents. Provincial communities of master-surgeons are listed in "Procès-verbaux de l'Académie de Chirurgie", Mss 20-22, Académie de Médecine.

<sup>16</sup> The problem of the representativeness of the surviving responses is taken up in Appendix 2. To summarize our conclusions: 1) the geographical distribution of surviving responses to the *enquête* is broad; all provinces are represented, but there is a bias in favor of the South of the realm. 2) the distribution by population level of the responding communities corresponds closely with the overall distribution of surgical communities in France. Town sizes are defined as "large" (12,000 inhabitants and above); "medium" (4,000-12,000); "small" (2,000-4,000). Such categories are inevitably somewhat arbitrary since other factors besides simply population entered into the importance of towns. There is general agreement that a place with fewer than 2,000 inhabitants was a *bourg* or village. For the larger categories, I have adopted the same population break-points which the *Comité de Mendicité* proposed in 1790 when dealing with the distribution of medical personnel and institutions. See C. BLOCH and A. TUETÉY, *Procès-verbaux et rapports du Comité de Mendi-*

A second problem with our source is an obvious bias on the part of the surgical respondents against "charlatans, empirics, and persons with secrets". It would be naive to expect legitimate practitioners to report objectively on their illegal competitors. We are dealing not with disinterested accounts but with surgeons' perceptions of irregular practitioners. Yet, if such bias is inevitable with medical professional sources, it is, in part, compensated by the nature of the questionnaire and the responses. To the precise questions put by the *Comité*, the vast majority of surgical communities gave equally precise and succinct answers, sometimes only a sentence or two speaking directly to the question. Those who felt inclined to add suggestions for future action against charlatanism or other reform plans did so only after they had provided the factual information requested by the *Comité*. The replies, taken as a whole, do not prescribe ideals for the future, but describe present conditions.

Of the 106 places with surgical communities whose responses survive, only two failed to reply explicitly to the question on charlatans. The diligence with which the other questions were answered is nearly of the same order. Quantitative statements on the prevalence and/or tolerance of charlatans are rare; almost always the reply takes the form of "very common", "widespread", "present", "few", "rare", or "absent", or some variant of one of these qualitative evaluations. The completeness, precision, and overall homogeneity of the form of the replies make possible an analysis of this qualitative material as a uniform series. One may then pose certain more or less quantitative questions about the professional-charlatan relationship.

The responses to the *Comité de Salubrité enquête* of November 1790 give access to a level of medical practitioner, both legal and illegal, whose discourse is imperfectly transmitted, if not entirely mute, in the medical literature of the 18th century. Surgical communities situated in small towns and villages (defined here as places with populations under 4000) constitute nearly 45% of the respondents. They speak not only for their small urban settlements but also for the surrounding countryside within the jurisdiction of the lieutenant of the given surgical community. Their replies bear simple yet vivid testimony to the difficulties medical practitioners encountered in the small urban and rural environment of the late 18th century.

#### SURGICAL COMMUNITIES: SOURCES AND WITNESSES OF MEDICAL PRACTICE

To define a surgical community in 18th-century France, one must consult a large corpus of legislation. The royal declaration of 1760 ruled that surgeons could form a community in any place where a court of royal

*cité de la Constituante, 1790-1791* (Paris, 1911), p. 401. All populations of towns are based on the census of 1806, the results of which are in R. LE MÉE, "Population agglomérée, population éparse au début du XIX<sup>e</sup> siècle," *Annales de Démographie historique* (1971): 455-510.

justice existed. In effect this meant that the minimum requirement for establishing a surgical community was the *bailliage royal* (or *sénéchausée* in the South). The community's authority over other surgeons in the area was co-extensive with the "ordinary jurisdiction" of the *bailliage*. In addition, communities could be formed in towns with archbishops or bishops.<sup>17</sup> Thus Narbonne, though it belonged to the *sénéchausée* of Carcassonne, had its own surgical community because it was an episcopal town.

By statute the *premier* surgeon of the king had jurisdiction over "all surgical communities of the kingdom, with the exception of no province or colony."<sup>18</sup> The king's surgeon delegated his authority to local lieutenants whom he selected from a list of candidates submitted by each community, and from whom he collected the purchase price of the office. Along with personal honorific and financial benefits, the lieutenant's post provided ample opportunities for the recovery of the initial investment. The right to visit and inspect credentials and instruments of all surgeons or practitioners of a branch of surgery resident within his jurisdiction was one such occasion. Thus the lieutenant might check to see that the license of a midwife were in order or that a bonesetter's instruments were satisfactory. Such visits involved fees, if not fines, payable to the lieutenant. He convoked periodic meetings of the surgical community and special sessions for the examination and reception of new masters. The latter furnished still another occasion for pocketing fees. The lieutenant presided over meetings, had the right to speak first, conduct votes, and comment on the deliberations and decisions. Assisted by the *greffier* or registrar, he kept financial and other records of the community. It was the lieutenant's ultimate responsibility to see that the statutes were observed. In sum, he was the surgical community's leader, official spokesman, and the logical person to whom the *Comité de Salubrité* would address its inquiry.

Surgical lieutenants prepared and signed the vast majority of replies to the *Comité's enquête*.<sup>19</sup> Occasionally, they revealed something of their own background, enough to suggest that some, at any rate, were more than simply purchasers of venal offices. One lieutenant was a correspondent

<sup>17</sup> *Déclaration du Roi du 29 mars 1760, qui fixe le District ou Département des Lieutenants du Premier Chirurgien du Roi dans les différentes Provinces du Royaume, in Statuts et Règlements Généraux pour les Maîtres en Chirurgie des Provinces du Royaume*, 5th ed. (Paris, 1772), pp. 107-113. DOISY, *Le Royaume de France et les États de Lorraine, disposés en forme de dictionnaire* (Paris, 1753), pp. 113-122 lists 326 *bailliaages* and *sénéchausées*.

<sup>18</sup> *Statuts et Règlements Généraux* (24 février 1730), p. 11. There were in fact exceptions. The *premier* surgeon's jurisdiction did not extend to surgical communities in Artois, Roussillon, Alsace, and Dombes. See J. VERDIER, *La Jurisprudence particulière de la Chirurgie* (Paris, 1764), vol. 1, pp. 324-371.

<sup>19</sup> Lieutenants signed 80 responses either alone or together with their fellow members of the community. Other signatories included surgical community officers, hospital surgeons, and, occasionally, physicians and local officials. On 20 November 1790; i.e., just before launching the *enquête*, the *Comité de Salubrité* obtained a list of his lieutenants from Andouillé, the *premier* surgeon. The list is now lost.



of the *Société Royale de Médecine*<sup>20</sup>. Several others mentioned their posts as hospital surgeons.<sup>21</sup> The lieutenant at the tiny community of Rosières, near Nancy in Lorraine, held a medical doctorate and had completed examinations at both Lunéville and Nancy. Lieutenants of larger communities contributed to the *Mémoires* of the Academy of Surgery. One of the most distinguished, Pierre Pontier of Aix-en-Provence, anatomist and surgeon-physician, died in 1789 after forty-seven years as lieutenant of his community.<sup>22</sup> Several others boasted tenures as long or nearly as long, if perhaps not as illustrious as Pontier's: more than forty years for Sumian, the lieutenant at Riez, thirty-five years for Poutingon, his Montpellier colleague. Simple longevity in office might be misleading; but, clearly such men, could be expected to know their particular fiefdoms.

How pervasive in fact was the authority of the surgical communities and their lieutenants? How well-informed were they about conditions of practice outside of their towns of residence — in the smaller towns, villages, and countryside of their jurisdictions? Two points should be kept in mind as part of a general frame of reference for these questions. First, if we consider only the towns of residence of surgical communities, we are already dealing with a vast network extending into small population centers. Of nearly 400 surgical communities identified, 163, or more than 40%, were located in small towns or villages. This fact of diffusion alone placed the surgical communities in a privileged position as far as access to information was concerned. They existed at a lower and, consequently, broader stratum than other professional medical persons of the Old Régime. Neither the correspondents of the *Société Royale de Médecine*, communities of physicians, nor apothecaries were comparable.

Second, every practitioner of surgery living outside a community town, even those in remote villages, had in principle at least one formal contact with the surgical community — his day of examination. This does not mean that the contact was maintained; we shall see that the contrary was often true. But the certification process did extend into the countryside, serving, at least for the community lieutenant and his colleagues, to distinguish the legal from the illegal practitioner.

Surgical communities composed a maze of jurisdictions of varying sizes and irregular shapes as bewildering as their model — the royal judicial system — and equally subject to conflicts as to their exact dimensions. At one extreme were those communities extending slightly if at all beyond their central towns. The surgical lieutenant at Seurre, a small Burgundian town, had authority over just the town and "nine small villages" nearby; his colleague at Châtel in Lorraine reported an equally modest jurisdiction. The Triel and Ham surgical communities were coterminous with

<sup>20</sup> Narbonne. Whenever a town is cited by name in footnotes or text, the reader should consult the alphabetical list in Appendix 1 for exact reference.

<sup>21</sup> Morlaix, Mortagne, Le Puy.

<sup>22</sup> Aix. See. G. Fleury, *Histoire de la Communauté des Maîtres Chirurgiens d'Aix* (Marseilles, 1929), pp. 162, 197-198.

their respective small settlements. Other communities claimed jurisdiction over substantial territories containing numerous subordinate towns: Moulins took in more than 400 parishes or towns where surgeons lived, Vitry-le-François counted 133 parishes.

The number of practitioners likewise varied widely. In the cases cited above, Seurre reported five surgeons, Vitry-le-François 49, and Moulins "about 140". Twenty-three communities indicated less than twelve surgeons in their regions. At the other end of the spectrum, thirty communities counted forty or more practitioners, seven more than 100.<sup>23</sup>

Surgical communities with relatively large jurisdictions and many members have a deceptive attractiveness as sources for a general picture of France: deceptive, because information available to lieutenants in the central towns of large communities often tended to be vague. Several respondents admitted that they could only guess at the numbers of surgeons under their jurisdiction. Aix-en-Provence noted that an exact count would require "someone to take himself to the places [all the localities in the jurisdiction]; writing for such information obtains only false replies or none at all". The best he could do was to report 88 surgeons received for the town and region over the past twenty years. Montpellier echoed the note of uncertainty. The lieutenant had personally received about 70 country surgeons, but he simply did not know who had died over the past few decades. At Pau, the lieutenant did not make the inspection visits called for in the statutes.<sup>24</sup> On the other hand, some lieutenants — those at Tours, Riom and Figeac, for example — submitted precise lists of names and dates of receptions of surgeons and midwives in each town and village of their respective jurisdictions. Accurate information, it appears, could be gathered provided the lieutenants were willing to do so.<sup>25</sup>

Surgical communities, in general, succeeded in defining standards for practitioners and the organization of the art. Nearly all the respondents to the *enquête* said their communities were organized according to the general provincial regulations of 1730.<sup>26</sup> These statutes provided three levels of examinations for surgeons, varying in difficulty, duration and expense, depending upon whether the surgeon sought to qualify for the mastership in the community town itself (nine examinations over a period of several months, about 300 £ of fees), a town without a community (two examinations on separate days, 106 £), or a *bourg* or village (one examination, 70 £). Those in the last and lowest category underwent the so-called *légère*

<sup>23</sup> The largest were: Tartas (more than 200 surgeons), Lyon (174, 111 of whom were in the city and fauxbourgs), Angoulême (160), Pau (143 received since 1770), Saint-Pierre-le-Moutier (approx. 120). See Appendix 1 for number of surgeons reported by surgical communities.

<sup>24</sup> Similar replies came from Villeneuve-le-Roy and Arras. The latter lay outside the jurisdiction of the king's surgeon and thus did not have a lieutenant to make inspections.

<sup>25</sup> Auch and Nevers advised the *Comité* to consult the secretary of the king's surgeon for precise lists of practitioners, since that official levied a tax on every surgeon and midwife when he assumed office.

<sup>26</sup> Ninety communities followed the general statutes; the largest communities; e.g., Lyon, Montpellier, had their own statutes. Only 9 omitted mention of a statutory code.

*expérience*, "a single examination of three hours dealing with the principles of surgery, bloodletting, abscesses, wounds and medications."<sup>27</sup> Unlike the more demanding trials, the *légère expérience* required neither a practical demonstration of anatomical knowledge, nor the performance of surgical operations on cadavers, nor even a test of competence in setting fractures and dislocations. Nevertheless, aspirants to these modest titles, had to present legal certification of completion of an apprenticeship and journeyman service, and they had to pay fees. The country surgeon, like his colleague in town, had invested time and money in his future *métier*.

The elasticity of their statutes permitted the surgical communities to examine most country surgeons and thus "receive" them as masters of a common art, members of a common body. The lieutenant at Digne, a small town in the Alps, wrote that all surgeons in his region had been received except for a few in inaccessible mountain areas. His counterpart at Vitry-le-François reported all but a few surgeons received throughout a large jurisdiction of 133 parishes.

Others noted more serious infractions, sometimes as a consequence of the Revolution: Agen claimed that 50 surgeons were waiting to be received; at Mende, as many as one-third of the 57 surgeons in the region had not been received. Clermont-Ferrand voiced a complaint, shared by more than a few communities:

No other [than master] surgeons practice in public without being aggregated; but there are a great many renegades [*réfractaires*] who abuse the people's credulity, undertake everything, and provoke complications which are normally impossible to deal with.<sup>28</sup>

Such problems notwithstanding, the lieutenants, as a whole, seemed satisfied that most surgeons complied with the examination requirements.

Several ways of circumventing the statutes existed and were exploited. Perhaps the commonest was acquisition of a special permit, a *privilege*, which exempted the holder from the usual examinations and fees and enabled him to practice surgery. A vast majority of the respondents to the *enquête* categorically denied that anyone practiced in their region by virtue of *privilege* or *charge*. Among the 14 communities who acknowledged such exceptions, the largest category of privileged practitioners consisted of military surgeons.<sup>29</sup> In addition, the Lyon surgical community permitted widows of former masters to rent out privileges to practice; so did Saint-Sever, Vierzon and Vesoul. The lieutenant at Villeneuve-de-Berg complained of trafficking in privileges at Nîmes by means of which outside surgeons penetrated his jurisdiction. He added that letters of mastership were sold at bargain prices on fair and market days, a complaint echoed by the Ussel community with regard to the purchase of medical degrees.

<sup>27</sup> *Statuts* (1730), pp. 42-46.

<sup>28</sup> See also Luxeuil.

<sup>29</sup> There were 8 instances.

Privileges were a familiar, if irregular, feature of the Old Regime legal landscape. Although they did not directly call into question the rights of professional guilds, they punctured their pretensions to exclusive control over entry into a craft or trade. In the case of surgery, privileges opened a way to those who may have lacked any other credentials. Even those lacking a privilege could exploit the convenient loophole. Several communities thought such quasi-legal types worth particular mention apart from their comments on charlatans. Avesnes, for example, denied having a problem with charlatans, but admitted enormous difficulties with "illegal" practitioners who had virtually destroyed the community. The lieutenant at Poitiers complained of a former surgeon-major of a Normandy regiment who had settled in his jurisdiction, claiming to have a privilege, though no one had ever seen it. Nothing daunted, he pursued his art with the approval of city officials and their generous annual pension of 200 £. The surgeons of Saint-Dié named a certain "Sr. Noel" who refused to present his letters; those of Clermont-en-Beauvaisis had to tolerate an outsider who had the *protection* of the duc de Liancourt.

So-called "experts", those who claimed the right to practice certain parts of surgery but not the entire art, constituted another category which might be received by the community or, more often, simply practiced illegally. Here again, the majority of respondents refused experts, believing, as the surgeons of Dun-le-Roi explicitly stated, that they were the same as charlatans. Nevertheless they came to work at Clermont-Ferrand, Villeneuve-de-Berg and at least ten other jurisdictions; about half singled out bonesetters as the main culprits among "experts".<sup>30</sup>

Sixteen communities received "experts" of one kind or another. In no case were they specialists of the modern type in which general knowledge of surgery preceded the choice of a particular branch.<sup>31</sup> The knowledge of an expert did not exceed his practice and perhaps a familial oral tradition, a "family secret". Dentists predominated among those named, followed by oculists, bonesetters, and hernia experts.<sup>32</sup> Few communities went as far as the Albi lieutenant who said that the bonesetter he received had a "special skill" in his craft.<sup>33</sup> Most were more grudging like the Montpellier lieutenant who resented the "self-professed oculist who never did anything but cataract operations" and who had a royal privilege to work in the Languedoc capital. In contrast to their attitude toward outsiders forced upon them, surgical communities in large towns tended to be favorably disposed toward those experts who took the community's examination and paid its fee. Thus, more than 50% of the large communities received experts. Medium and small communities liter-

<sup>30</sup> See Arras, Clermont-en-Beauvaisis, Narbonne, Riom, Saint-Omer, Tartas, Ussel, Viviers.

<sup>31</sup> See T. GELFAND, "The Origins of a Modern Concept of Medical Specialization", *Bulletin History of Medicine*, 50 (1976): 511-535.

<sup>32</sup> There were 10 mentions of dentists, 5 oculists, 5 bonesetters, and 4 hernia experts.

<sup>33</sup> Le Quesnoy also reported that the former surgeon-major of the local military hospital enjoyed "great success" dealing with eye diseases.

ally could not afford this indulgence. (Only 10% of the former and 2% of the latter admitted experts.) They remarked that their surgeons had to practice the art in its entirety to make a living.<sup>34</sup>

Certain of the respondents maintained a community existence which was at best precarious. Some, in fact, like Hyères in Provence, failed to survive the death of their lieutenants.<sup>35</sup> Others faced a deteriorating situation in which they could no longer recruit an active constituency. At Nuits, a small Burgundian town, only two of eight surgeons remained; the others had either died, retired, or left town. At Guingamp in Brittany and Crest in the Dauphiné, both medium towns, competition from illegal practitioners had virtually destroyed the local surgical communities. The Guingamp lieutenant and just two colleagues surveyed "50 large parishes" completely devoid of master surgeons, "an astonishing thing", he remarked. The Crest lieutenant himself had been obliged to abandon the town as a result of a take-over by "sedentary empirics".

The kind of surgery practiced in these communities and by the vast majority of healthy communities as well had little in common with the *grande chirurgie* of Paris and leading provincial centers. Indeed, most surgeons, whether Parisian or provincial, rarely performed lithotomies, amputations, strangulated hernia resections, trepanations, or other major procedures. Such interventions provided a small amount of work for the élite of the profession, generally those with hospital posts.<sup>36</sup> The rank and file earned a living, and then with difficulty, doing *petite chirurgie* (tending minor wounds and other "external" ailments, including broken and twisted limbs, skin conditions, venereal diseases, urinary tract disorders, etc.) and every other medical task they could find. According to the lieutenant at Auch, a medium town, his surgeons, like those elsewhere, practiced all parts of the healing art, "especially [internal] medicine. Otherwise, we would have absolutely nothing to do."<sup>37</sup> At Seurre, the situation was still more difficult: "it is at the moment impossible for a surgeon in a small town or the countryside to be able to live by his profession if he does not mix it with some trade as well." "Trade" may have meant the preparation and sale of remedies as the context here suggests. But it is well known that surgeons did not confine their labours to the healing arts and pharmacy.

For the most part, the respondents avoided explicit mention of barber's work. However, the lieutenant at Saint-Gaudens in Gascony noted that the majority of surgeons in his region knew only how to *raser et saigner*. One found, he added, surgeons of this sort in every *bourg* and hamlet; even tiny villages had their barber surgeons and, only rarely, *des très*

<sup>34</sup> See e.g. Figeac, Saint-Pierre Ile d'Oléron. Of the 16 communities who admitted experts, 11 were large, 4 medium, and 1 (Montereau) small.

<sup>35</sup> Avesnes, Boisseaux, and Chaussin shared the same fate.

<sup>36</sup> T. GELFAND, "The Training of Surgeons in 18th-Century Paris and its influence on Medical Education" (Unpublished Ph. D. thesis, Johns Hopkins University, 1973), pp. 40-42.

<sup>37</sup> See also Saint-Sever.

*bons sujets* among them. Other sources make clear that surgeons generally, including those in cities as large as Rouen, mixed barber's and wigmaker's work with medical functions and openly defended their legal right to such practice.<sup>38</sup> Notwithstanding its social liabilities at the end of the 18th century, barber-surgeon remained an economic necessity.

If most respondents observed a discrete silence on the competence of country surgeons, a few remarked their deficiencies. The Tartas lieutenant deplored the poor medical care available to country people, a consequence he thought of absent motivation, inadequate education, and severely limited skills on the part of their surgeons.

Medical reformers, together with a broad cross-section of French society who spoke through the *cahiers de doléances*, denounced country surgeons in much stronger terms. So had enlightened medical men and provincial administrators of the Old Régime.<sup>39</sup> These critics, unlike the respondents to the *Comité de Salubrité's enquête*, had either no professional link with the object of their criticism or one which they wished to terminate. On the whole, they were probably objective. However, they spoke in a context of reform and, later, of revolution. In particular the town-country distinction in the quality of medical services offended Revolutionary egalitarianism. Country people, it was now held, deserved equal health along with their other newly acquired rights.<sup>40</sup>

Surgical communities had a different perspective. They acknowledged the *légère expérience* for country surgeons to be a minimal, possibly an inadequate test of competence. A last feeble distinction between professional and charlatan, the brief examination reflected the surgical leadership's optimistic belief, its faith that some kind of formal certification process served better than none. The result was a compromise intended to provide inhabitants of the countryside with admittedly marginal practitioners. In places where no other medical men lived, the surgeons argued, a little was preferable to nothing.<sup>41</sup>

In summary, the surgical communities of the late 18th century composed a professional structure. Legally and administratively, they were held together by the personal leadership of the king's surgeon and his network of lieutenants and by a common body of legislation expres-

<sup>38</sup> F. HUE, *La Communauté des Chirurgiens de Rouen* (Rouen, 1913), pp. 139-140, 158-161.

<sup>39</sup> E.g. AD Maine-et-Loire 1L 934-2 (district of Angers); *Cahiers de doléances du Bailliage de Blois*, F. LESUEUR and A. CAUCHIE ed. (Blois, 1907), vol. 1, p. 528 (ville de Marchenoir); *Procès-Verbaux du Comité de Mendicité*, pp. 391-92.

<sup>40</sup> *Nouveau Plan de Constitution pour la Médecine en France*. in *Histoire et Mémoires de la Société Royale de Médecine (1788-89)* (Paris, 1790), pp. 4-8.

<sup>41</sup> *Statuts et Règlements Généraux*, "advertissement", pp. 4-5. Probably written by Le Blond d'Olblen, secretary to the *premier* surgeon. The contrary position, that poorly trained surgeons might do more harm than none at all gained currency even among surgeons as the medical reform movement built up in the 1780's. See AD Meurthe-et-Moselle D #87, "Délibérations du Collège Royale des maîtres en chirurgie de Nancy", fol. 56 r: "Ne serait-il préférable de manquer des secours, à en avoir de mauvais?"

sing collective interests and goals. It was a loose, fragile, hierarchical confederation embracing three levels of quality by statute and still more diverse in practice. Knowledgeable sources guessed the total number of "surgeons" to be as many as 40,000 or about 1.6 for every thousand inhabitants.<sup>42</sup> This estimate would make surgeons virtually as common as any other village artisan. It should be remembered, however, that in quantity and quality the medical activities of most were marginal.

Given such diversity one can only be surprised that sufficient structure existed (and survived in late 1790) to answer the *Comité de Salubrité's enquête*. The lieutenants appear reasonably well-informed about their jurisdictions. The general provincial statutes of 1730 governed surgical communities and prescribed examinations for town and country practitioners. Though there were exceptions, compromises with standards, and some breakdowns, the surgeons generally repulsed privileged practitioners and experts. At most about one-quarter of more than 100 respondents noted a problem with these types of "irregulars".

If the surgeons appeared to have their own house in order, the same cannot be said of their domain. The exclusive right to practice the art and to prosecute illegal intruders, both rights guaranteed by their statutes, obviously were important tests of professional control. It was precisely here, in response to the *Comité de Salubrité's* final question — on charlatans — that the surgical communities proved most vulnerable.

#### CHARLATANS

*Prevalence:* Leaving aside for now the problem of definition, one may consider the prevalence of those whom the *Comité de Salubrité* called "charlatans, empirics, and persons with secrets". How common did the responding surgical communities perceive them to be?

Even this question contained pitfalls: "Their number and the degree of confidence accorded them varies, subject as it is to the influence of the seasons and a thousand tiny circumstances dependent upon caprice and chance," remarked the surgeons of Aix-en-Provence. Aix's vagueness came close to an admission that charlatanism might be a relative condition as well as a subjective label, dependent upon who was calling whom a charlatan. In any case, Aix's tentative response was exceptional. The other communities gave unequivocal answers, though few ventured the numerical precision of the lieutenant at Saint-Sever: "charlatans, empirics, and persons with secrets are extremely numerous in our arrondissement... some practice under the title of surgeon. There are fifty well known to us (without counting the curés who distribute powders of alliat and other unknown remedies)."

Virtually all the communities offered an opinion on the prevalence of charlatans. The replies may be divided into two broad groups: (1) those

<sup>42</sup> F. CHAUSSIER, *Mémoires sur quelques abus dans la constitution des corps et collèges de chirurgie* (Dijon, 1789), pp. 28-29.

who perceived charlatans, etc. to be present in their region to a degree varying from moderate to extreme, and (2) those who perceived them to be few, rare, or absent altogether. When this is done, we find 73 respondents (or just over 70% of the total) who saw charlatanism as a problem within their jurisdictions. The minority report is nonetheless surprising considering the jeremiads of contemporary medical reformers who denounced charlatans as ubiquitous, a claim which several respondents to the *enquête* also made.<sup>43</sup> Far from being universal, illegal practitioners evidently posed only a slight problem or none at all for more than one-quarter of those who should have been most sensitized to their presence.

The surgical communities' replies suggest an uneven distribution of charlatans across France. They give rise to questions of where were they more prevalent, where less. Our data does not permit reliable generalizations on a broad regional basis. However, some tendencies are worth noting. All five respondents from Brittany report a high prevalence of charlatans, and express genuine alarm about the phenomenon.<sup>44</sup> Similarly, the entire Southwest of the realm appears particularly affected with 23 out of 27 respondents noting a problem. On the other hand, some pockets of low or absent charlatanism can be discerned: four surgical communities (Nevers, Moulins, Dun-le-Roi and Issoudun) extending over an area of about 100 kilometers in the center of France considered the problem to be minor. Their neighbouring communities, Bourges and Saint-Pierre-le-Moutier reported charlatans in the region, but claimed to have none in the central towns. In the *département* of the Basses-Alpes, Digne and Sisteron agreed on the absence of charlatans in their adjacent regions; Saint-Gaudens and Rieux, neighbours in the Haute Garonne echoed this perception.

Turning to an analysis according to population of responding towns, one finds some suggestive tendencies though scarcely any clear pattern. To be sure, a majority of surgical community towns of all sizes considered charlatanism a problem in their respective regions. Communities located in large and medium towns, however, register a somewhat higher proportion of complaints than do their smaller counterparts. The median population of towns reporting a charlatan problem is nearly 5200 as compared to about 3500 among charlatan-low respondents. Figure 1 shows a marked increase in the proportion of "charlatan-high" replies once a central town exceeds a population of about 6,000.

One might explain this apparent difference as simply the result of a proportionality distortion whereby smaller places report fewer charlatans but in fact have as many or perhaps even more than large towns per unit population. Or the surgeons in small places may be relatively poorly informed about the presence of charlatans in their regions. Smaller surgical communities may be less willing to employ the label "charlatan", given their own marginal level of organization and standards of practice. Tiny

<sup>43</sup> See Agen, Nuits.

<sup>44</sup> Guingamp, Josselin, Morlaix, Ploërmel, Pontivy.



places like Châtel-sur-Moselle ("we have no complaints about charlatans. They rarely come by here now") may have had a higher threshold of tolerance for charlatanism than did cities like Metz ("Charlatans, empirics, and people with secrets... are extremely widespread"). It would scarcely be surprising for charlatanism to mean quite different things to the surgeons of giant Lyon and those of tiny Lyons-la-Forêt.<sup>45</sup> Finally, smaller communities might choose to conceal embarrassing information from the inquisitive Paris committee.<sup>46</sup>

The above considerations underline the fact that we are dealing with subjective perceptions about the prevalence of charlatanism. They suggest reasons for the differences in our data according to population level. On closer inspection however, the explanations do not appear entirely sufficient. First, a distortion due to the failure to consider the proportion of charlatans in the population is unlikely because the communities reported qualitative estimates, not absolute numbers of charlatans. Thus, the reply "extremely widespread" or "few or rare" already has built into it a tacit judgement of proportionality. Second, even small surgical communities generally observed the statutes of 1730; they had, if anything, a greater incentive than larger, more secure communities to try to protect their statutory rights to exclusive practice by identifying and exposing charlatans. If their access to information was limited, so too was their jurisdiction.

We are left with the possibility that charlatans were in fact more prevalent in regions which also had surgical communities in medium and large towns. The following hypothesis seems worth exploring: charlatans did not simply fill in gaps at the periphery of the medical professional economy. When possible they opted against practicing in smaller population centres, even though they probably would have faced less competition from professional surgeons and virtually none from medical doctors. Instead, charlatans, like their professional counterparts, followed an economic gradient toward larger towns which offered more and wealthier clients; in short, a more lucrative business. The fact that charlatans clearly posed serious problems for surgical communities located in medium and large towns suggests that they proved viable competitors.

Charlatans clearly also flourished in the countryside. According to the Strasbourg surgical community, country people being "more credulous" than town dwellers and having difficult access to medical professionals, easily fell victim to illegal practitioners. Doubtless country charlatanism was prevalent. Charlatans may well have been initially attracted to a town and subsequently deflected to the surrounding countryside by local officials and medical professionals. This evidently happened at

<sup>45</sup> A surgeon legitimately received by one community might be rejected as a charlatan if he sought to practice in another. See AD Seine-inférieure C 85 for this happening to a Falaise surgeon wishing to practice at Le Havre.

<sup>46</sup> See R. COBB, *Paris and Its Provinces 1792-1802* (London, 1975), pp. 14-56

Bourges and probably at Moulins as well.<sup>47</sup> The respondents, for the most part, did not localize where charlatanism occurred within their regions. Of those who did, as many made explicit reference to the phenomenon in the town itself as in smaller centers, villages and countryside.<sup>48</sup>

Lyon and Montpellier, cities of about 100,000 and 30,000 inhabitants respectively, seem to refute the notion that charlatans tended to be prevalent in and around large centers. Both cities reported few charlatans in their regions. However, the lieutenants of both surgical communities attributed this happy state of affairs to their own vigorous action against charlatans, not to the latter's neglect of their cities. Lyon and Montpellier in fact possessed strong, well organized surgical communities. Each had royal surgical colleges with special statutes modelled after those of Paris. These structures in concert with other scientific institutions, notably provincial academies and medical corps, conferred an added legitimacy upon professional practitioners. When supported by local administrators and courts, they may have been sufficiently effective to discourage charlatanism.<sup>49</sup>

Few large towns could match the success claimed by the Lyon and Montpellier surgeons. Several had tried. At Moulins and Bourges, the professionals and municipal officials issued temporary permits to some irregular practitioners, chased those who violated their agreements, and deflected some into the countryside. The Strasbourg community reported an abundance of charlatans "in spite of the vigilance of the administrators in this arrondissement." Of nine surgical communities where charlatans successfully penetrated more or less feeble regulatory barriers, all but one were in either large or medium towns.<sup>50</sup>

The notion that charlatans gravitated toward larger centers gains support if we return to a regional analysis. The pockets of low frequency mentioned above — in the centre of the country, in the Basses-Alpes and in the Haute-Garonne, occurred in largely rural regions, sparsely populated and difficult of access. Several instances of charlatan-low respondents in close geographical proximity to jurisdictions who reported a problem are particularly suggestive. In these cases, the charlatan-low member of the pair had a smaller central town. Thus, the lieutenant at Montmorillon, a small town in Poitou, had not seen a charlatan in three years; his counterpart in nearby Poitiers, the chief city in the region, wrote: "empirics

<sup>47</sup> Moulins wrote: "Depuis plusieurs années on ne voit que très peu de charlatans... ils finissent toujours par outrepasser leurs permissions et on est obligé de les chasser. Il en est pourtant toujours quelques-uns qui parcourent les villages et qui font autant de dupes qu'ils peuvent."

<sup>48</sup> Eighteen mention charlatans in town as compared to 13 references to *bourgs*, villages, and countryside. Most of the others gave only a vague designation of "jurisdiction," "arrondissement," "pays," "in these parts," etc.

<sup>49</sup> Lyon and Montpellier each sent printed copies of their special statutes to the *Comité*. For the overall cultural status of these provincial centers, see D. ROCHE, *Le Siècle des Lumières en province. Académies et académiciens provinciaux 1680-1789*, thèse pour le doctorat d'État (Paris, 1973), *passim*.

<sup>50</sup> Belley, the single small town, had a population of nearly 4000.

and charlatans are very common in the arrondissement of my lieutenancy and notably in the town..."<sup>51</sup>

The entire South-west region illustrates a striking tendency of charlatans to seek out important population centres. Eleven communities in chief places of *départements* in the South-west answered the *Comité's enquête*. All, without exception, reported a problem with charlatans. Several — Agen, Auch, Mont-de-Marsan, Pau — fairly shrieked their protests.<sup>52</sup> On the other hand, the four charlatan-low replies from this region, came from places with under 6,000 inhabitants, two from settlements with fewer than 2 000.<sup>53</sup>

One is tempted to suggest a greater prevalence of charlatanism in the South of France as a whole than in the North. To be more precise, if the so-called Saint-Malo-Geneva line noted by historians of education is taken as the line of division, we find "only" about 60% of northern surgical communities reporting charlatans as compared with nearly 80% in the South.<sup>54</sup> South of the Saint-Malo-Geneva line lay a relatively more tradition-bound society, one with much higher rates of illiteracy and, in general, trailing the northern part of France in other indices of high culture.<sup>55</sup> Perhaps too, our data hints, the medical services of charlatans found a warmer reception in the Midi.

Finally, an important qualifier to the above point is in order. Although the *enquête* of 1790-91, lacks a response from the Paris surgeons, it is clear that medical charlatanism flourished in the capital.<sup>56</sup> Paris evidently acted as a magnet for charlatans in the Île de France and beyond. Thus of some twelve responding communities within about seventy-five kilometers of Paris, eight claimed to be untroubled by mobile charlatans.<sup>57</sup> The lure of the great city probably accounted for this pattern of relatively low charlatanism.

<sup>51</sup> A similar situation existed with respect to Nérac (low charlatanism) and Agen (high charlatanism); Dun (low), Issoudun (low) and Bourges (high).

<sup>52</sup> Auch: « Les charlatans fourmillent dans notre département et se succèdent rapidement les uns aux autres. Les municipalités de l'ancien régime et du nouveau sans consulter ni les médecins, ni les chirurgiens, ni les apothicaires, leur permettent tout... » Mont-de-Marsan: « Les charlatans, les empiriques et gens à secret sont très répandus dans notre arrondissement comme partout ailleurs; et ils n'y sont tant répandus que parce qu'ils sont tolérés par ceux même qui devraient les pourchasser... » For other chief places see map. 1. We define "Southwest" as the region south of 46°N. latitude and west of the chain of the Cevennes.

<sup>53</sup> Nérac, Saint-Gaudens, Rieux, and Saint-Pierre Île de Ré.

<sup>54</sup> 24/39 north of the line versus 53/67 south. The greater prevalence of charlatans in the South holds good independent of town size. Thus, for small places, 75% of Southern communities reported charlatans as compared with 56% of Northern places.

<sup>55</sup> R. CHARTIER, D. JULIA, M.M. COMPÈRE, *L'Éducation en France du XVI<sup>e</sup> au XVIII<sup>e</sup> siècle* (Paris, 1976), pp. 16-20, 90-91.

<sup>56</sup> See P. DELAUNAY, *Le monde médical parisien au dix-huitième siècle* (Paris, 1906), pp. 299-308. Numerous regulations against charlatans in the second half of the 18th century testify to the ongoing problem. See B.N. T 18 121, vol. 6, pièces 33, 34. There were several thousand illegal surgeons in Paris in the 1730's. See GELFAND, "Training of Surgeons," p. 62.

<sup>57</sup> Boisseaux, Clermont-en-Beauvaisis, la Ferté Alais, Fontainebleau, Lyons-la-Forêt, Meulan, Montdidier, Triel.

Most of the respondents to the *enquête* estimated the numbers of surgeons received into their community. Such figures permit a description of each community both by the size of the central town and by the number of legal practitioners of surgery. No correlation between the two variables applied for the smaller central towns, some of which claimed upwards of 30 and even 50 surgeons in their jurisdictions. However, once the size of the central town exceeded about 8,000, the surgical community nearly always reported more than 30 members. There are a total of eighteen cases of such large jurisdictions. Leaving aside Lyon and Montpellier whose charlatan-low status has already been discussed, all but two of the remaining sixteen communities perceived a high prevalence of illegal practitioners. Only Moulins and Falaise claimed to have no problem, and Moulins' claim did not include its surrounding region.

In the end, our tentative hypothesis about charlatan prevalence raises more questions than our source is capable of answering. Why does Falaise appear to be an exception? Was this Calvados community, like Lyon and Montpellier, successful in repulsing charlatans? The lieutenant's terse, "I know of no charlatans, empirics, and persons with secrets in my arrondissement" certainly gives no clue to an explanation. Why did Belley in the Franche-Comté have problems with charlatans while Sainte-Menehould in Champagne, a town of about the same size and numbers of surgeons in its region, did not? Why were charlatans "extremely rare" on the Ile d'Oléron yet a problem for surgeons on neighbouring Ile de Ré? Obviously, such questions demand regional studies addressed to the interplay of local medical, geographical, socio-economic, and cultural factors.<sup>58</sup> The regional analysis, on the other hand, becomes meaningful to the extent that it is also comparative, since some evidence for the presence of charlatans can certainly be found in each region. Meanwhile, our hypothesis can perhaps best serve as a cautionary counterweight to the received wisdom which assumed charlatanism to be everywhere prevalent and especially so in more remote medically-deprived places.<sup>59</sup>

### *A Typology of Charlatans*

Medical jurisprudence of the 18th century understood the label "charlatan, empiric or person with secrets" to fit anyone who practiced any part of the healing art without the certification of a community of physicians or surgeons.<sup>60</sup> It served in essence as a legal rubric for a wide variety of extra-professional healers. Occasionally, "persons with secrets" took on a more nuanced connotation; the reply from Hyères deemed such persons — "those who ingratiate themselves with the gullible

<sup>58</sup> See e.g. J.-P. GOUBERT, *Malades et médecins en Bretagne, 1770-1790* (Paris, 1974); F. LEBRUN, *Les Hommes et la mort en Anjou au XVII<sup>e</sup> et XVIII<sup>e</sup> siècles* (Paris, 1971).

<sup>59</sup> P. DELAUNAY, *La vie médicale aux XVI<sup>e</sup>, XVII<sup>e</sup> et XVIII<sup>e</sup> siècles* (Paris, 1935), p. 316; J.-P. GOUBERT, *Malades et médecins* pp. 240-41.

<sup>60</sup> Usually the certification had to come from a local community unless the individual in question could produce a Paris degree. See above fn.45.

by passing for sorcerers” — a serious problem whereas “[charlatans] rarely pass through our cantons”. “Persons with secrets”, in this instance, meant occult healers. But, in general, the respondents to the *enquête* of 1790-91 used the three terms interchangeably as synonyms for the illegal intruder.

The notion of charlatans as mobile, and thus alien to their region of practice, appears regularly if not invariably. A connection with roving peddlers or *colporteurs* seems likely. Often they travelled in groups, sometimes large. At Belley, the lieutenant complained of a “troup of charlatans who for two months distributed very harmful remedies...” Nuits wrote with relief that they no longer saw the “large troupes” which settled in town for as long as six months and made forays into villages of that Burgundy region on holidays and Sundays. Now, the few charlatans generally stayed for a week or two at most. They came to tiny Ham, in the Somme, once each year as well as to Narbonne, at the opposite pole of the country. At Le Quesnoy, charlatans offered their wares and services along with other tradesmen on market and fair days; a country bonesetter name Charry arrived in the city of Carcassonne the first Saturday of every month. Large numbers of charlatans came to Mende in the *département* of the Lozère and to Villeneuve de Berg in the neighbouring Ardèche, and stayed between two weeks and a month.

If most charlatans tended to be ambulatory, a handful of surgical communities also mentioned a more settled type. The lieutenant at Mende noted that some established themselves for several years in the countryside of his jurisdiction. Perhaps urban centres managed to discourage a protracted residence by charlatans. In any case, towns generally reported only the mobile species. The exceptions are worth noting. Crest, a smaller medium town (about 4,500 inhabitants) whose lieutenant retreated before *des gens empiriques sédentaires*, no longer saw mobile charlatans, empirics, or persons with secrets. At the village of Boisseaux (less than 2,000 inhabitants), where the lieutenant of the surgical community had died in 1770 and no surgeons had since been received, the four surviving members reported: “empirics and ambulatory charlatans are beginning to disappear. But settled ones [*domiciliés*] practice all the time.” Crest and Boisseaux, places evidently inhospitable to professionals, proved equally unattractive to mobile charlatans.

Surgical communities also faced serious competition from various kinds of local practitioners. Nearly half the respondents identified such “irregular” types, sometimes conflating them with “charlatans, empirics, and persons with secrets,” sometimes distinguishing them as a separate but no less threatening kind of illegal healer. One may usefully consider three categories most frequently cited: clergy, women, and army surgeons.

The clergy, multifarious and widely distributed in terms of personnel (male and female, regular and secular), institutional niches (convents, monasteries, abbeys, hospitals, hospices, schools, etc.), and functions, constituted the most serious challenge to the surgical communities’ exclu-

sive right to the exercise of their art. The brothers of the Charité hospital made good ambitious claims to practice surgery in their network of hospitals which included Paris itself, important provincial centers (e.g. Metz, Poitiers, Moulins, Grenoble, Saintes, La Rochelle), and smaller places extending down to the village level and colonial establishments at Saint-Domingue and Martinique.<sup>61</sup>

At Domfront in Normandy, the surgeons complained about *prêtres*; the *soeurs de la miséricorde* treated "wounds, ulcers, and fistulas, and I don't know what else", lamented the Narbonne lieutenant. At Beaufort in Anjou, a *société de filles sous le nom de providence* exceeded their proper task of school teaching: "all are healers and their presumption is such that they undertake the most delicate procedures of three sciences by combining the two medicines [medicine and surgery] with pharmacy". At Digne and Riez, small towns in the Alps bypassed by charlatans, village curés defied the local surgeons and treated the sick with "mud of Helvetius" and "Saone waters"; they applied plasters to "all [external] ailments", distributed healing waters for eye problems, treated venereal diseases, and opened abscesses. The lieutenant at Bergerac protested against two *communautés de filles* who had formed a *maison de charité* at the town hospital, an institution under their complete control. Not content with this base for their medical activities, the religious sisters also sold remedies and practiced surgery in town.<sup>62</sup>

The surgeons wrote frankly of the economic threat posed by their clerical competitors. Under the pretext of distributing charity to the poor, the *soeurs de sagesse* and *soeurs hospitalières* of the Ile d'Oléron and their counterparts on neighbouring Ile de Ré treated all kinds of diseases and patients of all social classes, "even the most well-to-do." At Agde the *soeurs grises de la charité* extended medical and surgical services to "the wealthiest houses". Although their fees were small, they had a cumulative impact upon the surgical community of Agde. Several masters had been obliged to leave town for lack of business. The remaining three master surgeons could not deter the practice of "these women protected by our former bishop." At Mende, curés, vicars, and even their domestic servants "enriched themselves" at the expense of the local surgeons; the Morlaix community accused the *soeurs grises* of the town and the *soeurs blanches* of the countryside of giving more attention to the rich than the poor.

Women, outside as well as within clerical orders, often practiced the healing art. Ineligible for membership in medical faculties or surgical communities, women could not acquire any legal status in the medical

<sup>61</sup> *Mémoires pour les religieux de la Charité, défenseurs contre les prévôts et gardes de la communauté des maîtres chirurgiens jurés de Saint-Côme* (Paris, 1715) Copy in B.N. T18 121, vol. 1 pp. 387-402.

<sup>62</sup> "...saignée, application des vessicatoires, cautères, setons et divers pansements, offrent leurs remèdes ou soi-disant leurs spécifiques, toujours disent-elles à meilleur compte que les chirurgiens, et par là s'attirent une bonne partie des pratiques de la ville, tout cela au préjudice de la chirurgie. Cela doit-il leur être permis?"

professions other than that of midwife. Nonetheless, the respondents to the *enquête* confirmed, women engaged in all kinds of healing functions, including major surgical procedures. Nuits reported a female oculist. From Beaufort, the surgical lieutenant wrote of "a certain Madame Souchure, a maker of oil, who recklessly plunges the knife into the delicate parts of the body to cut away or open abscesses [dépôts] regardless of their location. In spite of her rashness, she has helpers who procure dupes for her whom she ruins without curing." Other women worked as hernia experts and dentists.<sup>63</sup> That women engaged in healing activities to an even greater extent than men was indicated by the lieutenant at Luxeuil in the Franche-Comté: "...persons with secrets are tolerated to such a degree in this district that not a single village is without three or four persons — women especially — who practice medicine."

Army surgeons, unlike clergy and women, did not have a virtually ubiquitous distribution. One finds them threatening local surgical communities only in large and/or frontier towns: Strasbourg, Metz, Carcassonne, Arras, Tours, Avenes, etc. among our respondents. The surgeons of the small town of Saint-Martin Ile-de-Ré protested against regimental and army hospital surgeons, "common in garrison towns like ours," who competed for business in the town. At the port city of Rochefort, naval surgeons controlled not only the royal hospital but the municipal civil hospital as well to the detriment of the town masters. The latter lost opportunities to perform major operations "which indisputably take place more often here [in hospital] than elsewhere". At Morlaix, a new military hospital for venereal diseases opened the way for army surgeons to extend their services to "a great number of patients of all kinds". The Strasbourg surgeons were obliged to tolerate the surgeon-majors of hospitals and regiments, their students, and common *fraters* or barber-surgeons who tended the troops.

The respondents noted various other kinds of persons who trespassed into the practice of the healing art: artisans, peasants, self-styled bonesetters, oculists, dentists, apothecaries, etc. A rare physician respondent, from Josselin in Brittany, claimed nearly every parish had "its healer by touch [*thaumaturge*], consulter of urine, bonesetter, or sorcerer". The harried lieutenant of the defunct Crest community wrote that his region lacked "neither women nor men characterized by no particular name who treat the sick in town and countryside alike". Most common were the bonesetters (*rebouteurs*, *rhabelleurs*, *restaurateurs*). Executioners of high justice conserved their time-honored right to treat fractures and dislocations despite the objections of the surgeons at Angoulême, Guingamp and Poitiers. The Poitiers executioner had recently secured a ruling from the Parlement of Paris which reasserted his *privilege* to work on the living. Joining the hangman in this particular healing craft were "an

<sup>63</sup> See *Arrest de la cour de parlement qui ordonne qu'à l'avenir les femmes et les filles ne pourront être agrégées dans l'état d'herniaires et dentistes, ni dans aucune autre partie de la chirurgie, excepté à celle qui concerne les accouchements, sous quelque prétexte que ce soit, etc.* (19 avril 1755). Copy in BN T18 121, vol. 6, pièce 31.

infinite number of country folk, both men and women", the clergy of both sexes, various artisans, and "certain families".<sup>64</sup> At first glance, they appear a random collection. But, in general, they occupied a privileged position with respect to the body and/or the biological cycle of birth, life, and death. This was obviously true of women and clergy. It applied as well to the executioner entrusted with administering death and to the blacksmith,<sup>65</sup> the shepherd,<sup>66</sup> and others who took care of animals.

A few communities reported the classical charlatan who mounted a strategically-placed stage. The one at Seurre in Burgundy was perhaps typical: "we have at this moment an empiric named Audey who gets up on a stage on the central square, begins by amusing his audience, then sells syrups, followed by balms; he also takes the liberty to treat sick people in town and to do operations." At nearby Nuits, the surgeons caustically wrote of the charlatan who had been in their town for the past six weeks: "... a worthy Hippocrates who two years ago was only an unfortunate clown [*saltimbanque*] who could at most entertain our children with poor marionettes and a few tricks."

One would like to know more about the socio-economic level of "charlatans, empirics, and persons with secrets" than the surgical communities were willing or able to say. The obvious heterogeneity of these practitioners cautions against generalization and, especially, against assuming they were all marginal types. Of the two main categories — the fixed and ambulatory — those established in a locality, particularly the clergy and military surgeons, probably were roughly comparable in terms of economic and social status to the master surgeons themselves. Our sources contain intriguing hints that women *de toute condition* and *persons de tout état et sexe* treated the sick.<sup>67</sup> Women, artisans, and peasants engaged in healing activities only as "part-time" practitioners. Doubtless there were financial as well as psychological rewards, though the former must have been modest.

In the case of the mobile practitioners, some, like the "worthy Hippocrates" at Nuits, may well have been marginal persons. But, here too, further study of the charlatans' own discourse rather than that of their enemies is needed.<sup>68</sup> Enough ambulatory healers carried "permissions"

<sup>64</sup> Guingamp, Angoulême. The most famous family of bonesetters was without question the Valdajou, who came from a small town in Lorraine and eventually set up a school for their art in Paris. The entire development occurred outside the regular surgical profession, but received generous support from royal and revolutionary governments. See P. DELAUNAY, "L'École militaire de chirurgie renouëuse et la dynastie médicale des Valdajou," in *Médecine Militaire d'Autrefois* (Paris, 1913), pp. 17-75.

<sup>65</sup> Narbonne, Crest.

<sup>66</sup> St-Sever "...même des bergers qui descendent des montagnes, qui nous viennent tout le temps que dure l'hiver..."

<sup>67</sup> See Arras, and #271 (a fragment of a response which lacks name of locality).

<sup>68</sup> M. RAMSEY "Medical Power and Popular Medicine: Illegal Healers in Nineteenth-Century France," *Journal of Social History*, 10 (1977): 560-587 makes a promising start in this direction for French medicine of a slightly later period. I thank the author for sending me his article and his unpublished MS "Popular Medicine and Medical Enlightenment: The Regulation of Secret Remedies in the Ancien Régime." both of which relate to the problem of popular medical discourse. Unfortunately, these did not come to my attention until after the present paper was completed.



from Paris and provincial authorities (though not necessarily genuine ones)<sup>69</sup> to impress local officials and to suggest a more than marginal status. Court physicians and surgeons and members of the Paris Faculty of Medicine itself sold remedies in the provinces, usually as entrepreneurs,<sup>70</sup> but sometimes they personally took to the road. To cite one humbler example (deriving from outside the 1790-91 *enquête*), the *sieur Cuchet-Salomon, médecin, chimiste et botaniste, domicilié à Paris* arrived in Dijon in the late 1760s.<sup>71</sup> Here he presented a royal permit to sell his *eau cordiale et stomachique* and several other panaceas. He described himself as “twenty years a surgeon-major, much travelled... having received a gunshot wound in the head during the last war, the marks of which remain on his face; he lost his vision for a long time and his wounds were thought to be mortal. But, thanks to his remedies, he enjoys a perfect health, though 80 years old.” The Dijon city fathers approved Cuchet-Salomon’s request.

### *Medical Practice*

The functions of irregular practitioners consisted of two main sorts: ministering to surgical conditions and distributing remedies.<sup>72</sup> Among the diverse ailments subsumed under “surgery”, injuries loomed large in the charlatan’s practice. Bonesetters tended everything from bruises, twists, and sprains to complicated dislocations and fractures. Sometimes, they went further: “...even to remove our dressings and trepans...” or “to dig out crushed ribs and xiphoid cartilage.” (Cognac) An instance of still greater boldness was “a family in this region, of many surgeons, who have no other talent than operating on all simple inguinal hernias by castration. A multitude of victims extending over an area of more than ten leagues around attests to the criminal practice of these destroyers of the human race.” (Arras) Minor surgery — bloodletting, wound dressing, incision of superficial abscesses, fistulae, and tumors, treatment of ulcers and venereal disease — formed the bulk of the charlatan surgeon’s practice just as it did for his legal counterpart, the 18th-century master surgeon.<sup>73</sup>

Even in an *enquête* addressed to surgical communities, the most common complaint against charlatans was dealing in medicinal drugs.<sup>74</sup> The remedies when specified seem fairly innocuous: waters of Seville and of Saône, flower waters, eye drops, powders of Alliat, mud of Helvetius,

<sup>69</sup> Luxeuil, Mont-de-Marsan and Ussel noted the use of fake or forged permits.

<sup>70</sup> Charles Dionis, a leading entrepreneur of the second half of the 18th century and a doctor of the Paris Faculty, commissioned agents to sell his remedies, especially the famous *orviétan*, in various parts of the kingdom. Archives Académie de Chirurgie, carton #4. See also P. DELAUNAY, *Le Monde médical*, pp. 301-304.

<sup>71</sup> AM Dijon I 134.

<sup>72</sup> Slightly more than half (i.e. 40) of the respondents who complained of charlatans described their healing activities. Most of these accounts were quite brief.

<sup>73</sup> See Cognac, Narbonne, Riez.

<sup>74</sup> Mentioned in 28 instances; i.e., 70% of those who described the practice of charlatans. There were 19 instances of explicit complaints about charlatans doing surgery.

herbs, plasters, unguents, purgative pills, etc.<sup>75</sup> The respondent who observed such remedies to be useless at best may have been correct in a strict pharmacologic sense. (La Chataigneraie) It may be doubted, however, that the adverse effects, if any, outweighed a positive placebo action. No explicit mention was made of efficacious preparations such as cinchona bark, ipecac, or opium, though they probably entered into the charlatans' remedies of "secret" composition.

The surgeons directed their strongest protests against those who sold secret remedies such as the *beaume sans pareil* or a *paquet de drogues soi-disant miraculeuses*.<sup>76</sup> Unlike professionals, empirics prescribed and administered remedies without knowledge of causal indications or physiological effects.<sup>77</sup> If charlatans confined themselves to the simple sale of substances of known composition, the surgeons reciprocated with a reluctant tolerance. Those of Saint-Gaudens found that the acceptance of such drug-dealers spared them a more troublesome type of competitor.<sup>78</sup> To the extent that charlatans did not behave as healers, they seemed less offensive to the surgical communities. But this was largely wishful thinking on the part of the surgeons; it ignored the normal meaning and function of charlatanism.

Charlatans, it is clear, were practitioners of the healing art. They did not offer an alternative mode of treatment to the sick. They competed with the professionals on the latter's own ground, employing, for the most part, an empirical and secularized healing art. Although an argument from silence is always hazardous, the relatively few explicit references to magical healers or medical practices suggest that surgeons did not consider such activities (usually taken to have been very widespread) a serious problem. Occult healing may in fact have been regarded not as competitive with secular medicine but rather as compatible or parallel with it, as is the case in many developing countries of the 20th century.<sup>79</sup> In any event, mention of magical healers or healing practices was uncommon: Josselin in Brittany reported those who healed by the laying on of hands (*thaumaturges*), witches, and urine "scanners" in virtually all parishes of the region. Several other respondents noted the presence of persons with "knowledge of urine", witches, magicians or *magés*.<sup>80</sup> Only one — the surgical lieutenant at Beaugency in the Loiret — gave a detailed account of this other medical world:

<sup>75</sup> See Moulins, Digne, Riez, Dourdan, Saint-Sever, Avesnes.

<sup>76</sup> #271. See also Saint-Sever.

<sup>77</sup> Sainte-Menehould, Bray-sur-Seine.

<sup>78</sup> Saint-Martin Île de Ré evidently also found toleration the wisest course of action: "... on n'accorde que deux ou trois jours pour le débit de leurs drogues dans chaque endroit de l'île."

<sup>79</sup> See H. FABREGA and D. SILVER, *Illness and Shamanistic Curing in Zinacantan, an Ethnomedical Analysis* (Stanford, Calif., 1973).

<sup>80</sup> Domfront: "Des habitants de campagne, même un médecin, un chirurgien qui jugent l'eau à la vue..." Tonnerre: "un ou deux connaisseurs en urines." Pontivy and Dourdan also reported urine scanners. Thus, all five such complaints derived from Northern surgical communities in towns with less than 5,000 inhabitants. In the South, Agen, Hyères and Ustaritz noted *magés*, sorcerers and magicians.

For some years a smith at Meury-sur-Loire worked as a charlatan. His reputation was meager for quite some time. Last year a miller from Tavens, near Beaugency, went to consult him about his wife. On inspecting the urine, the smith proclaimed the woman to be bewitched, but that he would cure her for 100 *écus*. The gullible miller brought him the sum; he then proceeded using the heart of a steer pierced with needles, an inverted crucifix, holy candles, and a few incantations pronounced in the miller's presence.

Evidence of charlatans harming the sick is not so impressive as their detrimental effects upon surgical communities. Accusations abound. But once one looks beyond vague, often metaphorical flourishes — the unspecified “cripples”, “victims”, “martyrs”, the “evils”, “misfortunes”, and “ravages”, and the alleged “increase in business after their [charlatans] departure” — circumstantial evidence of physical damage is thin.<sup>81</sup> Only rarely does a lieutenant report, as did the one at Vouveans: “I know two fathers and one mother of families, as well as many others, who have died as a result of their work.”<sup>82</sup> Besides the family who did castrations for hernias, perhaps the most serious explicit accusation was that levelled against a “certain Toscan”, the “chief” of a band of three charlatans and their “students”, who worked in and around Auch in Gascony. This charlatan, according to the Auch surgical lieutenant, had rashly discarded remedies which a local physician had prescribed for an outbreak of mushroom poisoning, and substituted his own drugs. When the six victims took a turn for the worse, several physicians finally intervened, and Toscan took flight. The professionals managed to save four persons with their “counterpoison”. The remaining two died.

Surgical communities repeatedly criticized the diagnostic abilities of charlatans. Their most frequent targets were bonesetters, who, it was alleged, regularly mistook minor contusions and sprains for fractures and dislocations. Such ignorance or, at times, willful fraud underlay empirics' claims of “rapid” cures which in fact cheated patients of time as well as money.<sup>83</sup> Even if one accepts the validity of these criticisms, they accused charlatans of a form of malpractice which generally did not involve physical harm to its victims. In the end, the surgical communities failed to make a persuasive case against their rivals. Differences in practice between the two groups are less striking than the similarities.

<sup>81</sup> Typical of the surgeons' grandiose charges against charlatans was the response from Breteuil: “... cette secte d'Autopophages qui ne semble respirer que pour déprécier l'art de guérir et moissonner impunément le trop crédule campagnard.” Some 25 respondents asserted that charlatans harmed the sick.

<sup>82</sup> Cognac claimed that bonesetters' crude manipulations crippled their victims and often gave rise to “accidents les plus graves, car nous avons vu plusieurs fois les vomissements du sang être la suite de ces attouchements durs et peu ménagés qui souvent nous ont fait craindre pour la vie des malades.”

<sup>83</sup> Crest: “J'ai deux rebouseteurs dans mon ressort... je peux prouver que l'un et l'autre avait réduit chacun un bras... disant d'être rompu et qu'ayant été appelé tant pour l'opération de l'un que de l'autre, je n'ai trouvé aucune fracture... ridicule absurde qui est extrêmement couteuse aux peuples se faisant payer pour fracture n'étant qu'inflammation... il [the charlatan] se flatte publiquement guérir les fractures en 19 ou 20 jours au plus, n'étant pas difficile dès qu'il n'a rien rompu.” Angoulême, Arras, Beaufort, and Cognac made similar accusations.

*Attitude of Authorities*

Questioned on the "degree of tolerance" accorded charlatans, the surgical communities responded with bitter complaints. Charlatans were not merely tolerated; they were encouraged, protected, and, when they bothered to ask, furnished with written permits to practice the healing art. Authorities at every level in the new government, as earlier in the Old Regime, ignored or rejected the surgeons' protests, accusing the legitimate practitioners of selfishness and jealousy. Formerly it had been the king or royal court (Mantes, Bergerac), the king's *premier* physician or the *Commission Royale de Médecine*<sup>84</sup> (Nuits, Tartas, Mende, Luxeuil), intendants (Limoges), parlements (Guingamp),<sup>85</sup> or provincial governors (Rieux), who had permitted charlatanism to flourish. Now, it continued to be tolerated, by local courts of justice (Angoulême, Boisseaux), municipalities (Vitry-le-François, Tartas), mayors (Vesoul, Luxeuil), police (Rochefort, Narbonne, Metz, Tours, Meaux, etc.), and the National Assembly itself (Mende). Surgical communities themselves sometimes refrained from prosecuting charlatans for fear of popular reprisal.<sup>86</sup>

A small minority of respondents noted regulatory efforts by central and/or local authorities, praising in particular the *Société Royale de Médecine's* campaign against charlatans during the last decade of the Old Regime. Sometimes, the result had been a measure of success, as in the case of La Ferté Alais: "we see few charlatans... tolerating only those with permits from the *Commission Royale de Médecine*,"<sup>87</sup> or even victory: "we have succeeded in ridding our town of charlatans, etc." claimed the Saint-Dizier lieutenant, "by means of requests presented to the police and the municipality". On the other hand, about half of the surgical communities who cited the cooperation of government officials still failed to control charlatanism.

The widespread indulgence of irregular medical practitioners by the entire spectrum of administrative and judicial authority is difficult to explain simply as another instance of bureaucratic venality. Surely, corruption existed; if money could be had from the sale of medical permits, many officials could be expected to exploit the opportunity.<sup>88</sup> At the same

<sup>84</sup> The *Commission de Médecine*, set up in 1772 to examine requests for the sale of new remedies and to grant permits to their inventors, was superseded by the *Société de Médecine* a few years later. Yet, respondents still referred to the defunct commission.

<sup>85</sup> "Ils [charlatans] ont par les lois faites de l'ancien ci-devant parlement de Bretagne tout pouvoir; plusieurs arrêts du Parlement les maintenir [sic] dans les privilèges. Si le Parlement de Rouen croyait aux sorciers, celui de Bretagne croyait aux inspirés." See also Beaufort, Poitiers.

<sup>86</sup> Albi: "nous sommes forcés de les tolérer malgré le mal que nous leur voyons faire pour éviter le blâme public."

<sup>87</sup> See above note 84. Beaugency praised the efforts of the *Société* and its secretary, Vicq d'Azyr. Nuits credited the *Société* "qui avait coupé le cou à tous les charlatans entretenus par le premier médecin du Roi..."

<sup>88</sup> The Metz surgeons flatly accused the police of taking bribes from charlatans. A few other communities implied similar practices, but the evidence for straightforward toleration overwhelms these instances: 56 respondents; i.e., 77% of those reporting charlatans, complained of official toleration.

time, those in positions of power genuinely valued the services charlatans provided. As one surgical community noted: "the majority of magistrates are as ignorant in their support of charlatans as the people themselves." (Boisseaux) Of the latter's ignorance or, to use the favoured word, their "credulity", the surgeons had no doubts: "the credulous people become their dupes," chorused one respondent after another.<sup>89</sup> From credulity it was but a short step to confidence; several communities explicitly remarked the "blind confidence" which the people had in charlatans.<sup>90</sup> The injured believed in the bonesetter's "secret" (Ussel), and the sick placed their faith in the druggseller's remedies. "It even seems," observed the Tours lieutenant with palpable distaste, "that the class of the wretched takes a kind of satisfaction in being fooled<sup>91</sup>."

Wealth and social standing did not necessarily confer skepticism. The rich too fell victim to charlatans, and for the same reasons as the poor, "hoping for more from one who promises everything". (Nuits) Kings, nobles and *philosophes* alike patronized charlatans and sought out their services. Even one respondent to the *enquête* noted that some empirics had considerable success. In this exceptional instance of candor, however, praise went to "a few good preparations" not to the healers themselves (Hyères).<sup>92</sup> Other professional medical men of the 18th century tended to make similar distinctions when they acknowledged, in rare and reluctant admissions, that charlatans were not always pernicious. The modern reader has less difficulty accepting the fact that charlatans sometimes succeeded in healing the sick. One is inclined however to invert the 18th-century interpretation of the healing dynamic and to attribute it less to the efficacy of drugs than to the charlatan's personal impact on his patient:

many of them take on such an imposing manner [*ton*] with their assumed titles and such an enchanting quality that almost no one, except members of our profession, escapes their seduction. You know as well as we how difficult it is to restore the reason of people dumfounded by the miraculous. (Mont-de-Marsan)

The ample testimony of popular reliance on charlatans suggests a widespread, firmly-held confidence in their power to cope with ailments, a confidence which must have had a positive healing action of its own and which acted synergistically with whatever "good preparations" happened to be used.

## CONCLUSION

Surgical communities perceived the advent of the Revolution with mixed feelings. To the extent that they observed any immediate impact of

<sup>89</sup> E.g. Viviers, Châtel, Narbonne, Breteuil, Auch, Saint-Omer.

<sup>90</sup> Cognac, Arras, Riom.

<sup>91</sup> A physician reporting from Saint Omer noted the same phenomenon: "...le peuple aime à être trompé."

<sup>92</sup> "...certaines personnes qui sont munies de quelques bonnes formules et qui guérient en empiriques, font souvent des bonnes cures." It is perhaps significant that a local physician rather than a surgical lieutenant signed this response.

political events upon the level of medical charlatanism, they expressed concern over a deteriorating situation: "They call themselves doctors and surgeons of the nation, [and] display permits from the National Assembly..." (Mende). Abuses had "increased infinitely since the people believe themselves above laws and regulations" (Boulay). The new Constitution had even abolished the surgical mastership (Pau).<sup>93</sup>

Such misgivings, however, were overwhelmed by Revolutionary optimism. A "new era" was dawning in which charlatanism, like other abuses of the Old Regime, would surely be swept away, perhaps by the wise rulings of the *Comité de Salubrité* itself.<sup>94</sup> The emotions which most respondents felt on the subject of charlatanism arose from several levels of past grievances and future hopes.

In the first place, illegal practitioners, as we have seen, threatened the very livelihood of often vulnerable professional communities. Second, they challenged the professionals' competence and tended to make a mockery of the notion of medicine as a science. From the time of Molière to that of Sébastien Mercier, the enlightened public's continuing and cruellest insult had been not that charlatans were necessarily superior to learned doctors, but that one could not really distinguish between the two in terms of what mattered most to patients — alleviation of illness.

On a more general level, charlatanism epitomized a disregard for law and order, a scorn for properly constituted institutions. Charlatans were corrupt and devious. They bribed local police and exploited the letter of the law which required that they be caught in the act to be prosecuted, an apprehension "morally impossible" in the case of illegal operators since it would be dangerous for the patient, and "physically improbable since operations and dressings are counted in minutes" (Metz). Charlatanism, ultimately, for professional medical men, was a flagrant denial of the social and medical order they envisioned.

Surgical communities, plagued with charlatans, dreamed of a new society in which medicine would have a prominent role. Many presented specific projects to the *Comité de Salubrité*: a new school or hospital (Rochefort, Limoges, Metz), a course of accouchements (Beaufort), state-supported surgeons in each canton (Crest, Rosières), etc. Even more striking was the utopian tone of their rhetoric; charlatans would be "entirely banished" (Avesnes), their "race" would be "extirpated" (Mont-de-Marson), the healing art, purged of a plague which strikes at all its parts without sparing any, will soon flourish and lavish its benefits upon suffering humanity" (Breteuil). Such benefits would transcend merely healing the sick: the destruction of "every kind of charlatanism to its roots" led directly to the "preservation of mankind in health" (Auch). Health, in short, became equated with the good life; its maintenance, the task of enlightened professionals. Scientific knowledge, wise

<sup>93</sup> Nuits, Vitry-le-François, and Belley also noted an increase in charlatanism since the Revolution.

<sup>94</sup> E.g., Viviers, Breteuil, Poitiers, Ustaritz.

regulations, and effective institutions would prevent disease and its attendant evils.

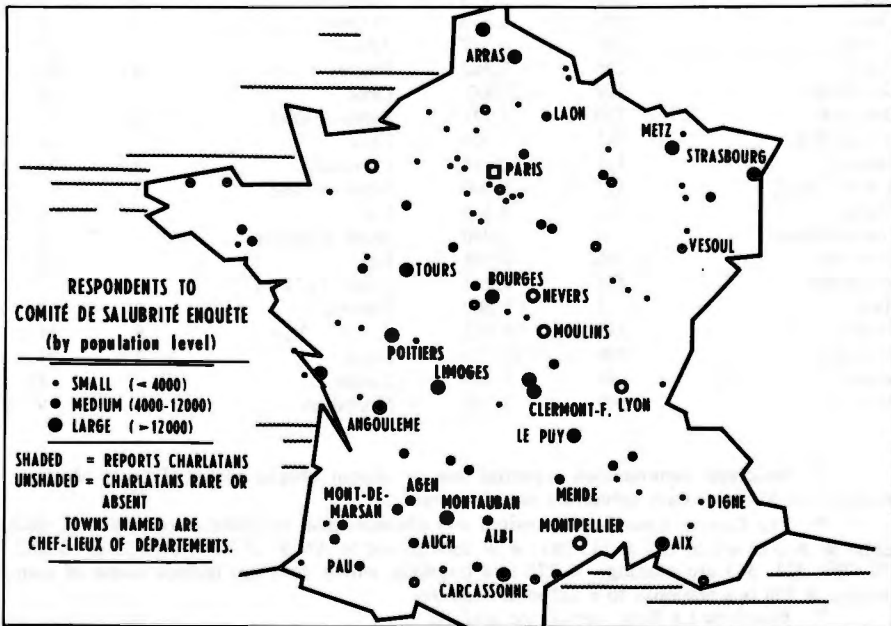
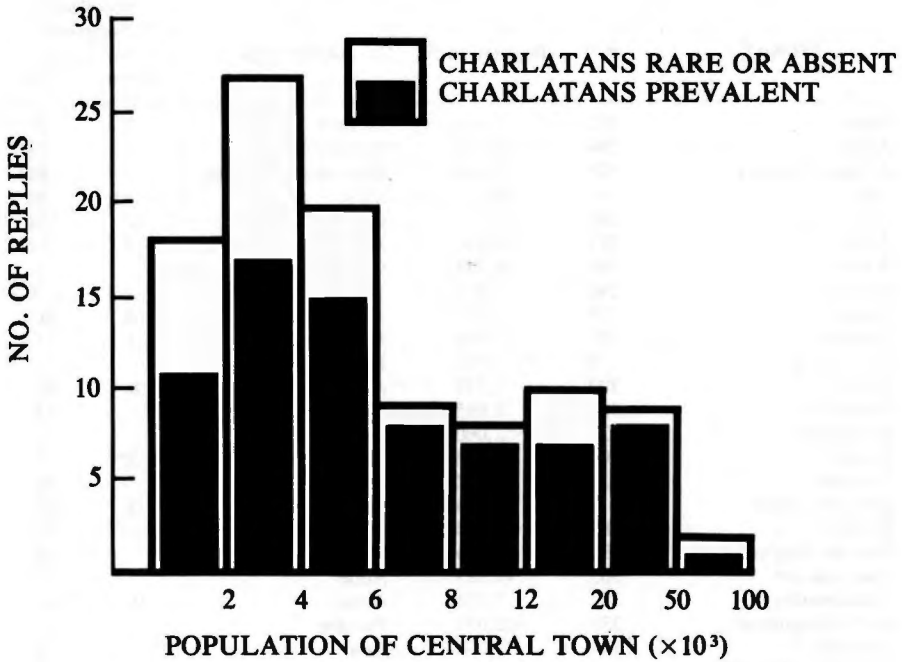
The hopes and dreams were ambitious, extravagantly so given the technical powers of late 18th-century medicine. In any case, they were not shared by a society which had other, more amenable abuses against which Revolutionary fervor could be exerted. This is not to deny that French medicine underwent its own revolution during the decade of the 1790s. The so-called Paris clinical school, established by the Convention in December 1794, may justly be considered the starting point for much of modern medical science and diagnostic techniques. Little attention, however, was devoted to improving treatment of the sick. Convinced that a positivistic description of diseases was a necessary precondition for therapy, the new medicine turned increasingly toward an impersonal science and away from the traditional doctor-patient or healer-sufferer relationship.<sup>95</sup> At the same time, the Revolutionary decade saw a flourishing of medical charlatanism, a phenomenon which continued to draw strength from a patient-centered, therapeutic orientation. Those who determined public policy showed a willingness to support professional medical science and teaching institutions. They continued to hedge their investment as far as medical practice was concerned. For the entire Revolutionary decade, no legal distinction was drawn between professional and charlatan.<sup>96</sup> Until the law of 1801, medical practice remained open to all.

French society apparently understood and accepted the results of the *Comité de Salubrité enquête* of 1790-91: the widespread prevalence and tolerance of charlatans, and their successful functioning on a competitive basis at the center of the medical economy as well as on its periphery. Unlike the alarmed professionals, Revolutionary France viewed the situation with indifference if not equanimity. Charlatanism had its uses, perhaps even its virtues.

<sup>95</sup> See E.H. ACKERKNECHT, *Medicine at the Paris Hospital, 1794-1848* (Baltimore, 1967).

<sup>96</sup> Patents replaced degrees: "Whoever wishes may call himself a physician or a surgeon. A patent, that is to say, the money to pay for a patent takes the place of all studies, all academic requirements." *Pétition au corps législatif*, 28 Prairial V [16 June 1797] (Paris 1797). Copy in AN, AD VIII 42. A group of 28 Paris medical men presented the petition.

DISTRIBUTION OF REPLIES ACCORDING TO POPULATION





Appendix 1: RESPONDENTS TO *COMITÉ DE SALUBRITÉ ENQUÊTE*

| Town <sup>97</sup>            | # <sup>98</sup> | Population <sup>99</sup> | Department       | Number of Surgeons |       |
|-------------------------------|-----------------|--------------------------|------------------|--------------------|-------|
|                               |                 |                          |                  | Town               | Total |
| Agde                          | 263             | 7,639                    | Hérault          | 3                  | 16    |
| Agen                          | 284             | 10,850                   | Lot-et-Garonne   | 7*                 | 82*   |
| Aix-en-Provence               | 325             | 21,960                   | Bouches-du-Rhône |                    | 88*   |
| Albi                          | 315             | 10,061                   | Tarn             | 4*                 | 80    |
| Angoulême                     | 266             | 15,011                   | Charente         | 12                 | 160   |
| Arras                         | 312             | 19,286                   | Pas de Calais    | 9                  | 64*   |
| Auch                          | 316             | 8,918                    | Gers             |                    |       |
| <i>Avesnes</i>                | 292             | 3,031                    | Nord             | 1                  | 8     |
| Baugé                         | 318             | 3,150                    | Maine-et-Loire   | 6                  | 40    |
| Beaufort                      | 339             | 5,968                    | Maine-et-Loire   | 5                  | 15    |
| Beaugency                     | 6               | 4,520                    | Loiret           |                    |       |
| Belley                        | 309             | 3,775                    | Ain              | 6                  | 58    |
| Bergerac                      | 331             | 8,665                    | Dordogne         |                    | 15    |
| Boisseaux                     | 337             | <2,000                   | Loiret           |                    | 4     |
| Boulay                        | 308             | 2,772                    | Moselle          | 3*                 | 7     |
| Bourges                       | 324             | 17,552                   | Cher             |                    | 30    |
| Bray-sur-Seine                | 7               | 2,024                    | Seine-et-Marne   | 3                  | 12    |
| Breteil                       | 289             | <2,000                   | Eure             |                    | 19    |
| Buis-les-Barronnies           | 291             | 2,196                    | Drôme            |                    | 16    |
| Carcassonne                   | 305             | 14,985                   | Aude             |                    | 52*   |
| Castelnaudary                 | 302             | 7,924                    | Aude             | 10                 | 42    |
| La Châtaigneraie              | 353             | <2,000                   | Vendée           |                    | 9*    |
| Chaussin                      | 344             | <2,000                   | Jura             |                    | 4     |
| <i>Châtel-sur-Moselle</i>     | 260             | <2,000                   | Vosges           | 2                  |       |
| <i>Clermont-en-Beauvaisis</i> | 1               | 2,135                    | Oise             | 3                  | 13    |
| Clermont-Ferrand              | 327             | 30,982                   | Puy-de-Dôme      | 12                 | 15*   |
| Cognac                        | 278             | 3,134                    | Charente         | 5                  | 7     |
| Crest                         | 326             | 4,370                    | Drôme            | 3                  | 6     |
| Cusset                        | 355             | 4,547                    | Allier           |                    | >25   |
| <i>Digne</i>                  | 295             | 3,362                    | Basses-Alpes     | 4*                 | ~30   |
| Domfront                      | 307             | <2,000                   | Orne             |                    | 24    |
| Dourdan                       | 320             | 3,147                    | Seine-et-Oise    | 5                  | 10    |
| <i>Dun-le-Roi</i>             | 267             | 2,929                    | Cher             |                    | 10    |
| <i>Falaise</i>                | 311             | 12,891                   | Calvados         | 8                  | 35    |
| <i>la Ferté Alais</i>         | 313             | <2,000                   | Seine-et-Oise    | 3                  |       |
| Figeac                        | 332             | 6,640                    | Lot              |                    | 38    |
| Fontainebleau                 | 5               | 9,040                    | Seine-et-Marne   | 3                  | 3     |
| Gourdon                       | 346             | 5,558                    | Lot              |                    | 25    |
| Guingamp                      | 275             | 4,973                    | Côtes-du-Nord    | 3                  |       |
| Ham                           | 2               | <2,000                   | Somme            | 3                  | 3     |
| <i>Hyères</i>                 | 333             | 6,982                    | Var              | 8                  | 31    |
| <i>Issoudun</i>               | 356             | 10,719                   | Indre            | 7                  | 24    |
| Joigny                        | 348             | 5,176                    | Yonne            |                    | 3*    |
| Josselin                      | 269             | 2,700                    | Morbihan         | 3                  | 9     |

<sup>97</sup> Italicized communities reported low or absent charlatanism. Hyères, Morlaix, Nevers, and St-Sever each submitted two responses.

<sup>98</sup> The *Comité's* numbering system was chronological by order of reception of each reply. # # 1-12 are in AN F 15 2281: # # 260-359 are in AN F 17 2276, doss. 2 (# # 282, 290, 297, 321, 343 are missing). # 271 is a fragment which does not include name of community; # 358 is a response to a different *enquête*.

<sup>99</sup> Based on LE MÉE, see above note 16.

| Town <sup>97</sup>             | # <sup>98</sup> | Population <sup>99</sup> | Department          | Number of Surgeons |         |
|--------------------------------|-----------------|--------------------------|---------------------|--------------------|---------|
|                                |                 |                          |                     | Town               | Total   |
| Laon                           | 314             | 6,976                    | Aisne               |                    | ~60     |
| Limoges                        | 340             | 21,757                   | Haute-Vienne        |                    |         |
| Luxeuil                        | 336             | 3,040                    | Haute-Saône         | 4*                 | 15      |
| Lyon                           | 299             | 102,041                  | Rhône-et-Loire      | 111                | 174     |
| <i>Lyons-la-Forêt</i>          | 288             | <2,000                   | Eure                |                    | 16      |
| Mantes                         | 265             | 3,976                    | Seine-et-Oise       | 5                  | 12      |
| Meaux                          | 10              | 6,573                    | Seine-et-Marne      |                    | 28      |
| Mende                          | 273             | 5,890                    | Lozère              |                    | 57      |
| Metz                           | 298             | 39,133                   | Moselle             | 15                 | 13*     |
| Meulan                         | 4               | 2,000                    | Seine-et-Oise       |                    | 2*      |
| Montauban                      | 261             | 23,973                   | Lot                 | 10*                | 49*     |
| Mont-de-Marsan                 | 357             | 5,256                    | Landes              |                    | 33      |
| <i>Montdidier</i>              | 3               | 4,130                    | Somme               | 5                  | 46      |
| Montereau                      | 12              | 3,453                    | Seine-et-Marne      | 4                  | 6       |
| <i>Montmorillon</i>            | 306             | 3,313                    | Vienne              |                    | 39*     |
| <i>Montpellier</i>             | 335             | 33,264                   | Hérault             | 28                 | 98      |
| Moret                          | 11              | <2,000                   | Seine-et-Marne      |                    | 9       |
| Morlaix                        | 303             | 9,937                    | Finistère           | 6                  | 13      |
| Mortagne                       | 8               | 5,148                    | Orne                | 3                  | 8       |
| <i>Moullins</i>                | 322             | 14,101                   | Allier              |                    | 48*     |
| Narbonne                       | 274             | 9,464                    | Aude                | 10                 | 40      |
| <i>Nérac</i>                   | 276             | 5,769                    | Lot-et-Garonne      | 6                  | 40      |
| Neufchâtel-en-Bray             | 272             | 3,063                    | Seine-Inférieure    | 2                  | 26      |
| <i>Nevers</i>                  | 347             | 12,077                   | Nièvre              | 9                  | 27*     |
| Nuits                          | 294             | 2,633                    | Côte-d'Or           | 2                  | 9       |
| Pau                            | 338             | 9,293                    | Basses-Pyrénées     |                    | 143*    |
| Parthenay                      | 304             | 3,527                    | Deux-Sèvres         | 7                  | 19      |
| Pithiviers                     | 280             | 3,038                    | Loiret              |                    | 16      |
| Ploërmel                       | 269             | 4,758                    | Morbihan            |                    | 22      |
| Poitiers                       | 293             | 21,465                   | Vienne              | 11                 | 64*     |
| Pontivy                        | 270             | 4,929                    | Morbihan            | 3                  | 13      |
| Le Puy                         |                 | 12,318                   | Haute-Loire         |                    |         |
| <i>Le Quesnoy</i>              | 9               | 3,624                    | Nord                | 2                  | 2       |
| <i>Rieux</i>                   | 283             | <2,000                   | Haute Garonne       |                    | 54      |
| Riez                           | 296             | 2,932                    | Basses-Alpes        | 1                  | 8       |
| Riom                           | 328             | 14,114                   | Puy-de-Dôme         | 7                  | 91      |
| Rochefort                      | 286             | 14,615                   | Charente-Inférieure |                    | 9*      |
| <i>Rosières</i>                | 329             | 2,754                    | Meurthe             |                    | 5       |
| St.-Dié                        | 264             | 6,152                    | Vosges              | 3                  | 7       |
| <i>St.-Dizier</i>              | 279             | 5,614                    | Haute-Marne         |                    | 5*      |
| <i>St.-Gaudens</i>             | 277             | 5,054                    | Haute-Garonne       |                    | 22*     |
| St.-Martin Île de Ré           | 268             | 2,230                    | Charente-Inférieure | 9                  | 17      |
| <i>Ste.-Menehould</i>          | 285             | 3,565                    | Marne               | 2                  | 55      |
| St.-Omer                       | 351             | 20,362                   | Pas-de-Calais       |                    | 38      |
| <i>St.-Pierre Île d'Oléron</i> | 350             | <2,000                   | Charente-Inférieure |                    | 14      |
| St.-Pierre-le-Moutier          | 352             | <2,000                   | Nièvre              | 3-4                | ~120    |
| St.-Sever                      | 334             | 5,244                    | Landes              | 9                  | 78      |
| Seurre                         | 319             | 3,111                    | Côte-d'Or           | 3                  | 5       |
| <i>Sisteron</i>                | 317             | 3,642                    | Basses-Alpes        |                    | 30      |
| Strasbourg                     | 359             | 51,465                   | Bas-Rhin            | 26                 | 15*     |
| Tartas                         | 342             | <2,000                   | Landes              |                    | ~250    |
| <i>Tonnerre</i>                | 349             | 4,190                    | Yonne               |                    |         |
| Tours                          | 330             | 21,703                   | Indre-et-Loire      |                    | 100-120 |

| Town <sup>97</sup> | # <sup>98</sup> | Population <sup>99</sup> | Department      | Number of Surgeons |       |
|--------------------|-----------------|--------------------------|-----------------|--------------------|-------|
|                    |                 |                          |                 | Town               | Total |
| <i>Triel</i>       | 341             | <2,000                   | Seine-et-Oise   | 1                  | 1     |
| Ussel Bas Limousin | 300             | <2,000                   | Corrèze         |                    | 21    |
| Ustaritz           | 354             | <2,000                   | Basses-Pyrénées |                    | 45    |
| Vesoul             | 287             | 5,703                    | Haute-Saône     |                    | 40    |
| Vierzon            | 345             | 7,201                    | Cher            |                    | 6     |
| Villeneuve-de-Berg | 301             | <2,000                   | Ardèche         |                    | 6     |
| Villeneuve-le-Roy  | 310             | 5,001                    | Yonne           | 4                  | 9*    |
| Vitry-le-François  | 281             | 7,194                    | Marne           | 4                  | 49    |
| Viviers            | 262             | <2,000                   | Ardèche         | 4                  | 6     |

\* Received since 1770

## Appendix 2. THE REPRESENTATIVENESS OF THE 1790-91 FRAGMENT

1. *Geographical*: At first glance, the 106 responses appear scattered throughout the entire kingdom with no conspicuous bias. (Map 1) Of the 30 odd *généralités* of the Old Regime, virtually all are represented, 19 with three or more replies. At the smaller level of the new *départements*, however, gaps become evident. Twenty-four of the 83 *départements* are not represented at all, and these silent areas tend to cluster. Three clusters of non-responding *départements* are discernible in the following regions: the Loire Valley (7 *départements* missing), the South-east (5 missing) and along the Spanish border (3 missing). Thus, the geographical dispersion of the replies, while broad, cannot be considered comprehensive in coverage.

2. *Urban Level*: The surgical communities who responded to the *enquête* may be classed according to the population of their towns as follows: 21 in large towns, 38 in medium towns, and 27 in small towns. (The remaining 20 replies came from places with less than 2000 inhabitants). If the proportions in each category are compared with the global distribution of French towns, one finds a marked overrepresentation of large towns in the 1790-91 *enquête* and a matching underrepresentation of small towns; the proportion in the medium range (44.2%) is only slightly in excess of the global figure (39.5%). The administrative status of the towns displays a similar pattern: 25 of the surgical communities were in departmental "chief places", 56 in district chief places, and 25 or slightly less than one-quarter of the total in places of an inferior administrative level.

One would expect the distribution of surgical communities to be thus skewed in favour of larger centers. It is, if anything, surprising to find as high a proportion of replies as we do from places which were *not* large. The approximate fit between medium towns in the 1790-91 *enquête* and medium towns globally suggests an accurate sample of that level of town. Clearly, however, the question which needs to be answered is not whether the fragment is representative of all French towns, but rather is it a balanced cross-section of towns with surgical communities; i.e. the towns to which the *Comité de Salubrité* report was addressed?

3. *Surgical Communities*: A complete list of provincial communities with lieutenants of the king's *premier* surgeon, such as the one the *Comité de Salubrité* used in 1790, is no longer available. There are however, in the *procès-verbaux* of the Paris *Académie de Chirurgie* several lists of surgical communities for the period 1755 to 1764. (Mss 20-22, Académie de Médecine). When combined with those in the *enquête* of 1790-91, one arrives at a total of approximately 380 surgical communities in France at the end of the Old Regime; an exact total would be illusory because of the continuous birth and death of surgical communities. Creations of new communities in Lorraine, for example, were numerous after the formal annexation of that province to the crown in 1766.

If the locations of surgical communities are then classed according to large, medium and small populations, one finds an impressive correlation at all three levels with the 1790-91 fragment:

|        | <i>French Surgical Communities</i> |       | <i>Respondents 1790-91<br/>Enquête</i> |       |
|--------|------------------------------------|-------|--|-------|
|        | N°.                                | %     | N°.                                    | %     |
| Large  | 61                                 | 16.2  | 21                                     | 19.8  |
| Medium | 157                                | 41.6  | 38                                     | 35.8  |
| Small  | 159                                | 42.2  | 47                                     | 44.4  |
| TOTAL: | 377                                | 100.0 | 106                                    | 100.0 |

The respondents to the *Comité de Salubrité enquête* thus appear representative of French surgical communities, as far as the population of their towns is concerned. Certain distortions in the geographical distribution of replies are evident; e.g. the province of Normandy is underrepresented proportionally (4.7% of respondents to the *enquête*, 11.5% of French surgical communities) while Languedoc is overrepresented (10.5% of respondents, 6.5% of surgical communities). The South in general, is better represented with 32% of surgical communities responding as compared to 24% from the North.