In search of a cure : the patients of the Ghent homoeopathic physician Gustave A. Van den Berghe (1837-1902)
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In Search of a Cure

The Patients of the Ghent Homoeopathic Physician Gustave A. Van den Berghe (1837 - 1902)
IN SEARCH OF A CURE

THE PATIENTS OF THE GHENT HOMOEOPATHIC PHYSICIAN
GUSTAVE A. VAN DEN BERGHE (1837-1902)

ACADEMISCH PROEFSCHRIFT

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aan de Universiteit van Amsterdam
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               Prof. dr. M. Dinges

Faculteit der Geesteswetenschappen

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When I started this research nearly six years ago, I had no real idea what I was to be involved with. With the help of the initiator for studying the patients of Gustave Van den Berghe, my promotor Marijke Gijswijt-Hofstra, it has been very fulfilling. Her indefatigable enthusiasm and interest in my work have been extremely welcome and necessary over the years. I am deeply grateful for her encouragement, support and friendship in completing this thesis; she has become more than my teacher. My other promotor Martin Dinges has shared his invaluable knowledge with me and I have benefited greatly from his interest and comments. Both, finally, have contributed meaningfully to my ‘scientific self-confidence’. In times of academic doubt, they were remarkably able to remove my worries and to inspire me to carry on.

This project would not have been initiated without the ‘historical consciousness’ of the great-grandson of Gustave Van den Berghe, Jean-François Vermeire. He appreciated the true value of Van den Berghe’s casebooks and permitted them to be used for the benefit of research. Mr. Vermeire offered me free use of the archive and even allowed me to move the material to Amsterdam. I had also the pleasure of spending some lovely afternoons at his home in St. Niklaas, Belgium, working my way through Van den Berghe’s library and collection of homoeopathic periodicals, and discussing Van den Berghe’s private life with him and his father, Pierre Vermeire. I am indebted to them for sharing invaluable information with me. I am also very grateful to Jean-François Vermeire for placing some personal photos of Van den Berghe and his family at my disposal.

One of the reasons for feeling so privileged for the last few years, lies in the fact that I have spent much time in one of Belgium’s most beautiful cities: Ghent. Besides the idea that, at times, I was walking through history itself, the enormous kindness and hospitality I met, almost made me forget that I was working and not on holiday. The personnel at the Centrale Bibliotheek have been invariably helpful. The staff of the Dienstencentrum Stad Gent, Phillipe Debergh, Annie Keverijn and Tania DeRoeck, lightened my dark days in the cellars containing the registers of births, marriages and deaths. A cup of coffee and a chat were welcome distractions during this ‘dusty’ work.

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Writing this thesis has been a pleasure because, amongst others, it was a relief to share the less happy side of scientific production with my fellow students. We all, at times, felt as if we were drowning and the assurance that I was not the only one made my life a lot easier. I would like especially to thank my dear friend and colleague Gemma Blok; she not only went ahead in having a baby and shared that experience with me but also she acted often as my ‘mental coach’ in times of PhD-stress. I love her for that. I want to thank also all those who made useful comments on the papers I presented at several Anglo-Dutch-German workshops in Stuttgart, Amsterdam and Warwick. John Woodward took up the task of correcting the English of this dissertation, a time-consuming and difficult assignment. I am greatly indebted to him for his help. Leo Dijkstra and Gerko van Beek designed the lovely cover. They had to put up with an extremely agitated individual. For that I apologize, their cover is splendid!

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Dear Eric: My thesis is finished and, besides an occasional ‘dipje’, I hope I did not let you suffer too much. Thank you endlessly for your encouragement, your capacity for logical thought, your mental balance (which, at times, I lack) and your layout expertise. Your support has been indispensable. I love you for brightening up my days and your infinite faith in me. Dear Teuntje: My little ‘smurf’. Your appearance into this world reminds me every day that the present is at least as important as the past. On to the future!
Contents

Acknowledgments iii
List of Illustrations vii
List of Graphs and Tables viii
Abbreviations x
Patients’ Privacy xi

Introduction 1

1 Homoeopathy as the True Key to Healing. Gustave Van den Berghe (1837-1902) and His Position Within the Belgian Homoeopathic Domain 20
  1.1 Samuel Hahnemann (1755-1843) and the Homoeopathic Healing Method 21
  1.2 Gustave Adolphe Van den Berghe (Zwevegem 1837 - Ghent 1902) 25
  1.3 Van den Berghe’s Career in Medicine: the Change from ‘Allopathy’ to Homoeopathy 29
  1.4 Van den Berghe’s Commitment to the Belgian Homoeopathic Movement 37

2 Patients from Everywhere: Gustave Van den Berghe’s Overall Clientele, 1865-1902 47
  2.1 From Zwevegem to Ghent: the Total Number of Patients Treated by Van den Berghe 47
  2.2 The Social Features of the Entire Clientele over Time. Patients’ Age, Gender and Residence: A Changing Composition? 53
  2.3 Renowned Across the Border: Patients from France and the Netherlands 63
  2.4 Recapitulation 73

3 Health, Illness and Healing in the Ghent Community 75
  3.1 The ‘Manchester of the Continent’: Ghent in the Nineteenth Century 76
  3.2 Sufferers’ Options for Healing: the Availability of Medical Care 85
  3.3 ‘I Have Tried Whatever Needed’: the Therapeutic Past of Van den Berghe’s Patients 98
  3.4 Recapitulation 108

4 Citizens Suffering: the Ghent Patients’ Profile 111
  4.1 A Patients’ Portrait: Age, Gender and Marital Status of the Clientele 113
  4.2 Sufferers and Their Environment: Living and Working in an Industrial Bulwark 119
  4.3 Too Poor to Pay: Patients Treated for Free 130
  4.4 Recapitulation 136
List of Illustrations

Chapter 1
Figure 1. Gustave A. Van den Berghe (1837-1902) 20
Figure 2. Letter by Gustave Van den Berghe to his Daughter Flavie 27
Figure 3. Portrait Van den Berghe Family 28
Figure 4. Cover 'De homoeopathie en hare tegenstrevers', 1881 40

Chapter 2
Figure 1. Number of Van den Berghe's New Patients per Belgian Province 57
Figure 2. Map Situating the Department Pas de Calais and the Province Zee-land in Relation to Ghent

Chapter 4
Figure 1. Map of the City of Ghent, Early Twentieth Century 127

Chapter 6
Figure 1. 'Appointment Card', 1882 186
Figure 2. Patient file, Casebook 8 (1881-1882): p. 82 188
List of Graphs and Tables

Chapter 2
Graph 1. Composition of Van den Berghe’s Clientele: Total Number of Patients, Adults and Children and their Numbers Treated for Free, 1865-1902
Graph 2. Number of New Patients (adults and children) per Year, 1865-1902
Graph 3. Number of New Patients (adults and children) per Year Treated for Free, 1865-1902
Graph 4. Numbers and Percentage of New Patients from Belgium and Abroad per Age Category
Graph 5. The Total Number of Patients Living in France, the Netherlands and other Foreign Countries within Van den Berghe’s Clientele, 1865-1902

Table 1. Number of New Patients from Belgium and Abroad
Table 2. Gender Ratio (males per 100 females) of Van den Berghe’s New Clientele from Home and Abroad
Table 3. Total Number of New Belgian Patients, Classified by Gender
Table 4. Average Number of Consultations of Non-Ghent Belgian Patients, Classified by Gender
Table 5. The Average Number of Consultations per ‘Residence/Country’

Chapter 3
Table 1. The Presence of Licensed Allopathic and Homoeopathic Practitioners in Ghent and East-Flanders, 1869-1900

Chapter 4
Graph 1. Van den Berghe’s New Ghent Patients per Age Category, 1869-1902
Graph 2. Gender of Van den Berghe’s Ghent Patients (adults and children), 1869-1902
Graph 3. Number of Van den Berghe’s Ghent Patients per Occupational Group, 1869-1902
Graph 4. Districts where Van den Berghe’s Ghent Patients lived, 1869-1902
Graph 5. Percentage of Patients per Social Class and Patients Treated for Free, 1869-1902

Table 1. Average Age of New Ghent Patients According to Gender
Table 2. Average Age of New Non-Ghent Patients According to Gender
Table 3. Marital Status of Van den Berghe’s Adult Ghent Patients, 1869-1902

Chapter 5
Table 1. Number of New Child Patients, from Ghent and Elsewhere, per Age Category
Table 2. Number of Patients Younger than 11, from Ghent and Elsewhere, Suffering from Children’s Diseases
Table 3. Total Number of Paying and Non-Paying Families within Van den Berghe’s Clientele, 1869-1902

Chapter 6
Table 1. Disorders of the Respiratory Organs in Men and Women
Table 2. Gastro-Intestinal Suffering in Men and Women
Table 3. Frequency of Consultations to Van den Berghe, 1869-1902
Table 4. Consultation Period of Van den Berghe’s Ghent Patients, 1869-1902
Abbreviations

AVB
Private Archive Gustave Van den Berghe

BMGN
Bijdragen en Mededelingen Betreffende de Geschiedenis der Nederlanden

BTNG/RBHC
Belgisch Tijdschrift voor Nieuwste Geschiedenis / Revue Belge d’Histoire Contemporaine

HM
l’Homoeopathie Militante

DSG
Dienstencentrum Stad Gent

RAK
Rijksarchief Kortrijk

SAG
Stadsarchief Gent

RBH
Revue Belge d’Homoeopathie

Union
l’Union Homoeopathique

JBH
Journal Belge d’Homoeopathie

MedGG
Medizin, Gesellschaft und Geschichte. Jahrbuch des Instituts für Geschichte der Medizin der Robert Bosch Stiftung

Handelingen
Handelingen der Maatschappij voor Geschiedenis en Oudheidkunde te Gent

TvSG
Tijdschrift voor Sociale Geschiedenis
Patients’ Privacy

The work I have done on the Ghent patients of Gustave Van den Berghe would not have been possible, except for being allowed by Dr. Vermeire to use his great-grandfather’s casebooks, had I not been granted official permission by the Ghent municipal executive to use the register of birth, marriage and death certificates (BMD) and the straatnamenregister. These sources proved to be extremely illuminating and, therefore, I am very happy with the granting of the dispensation.

This exemption was needed as Belgium has strict laws to safeguard individual privacy. The issue of patients’ privacy has exercised me well. Van den Berghe’s practice ended more than one hundred years ago, in 1902. Some patients were still alive at that point yet, many others were already deceased. As the purpose of this study is to reconstruct and to bring to life patients’ past experiences of illness, health and healing from their individual point of view, I preferred to depict them in a very personal manner. If they relate their stories of suffering, it will be known, at least, who they were. Therefore, I have decided to present, in general, the patients with their full names. An exception has been made when dealing with patients suffering from ailments that were socially unacceptable in the second half of the nineteenth century, for example, individuals who came to consult Van den Berghe about sexually related or venereal illnesses. These patients especially narrated occasionally on their feelings of shame and embarrassment, some even entered the casebook anonymously, underlining that they appreciated a little privacy. I have respected this wish.

I have maintained Van den Berghe’s spelling and use of language (of both names and notes), as well as that of the patients throughout the study, except when the patient involved has been found also in the municipal archives. Van den Berghe usually noted the French form of a name (e.g. Pierre for Petrus), whereas the BMD states the official, correct name of a newborn, groom or bride, or deceased.
Introduction

This is a history about and by patients. It is about hope, faith and disappointment, about the fears and joys in human existence, about the creation of new life and having to face death. It is about those dealing with illness and suffering and their search for a cure. It tells, at the same time, the story of one physician, the Ghent homoeopath Gustave Van den Berghe (1837-1902). He trusted unconditionally in the treatment he employed and dedicated his life to healing the sick. The experiences of the patients of Van den Berghe with health and illness are explored as well as the ways in which they tried to overcome their suffering. His casebooks contain the medical stories of pain, misery and, at times, the recovery of thousands of afflicted individuals. This study is not concerned with the history of homoeopathy in general or with its development in Belgium. It focuses instead on sufferers who, at one time or another, became users of homoeopathy by consulting a homoeopathic practitioner. Van den Berghe, born in 1837, the decade in which homoeopathy had just emerged in Belgian medicine, would become a dedicated and indefatigable homoeopath with a practice open to every one: young and old, men and women, rich and poor. He died in 1902 and left his house, practice and patient files to his son Ferdinand.

Van den Berghe practised medicine in the West-Flemish village of Zwevegem for four years and, then, moved to Ghent in 1869 where he opened immediately a practice based on homoeopathic principles. The news of his practice spread easily and it flourished quickly. Patients travelled to Ghent to be treated by this homoeopathic physician from far and wide and even from abroad. Ghent was one of the major industrial cities of Belgium and famous for its textile production. The city's continuing economic growth shaped its outlook; large factories were built accompanied by living districts designated as particular workers' neighbourhoods. The social inequality was striking as the contrast between the affluent and the destitute was enormous. All citizens, in spite of financial situation or social class, would be threatened, at one time or another, by sickness, epidemics and other natural disasters such as flooding. Disease and death lay in wait everywhere and, at times, seemed unconcerned about the status of its victims.

A Case Study

On 11th January 1899 Mr. Van Caemelbeke wrote to Van den Berghe on behalf of and/or about his thirty-three year old wife, Irma Van Caemelbeke-Wittock. She had consulted personally the homoeopath on 5th January with birth-related
complaints. She had given birth fifteen weeks previously and was left with a
defect and blocked uterus.¹

Monsieur le docteur,

Irma has followed the medication just like you had prescribed. Since her return from Ghent the pain is persisting like it did before her departure. It is true that the voyage has tired her and this is, without a doubt, why she has had considerable pains and fever, although not pronounced, during the first four days. At present the fever is gone.

She, above all, senses pains at the side of her womb (and in her womb) and in her left ovary, often in her entire belly. The pain has resumed, in her lungs, kidneys, feet, hands etc. etc. and especially joints. Lancet thrusts. Fortunately, she does not suffer from the head anymore. She eats well and has new good appetite. These complications, don't they result from the womb and nerves! When the womb is positioned by means of a ring, the pain in the ovaries will disappear, won't it?

Irma has a rebellious constipation. It is this bad [that she] only [uses] cocoa butter suppositories. I have observed immediately that when she is having chicory salad, her motion is more regular. The opposite is the case when she is deprived of this vegetable. Can she eat apples! Buttermilk? Oranges? Can't she have a bath at Liège - undergo hot water injections - an irrigation!

Irma is expecting her menstruation next week. Can she take the medication you have prescribed in case of a strong menstruation like the last time / what should she do?

Sincerely

Mr. Van Caemelbeke
Avelghem, 11/1 '99²

Madame Van Caemelbeke did not live in Ghent but in Avelgem some fifty kilometres away. Her husband informed Van den Berghe about her condition between consultations, her next visit was on 13th January 1899. Such written consultations were not uncommon.³ A husband, in this case, could be truly

¹ Letter by Mr. Van Caemelbeke to Gustave Van den Berghe, dated 11 January 1899. Casebook 17 (1898-1901): p. 44. See Appendix 1. ‘matrice déviée et engorgée’.
² Ibidem. See Appendix 1.
³ Cf. Chapter 2.
Introduction

cconcerned about his wife’s state of health and actively participated in her becoming well again, by playing a mediating role. Moreover, possible paths that may lead to recovery, the deployment of a uterus ring, irrigation or a water cure, are considered.

After Irma’s second consultation another letter about her state of health, again written by her husband, followed. She was unable to continue her consultations because her husband could not accompany her on the journey. Why was Irma’s need for a personal consultation overruled by her husband’s unavailability? Was she conditionally unable or unwilling to travel alone, or was a woman perhaps not supposed to travel by herself according to the standards of the time? Sharing the intimacy of her female body with her husband, however, was not forbidden territory. He offers a detailed report on the composition of her menstrual blood and on the contents of her vagina, based on personal observation:

The menses has not been abundant / lasted three days without whites; black blood like before. You will remember that five weeks ago it was plentiful.

[...]

It is perhaps good to let you know that a particular odour comes from the vagina, which I cannot define.4

This second letter seems to have been the last Van den Berghe received from the Van Caemelbeke’s, nor would they ever return to his practice. This case study illuminates the potential research fields of patients’ history. It provides information on the medical conditions suffered. It reveals that being ill or the perception of being ill was, besides being a personal matter, defined and mediated by people other than the actual sufferer. Furthermore, it shows features of gender relations and, perhaps, of authority. The written consultations of the Van Caemelbeke’s shed light on the relationship between patient, mediator and physician. Van den Berghe was asked for permission for the use of particular foods or drinks. Yet, his methods were more or less questioned at the same time, should not another treatment for the uterus resolve the problem? Finally, the possible treatments and options for healing people felt they had are illuminated. This homoeopath and his treatment was only one of a number of opportunities to recover such as hydrotherapy or orthodox procedures.

4 Second letter by Mr. Van Caemelbeke to Gustave Van den Berghe, not dated. Casebook 17 (1898-1901): p. 44. See Appendix 1. 'Il est peut-être bon de vous rappeler qu’il sort du vagin une odeur particulière que je ne puis définir.'
In Search of a Cure

The Social Construction of Illness

The recent interest in the illness-experience of past sufferers has led to changing research questions and, hence, different methods of inquiry and use of sources.\(^5\) The shift from 'medical history' to the 'social history of medicine' has enforced a considerable alteration in approaching the medical past. The limitations of traditional research into medicine from the perspective of professional dominance, the great developments, innovations and physicians have been broken to examine medical daily life. The experiences of ordinary people with health, illness and healing have become a major topic of interest alongside the study of the general processes of medicalisation of society and medical professionalisation.

A distinctive element in the social history of medicine as in the history of science, for example, is the notion that health and illness are not fixed and isolated phenomena but expressions of social, cultural and historical circumstances. Knowledge and perceptions of illness, health and healing are, to a certain extent, social-cultural constructions and the response to health problems is prompted by this social-cultural context.\(^6\) Illness is not a purely natural, objectively identifiable reality. Illness, instead of being a merely absolute biological fact, is partially a social-cultural construct and, accordingly, should be considered and studied as 'an individual condition which must be understood in terms of the relationship to the medical system (doctors and medical science) and also in terms of the relationship to other individuals (family members, friends, etc.) and to society at large'.\(^7\) The constructivist

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\(^7\) Robert Jütte, 'The Social Construction of Illness in the Early Modern Period', in: Lachmund and Stollberg (eds.), The Social Construction of Illness, 23-38, q.v. 23. Jütte only refers to doctors and medical science, whereas all types of other healing methods and non-licensed practitioners were present also in the medical system.
perspective in this study presents the perceptions, attitudes, behaviour and responses of the patients in relation to their social settings.8

Obviously, patients did turn to Van den Bergh with objectively noticeable deviations. Yet, before ever turning to him, they first had to conclude that something was wrong, probably they had discussed their conditions with others around them. Perhaps they had read several self-help guides to see if they could recover independently and they had considered or applied other available options for healing. An important question is how and to what extent social, cultural and economic settings influenced or constructed perceptions of illness and, hence, therapeutic decisions and choices. The main issue is not the diagnosis, but how the illness was labelled, explained, perceived and treated by the sufferers. Tuberculosis, for example, had victims in the best of families by the end of the nineteenth century. The medical profession laboriously responded to this epidemic threat, via publications and the demand for governmental regulations. Van den Bergh’s patients appeared rather worried about their suffering and that death might occur, but hardly anyone explicitly used the medical term tuberculosis. Did the disease’s social label of poverty, insalubrious surroundings and inner disposition restrain them from identifying their suffering as caused by consumption?9

Physicians too had different ways of interpreting complaints. ‘Allopathic’ (orthodox physicians practising university medicine) and homoeopathic physicians opposed each other in their construction of disease.10 The contrast may be exemplified by the way medication was (and is) administered. ‘Allopaths’ employed medication that opposed the symptoms, whereas homoeopaths held the basic assumption that ‘likes can be cured by likes’. They claimed that a sick person could be cured with medicines that produced the same illness symptoms in healthy people. Moreover, homoeopaths used medication in extremely small dosage. According to

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8 Biologist C. Brouwer labels this the moderate constructivist perspective, as opposed to a radical constructivist perspective. She defines the difference between the two variants as: ‘Whereas moderate constructivists seek for explanations within the social context, radical constructivists consider social relations, besides scientific knowledge, as the outcome of knowledge development’. Cf. Carolien Brouwer, Anatomische seke als uitvinding in de botanie. Hoe stampers tot vrouwelijke en meeldraden tot mannelijke geslachtsorganen werden (Amsterdam, Faculteit der Maatschappij- en Gedragswetenschappen, 2004), 18. The Dutch historian Huisman has outlined the development of social-constructivism in the history of medicine as opposed to the medical encyclopaedic tradition. Cf. Frank Huisman, Medische encyclopedie en sociaal-constructivisme. Twee hoofdstromen in de medische historiografie’, Groniek 131 (1995), 132-155.


10 The founding father of homoeopathy Samuel Hahnemann was the first to label university medicine ‘allopathy’ and especially homoeopaths used this term. NB: although the following is written in the past tense, the contrast in the construction of disease exists still.
‘allopathic’ medicine these dosages were too small to function or to proof scientifically their effects. Not only did these divergent interpretations and claims regarding the proper treatment of symptoms affect the government’s social esteem of ‘allopathy’ and homoeopathy\textsuperscript{11}, they influenced also sufferers’ therapeutic choices. ‘Allopaths’ and homoeopaths were involved constantly in disputes about the effectiveness of the therapies they offered and homoeopathic physicians struggled continuously to gain official recognition. They were hence preoccupied with convincing patients, as quickly as possible, of their rightful claim to be able to cure. In particular because ‘allopathic’ medicine made headway on quite a few fronts and thus gained more authority at the end of the century. The distinguishing homoeopathic holistic interpretation of symptoms, for example, claiming that illness is a concurrence of physical symptoms (body), personality (mind) and circumstances, therefore may have been a motive in Van den Berghe’s patients for choosing homoeopathic treatment. Moreover, homoeopathic physicians tended to reserve more time per patient and they offered treatment that, at least, was not too harsh to endure.

However, it is generally difficult to determine whether people consulted Van den Berghe because of his homoeopathic treatment or for completely different reasons. It is indistinct if patients were consciously consulting a homoeopathic physician or if they knew that Van den Berghe was a homoeopath. Could they become as dedicated to homoeopathy as they could become dedicated to Van den Berghe himself? Moreover, his patients seemed less interested in the ‘status’ of the medical therapies than the results obtained by them. They had tried other options for healing prior to the first consultation, usually when they had been ill already for a long period. The notes on other treatments or healers go no further than stating that the patient had seen a practitioner (praticien), mostly without specifying the therapy or the credentials of the healer. On the other hand, patients remembered the results of these treatments only too well. Therefore the patients in this study will be referred to as patients of a homoeopathic physician, instead of homoeopathic patients or a homoeopathic clientele. The extent of the affinity to homoeopathy needs to be assessed. Furthermore, if they went to consult Van den Berghe most patients were neither steady users of homoeopathy, nor present long-term in his practice and, therefore, cannot be regarded as ‘homoeopathic patients’.

This study evolves along two main lines, the homoeopathic physician’s clientele and the individual patient. The possible impact of the social-economic background on therapeutic behaviour will be analysed by studying the clientele. The influence of prevailing notions of gender differences on the way in which men and women perceived and explained their suffering will be demonstrated by studying the individual patient. Van den Berghe’s casebooks

\textsuperscript{11} Cf. Chapter 1.
offer good representations of lay constructions of illness because, following homoeopathic tradition, it is the sufferers telling their story rather than the physician revealing his observations. As patients’ own perceptions received extensive treatment, their files are extraordinarily suitable for elaborating on their experiences of health, illness and healing.

**Patients’ History: Patients as Object or Subject of Medical-Historical Research**

Patient-oriented historical research demonstrates rather divergent standpoints. Scholars regularly debate what patients’ history is or should be, as well as the position of the historical patient in the research. The patient as a bystander of, for example, institutional developments, as an object of academic medicine, hygienic reform or medical discourse, or as a historical subject, incorporating the individual’s personal feelings, perceptions, knowledge and behaviour, may be integrated as an aim of research. The various perspectives employed in the field of patients’ history link with methodological considerations as well as the availability and contents of the sources. Since Roy Porter’s plea for doing medical history ‘from below’, i.e. from the patient’s point of view, nearly twenty years ago, many scholars in the social history of medicine have reassessed past sufferers. Yet, there is a difference in the role that historical studies accord to the patient, making them patient-orientated in a broad or narrower sense, or a patient-related or a patient-specific perspective.

Patients’ history should entail and unfold perceptions, expectations, acts, and experiences of illness, health and healing on the part of the patients themselves. Therefore, the patients are the centre of this study, they do not figure as the object of Van den Berghe’s career development nor as a target group for the spread of homoeopathy. The nineteenth-century adult sufferers are approached as thinking and acting subjects, personally responsible and actively participating in their own healing process. However, responses to illness are rooted in their own time, in their geographic limitations and in their gender, social class and religion. Sufferers’ behaviour and perceptions are affected by individual circumstances and by the conditions of the society in which they participated. A broader view on, for example, the supply side of the medical market and the conditions in which therapeutic demand is created cannot be ignored or omitted.


This concept of and approach to patients' history are not exceptional; several studies have accorded, or attempted to accord, patients or lay sufferers a leading part. However, so far, early modern patients have been studied most often although the interest in nineteenth- and early twentieth-century patients is expanding.\textsuperscript{14} Their stories are revealed by diaries, autobiographies or letters which reflect predominantly the experiences of only a limited part of the population, the literate.\textsuperscript{15} This study of late nineteenth-century patients not only fits the new agenda of research into modern patients but also, through a physician's casebooks, contains information on individuals with various educational levels and different social backgrounds. Furthermore, as patients and sufferers are still \textit{terra incognita} in Belgian medical historiography, it


introduces the approaches of the social history of medicine and medical history ‘from below’.  

‘Everyone knows, that the history of science, particularly the history of medicine, is neglected in Belgium in comparison with neighbouring countries’. Fortunately, this complaint of 1998 is a little over-drawn as, for the last decade or more research has been conducted into the Belgian medical past. However, most has been rather traditional, based on sociological research strategies and concentrating on the progress of medical science, the processes of the medicalisation of society and the professionalisation of medical doctors. A social-cultural approach of the medical past has been used in studies of the social history of disease yet, these studies concentrate predominantly on the governmental hygienic politics or the perception of the sick nation. The historical human body has been the object in studies regarding the practice of abortion in research regarding sexuality, venereal disease and prostitution, and as an objective of education. However, the personal experiences of sick

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16 In contrast with, for example, Germany where the medical past is being studied profoundly from the perspective of society at large and from the patient’s perspective. For a survey of the historiography, cf. Wolff, Perspectives on Patients’ History. Further specific analysis on the historiography of the Belgian history of medicine will be found in later chapters.


20 For abortion etc. see for example: Karen Cels, ‘Socialisme en seksuele fraude. De houding van de Belgische socialisten tegenover abortus en anticonceptie’, in: Denise De Weerdt (ed.),
people in the past, their attitudes and behaviour towards health and illness and lay medical knowledge have hardly been the focus of research. The ill or the healthy have been studied as objects of regulation and education, instead of as subjects dealing with their bodies on a daily basis. Moreover, current medical-historical research in Belgium predominantly reflects developments in orthodox medical science, only touching indirectly on the alternatives, such as homoeopathy, for medical care.21

Users of homoeopathy, whether as patients of licensed and unlicensed practitioners or as their own doctors using homoeopathic home remedies, have gradually come to the attention of patients' history but not yet in Belgium. Some studies, which at first sight seem to fit the aim of patients' history from below, prove to use a very broad patients' approach, merely to exemplify the progress of homoeopathic practice.22 This ambiguity also speaks from a recent volume of essays entitled Patients in the History of Homoeopathy.23 Does it concern patients as users of homoeopathy or is it rather a history of

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21 For terminological considerations of orthodox medicine and medical alternatives to orthodox medicine see Chapter 3, 88-89.


23 Martin Dinges (ed.), Patients in the History of Homoeopathy (Sheffield: EAHMH, 2002).
homoeopathy portrayed by an occasional patient’s performance? Some contributions, for example, are classified in the section on patients in Samuel Hahnemann’s practice, whereas the real issue is not so much the experiences of the patients of the founding father of homoeopathy, but the ways in which Hahnemann managed his practice and clientele. Again, the issue is whether the chosen approach and methodology are patient-related and/or patient-specific.

Studies of patients as part of a homoeopathic clientele, or supporters of homoeopathy spreading homoeopathic principles via lay societies and other networks, represent patient-related research approaches. More patient-specific studies focus on the context for choosing homoeopathy: the availability of therapies on the medical market and the impact of sufferers’ socio-economic and cultural background on decision-making processes. The most patient-specific approach is when individual patients are studied through personal sources such as patient letters and other personal documents. It is seldom that...

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In Search of a Cure

a patient-related, including social context and composition of clientele, and a patient-specific approach, including patients' personal perceptions, expectations and behaviour, are incorporated into one study. Reflections on patients as constituents of a homoeopath's clientele, for example, often are hidden in the review of the social-economic composition of a patient group, omitting the stories of personal grief and suffering or their social surroundings. This account of Van den Berghe's patients combines both perspectives, providing more in-depth knowledge of the mechanisms of health and illness related experiences, expectations and decisions of those who lived more than a century ago.

Nineteenth-Century Sufferers and their Experience of Homoeopathy

The reconstruction of Van den Berghe's patients' perceptions, attitudes and behaviour is based on the analysis of this physician's casebooks. He kept files of the people who consulted him or whom he visited. He noted the contents of the consultations, paying attention to the length, means and, sometimes, the result of the treatment. This source principally served strictly medical purposes. The selection of the facts corresponds to the medical gaze of a trained physician; social contexts are integrated as long as, in the perception of the treating physician, they have an impact on the illness. This partiality and/or choice of the reported 'reality' are significant, yet, to this limited extent, the casebooks also can be read partially as a patient's diary, portraying personal features and circumstances. Moreover, patients' ideas on the origin and nature of the ailments are often registered. Therefore, the eighteen remaining casebooks, containing more than 20,000 patients' files, provide an opportunity to examine ideas, experiences and behaviour in times of physical and/or mental adversity. However, these physician reports could contain an unknown degree of distortion introduced by the physician.

Although the value of case notes for patients' history has been contested at times, they constitute one of the surest sources, besides patients' letters,


Introduction

diaries and autobiographies, for enhancing the knowledge and understanding of historical experiences of illness and the body. Casebooks provide more than insights into medical practice; they also reveal the day-to-day personal life of the patients involved. Van den Berghe did not intend that his manuscript notes would be published. Therefore, the filter effects of the medical gaze, introduced when publishing for colleagues or for a medically interested wider public, are not present.

Van den Berghe’s casebooks contain French-language notes, regardless of the mother tongue of the patients many of whom spoke Dutch. Although he was the judge of what was worth noting on proper treatment, the linguistic usage in the casebooks is far from solely medical; patients’ own terms and descriptions of their suffering were noted as well. Each consultation and, hence, written report started with the patient’s perception of the illness and its possible causes in the view of the sufferer. Thereafter, Van den Berghe added his theoretical findings to the anamnesis, sometimes supplemented with a physical examination. However, the physician’s medical gaze was already working, for example, in his systematic selection of what he found worth writing down. The illness was a real experience for the patient but the physical and/or emotional symptoms were communicated subjectively. The patient’s use of language was meant to clarify the nature of the problems; the patient needed the doctor to understand. The doctor then noted part of the sufferer’s account in a casebook, often in the patient’s own words, but occasionally supplemented with medical language. Thus, the sufferer communicated the


30 E.g. McCray Beier, Sufferers and Healers; Duden, The Woman Beneath the Skin. This current research has been inspired especially by Duden’s work, albeit that she has based her research on distinctively different sources. Duden studied printed material: a physician’s case notes that had been selected specially for publication by the physician himself.

31 Notwithstanding the special nature of her printed sources, Duden was partially able to dispose the physician’s notes of their medical purpose and to bring to the fore the body perceptions of the women he treated. Their body perceptions reflect, to a high degree, the vision of the physician or, at least, of popularised medical knowledge. Harry Oosterhuis, although predominantly focusing on reassessing Krafft-Ebing’s influence on the construction of modern sexual identity, convincingly demonstrated that case studies offer useful insight into individual experiences. Moreover, he established how much the patients’ experiences influenced the development of modern ‘science’.
experience, the doctor deduced the symptoms and events relevant for the treatment and, hence, subjectivity on the part of the physician was added to the story. Yet, the illness experience remained valid for the patient. Although Van den Berghe sifted the information offered, he was aware that what the patient had told him reflected the individual’s experience and was fundamental to the perception of the illness. Thus, the case notes do not offer one single objective truth, they reflect the patient’s perception, the doctor’s medical views and the ways in which both influenced each other. The knowledge of the patient and his physician was shaped and affected by the context of the medical encounter.

Hence, which influences played a decisive role in the construction of the patients’ files? Both the patient and the physician brought their personal knowledge and vocabulary to the medical discourse. Yet, it becomes abundantly clear that Van den Berghe’s purpose was not to convince the patient of his medical expertise, but that he wanted to know the patient’s personal observations. His aim, in noting the patient’s remarks, was to gain insight into the sufferer’s entire being and social circumstances. This was beyond the need for recollection on treatment and progress. However, Van den Berghe, at times, will have influenced the patient’s description and ideas of the ailment or body. The asking of particular questions irrefutably will have directed a patient in the observations made, just as a patient sharing particular information will have influenced Van den Berghe’s medical judgement.

The structure of this study has two approaches. Firstly, the patient as part of a larger entity, a homoeopathic physician’s clientele. Who were those that became Van den Berghe’s patients? Secondly, the patient as an individual, personally dealing with the issues of health, illness and healing. How and why did individuals perceive, explain and experience their suffering, how and why did they respond to instances of illness? Macro- and micro-perspectives are used. From the patients’ outer world, the city in which they lived, worked and suffered, including the development of social relations in times of illness and options for healing available in Ghent, to the inner circle of their personal surroundings and individual experience. The composition of Van den Berghe’s clientele, in terms of age, gender, occupation and residence, is contextualised by examining Ghent’s inhabitants and social-cultural circumstances. Any understanding or interpretation of a patient’s expectations and ideas requires consideration of their economic and health-related circumstances. These shaped the understanding and knowledge of the illness, which influenced the process of therapeutic choice and constructed the relations with others about

32 See the prior methodological discussion on the social construction of illness.
health and illness. Therefore, the study starts with the macro-perspective of Ghent’s society at large, continues with the social-cultural profile of the Ghent clientele and concludes with a micro-history of attitudes towards illness. The patients, at times, will be presented as constituents of a clientele but, at others, as individual sufferers.

The first two descriptive chapters are devoted to Van den Berghe and his entire clientele, i.e. patients from Ghent and elsewhere. The first chapter tells how Van den Berghe became acquainted with and, later, convinced of the efficacy of homoeopathy and describes his effort to promote homoeopathic medicine. He was most willing to introduce homoeopathy to people of all social classes, but his public contribution to the homoeopathic cause was aimed predominantly at protecting the therapy from ‘abusers’, people who employed homoeopathy without strictly complying with Samuel Hahnemann’s rules. The social-historical aspects of his entire clientele are discussed in the second chapter. The development of the practice, based on the total number of treated patients, will be presented as well as a number of social features of the clientele such as age, gender, residency and nationality to provide an overview of changes during his more than thirty years of practice.

Chapters three to seven are dedicated predominantly to the Ghent patients. Van den Berghe’s patients were only a small part of the Ghent population and the Ghent clientele, moreover, has been sampled. Therefore, it is rather difficult to make generalisations. However, the insights gained into an extensive clientele and patients’ individual perceptions and experiences, can contribute distinctively to future research. Not in the least because so far similar studies about ‘allopathic’ and homoeopathic physicians’ clienteles have not been carried out, neither in Belgium nor abroad.

Van den Berghe’s patients’ specific social-cultural and health-related circumstances are explored at two levels. Ghent’s general social-cultural context offers details on the circumstances of living in such a bustling town. What were the social-economic conditions and state of public health in which the citizens lived, loved, raised children and protected themselves from illness (Chapter 3)? Analysis of the composition of the Ghent clientele contributes to a more individual approach to patients’ social-cultural circumstances (Chapter 4). Who were the Ghent patients in terms of age, gender and marital status, where did they live and how did they earn a living? How many and whom did Van den Berghe treat free of charge? To which social class did they belong, and was there a change in the social composition of Van den Berghe’s clientele? Finally, the conditions and complaints of the patients are analysed in detail (Chapter 6). The illnesses are linked with age, gender and social-economic background, thereby determining whether specific diseases were resulting from or influenced by individual circumstances.
Responses to health-problems depend on, for example, the availability of practitioners and therapies. Therefore, the options for healing available in the Ghent medical market have been considered (Chapter 3). The offer of family or home medicine, licensed and unlicensed practitioners and religious healing are reviewed to show that there was ample choice. The concept of the medical market, a dynamic model of supply and demand of medical services, has influenced much research in the social history of medicine. The demand side of the medical marketplace, from the sufferer’s point of view, reflects the options for medical care, i.e. the availability of healing methods and healers. The supply side mirrors the specialisation, the popularity and the competition between healers.

In Anglo-Saxon studies the use of the model of a medical marketplace is almost solely restricted to research on the seventeenth and eighteenth centuries and based on the claim that the free market only functioned as long as there was no government intervention in the medical world. The government began to implement regulations during the nineteenth century, thus affecting the liberal character of the market. Moreover, the growing control of the medical profession over health-care services and the progress of medical science would have influenced negatively the principle of free choice. Sufferers would no longer ‘shop around’ in the medical market by the end of the nineteenth century. This present survey tests this presumption.

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38 Porter and Porter, Patient’s Progress, 28; De Blécourt, Huisman and Van der Velden, ‘De medische markt’, 369-370.
nineteenth-century Ghent sufferers, in spite of new medical insights, improved therapeutics, a demarcation of the medical profession and strict laws against the illegal practice of medicine, continue to make use of all available therapeutic options, or would their demand for unorthodox and unlicensed medical aid come to an end? As the availability of particular medical services does not signify its exploitation, the patients themselves will disclose which therapies and healers they actually had used before turning to Van den Berghe (Chapter 3).

One of the assets of Van den Berghe's inheritance is that his casebook relate to the illnesses of male and female patients and, hence, offer a possibility of writing patients' history from a gender perspective. Gender history often dwells on the experience of only one of the sexes, narrating on either female or male body perceptions and searching for their concepts of femininity or masculinity. The perceptions of men and women are seldom compared simultaneously to detect common denominators or extreme opposites between male and female patients. This entire study, on several levels, centres around the issue of the relation between illness and gender. Why did Van den Berghe attract more and more women to his practice over time, whereas the number of new male patients gradually diminished (Chapter 4)? Did men and women suffer equally from the same diseases or did there appear to exist illnesses bound specifically to gender (Chapter 6)? Finally, did men and women experience and, thus, explain and deal with their afflictions differently and, if so, why (Chapter 7)? It will be demonstrated that where patients suffered sex-related conditions, men and women could be concerned equally with their ill health, yet, dealt with and experienced their diseased bodies differently.

Patients' personal dealings with illness also will be reconstructed by examining the attitudes adopted towards others in their surroundings in facing health problems; family, friends, but also healers. Research questions in most patient-oriented studies on patients' social relations are related predominantly to their contact with people in the medical field and barely go beyond an interest in the relations between the doctor and the patient. This study demonstrates that disease could lead also to altering personal relations on a more private level, for instance, within the family. Illness was a family affair, influencing and interfering with daily life (Chapter 5). The average nineteenth-century family witnessed the loss of at least one child. Parents, therefore, were

39 Cf. Chapter 6, paragraph 4. In Het Amazonenleger, Willem de Blécourt has recorded that Dutch government intervention, in the sense of enacting laws benefiting the medical profession, did not terminate the existence and therapeutic offerings of unorthodox, non-licensed healers (whom he calls irregulars).

40 For the historiography of gender and patients' history or women and illness see Chapter 7.

concerned deeply about their children’s health and even the smallest complaints made them employ home remedies and/or call in the help of a medical practitioner. Whether the sick child was a boy or a girl did not matter to the parents taking their children to Van den Berghe.42

The separate discussion on Van den Berghe’s child patients serves to conceptualise the impact of illness on the suffering child and on the carers. The study of entire families gives insight into the process of responses to health problems and, moreover, the course of action considered the best to obtain recovery. Who, for instance, was the primary decision-maker within a family and, additionally, why would these families turn to Van den Berghe? If one relative had been treated successfully, would others soon follow? Would ‘sympathy for homoeopathy’ be passed from parent to child?

Patients often had tried all sorts of remedies and healing methods before turning to Van den Berghe. They had experimented with whatever they had encountered and had been fervent shoppers and consumers of the options in the medical market. Moreover, they did not take into consideration the legal or professional status of the practitioners (Chapter 3). As other players in the medical field, apparently, were unable to retain their customers, how did Van den Berghe fare? The behavioural patterns of his Ghent patients and their motivation, if that is what it was, for trying homoeopathy, will be examined.

How did his patients behave? How could the relationship between the patient and his homoeopathic physician best be defined? Were the patients passively co-operating with whatever Van den Berghe prescribed or demanded, or were they active agents in the medical encounter and, hence, in their own healing process? The examples of the frequency of consultations and length of treatment and the extent of compliance with Van den Berghe demonstrate that he was not able to persuade most of his patients to a definite and long-lasting commitment to him or to homoeopathy (Chapter 6). The claim that patient-power had diminished by the end of the nineteenth century will be tested by the example of the attitude of Van den Berghe’s patients in the clinical encounter.43

Patients’ expectations were very varied. Some patients, having been medically disappointed in the past, did not expect Van den Berghe to relieve them, although they hoped sincerely that he could. Was this a general distrust

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42 Hilary Marland and Marijke Gijswijt-Hostra have pointed out recently that knowledge on children as patients or the history of the sick child is still rather limited. Hilary Marland and Marijke Gijswijt-Hostra, ‘Introduction: Cultures of Child Health in Britain and the Netherlands in the Twentieth Century’, in: Marijke Gijswijt-Hostra and Hilary Marland (eds.), Cultures of Child Health in Britain and the Netherlands in the Twentieth Century (Amsterdam etc.: Rodopi, 2003), 7-30, q.v. 8.

43 This has been stated in several researches on patient-doctor interaction. For the historiography on patient-doctor interaction see Chapter 6, paragraph 4.
or lack of belief in the abilities of medical science and/or did many patients only have a little knowledge of the principles of homoeopathy? Were they consulting Van den Bergh because of an interest in a holistic natural life-style, or were they searching merely for the least harsh or harmful, the cheapest, easiest applicable or nearest accessible treatment?

The task of conveying patients' concepts, expectations and behaviour about illness, health and healing, the true heart of patients' history from below, entails a challenge. However, the personal experiences with illness and homoeopathy of nineteenth-century Ghent sufferers can be reconstructed to a certain extent. It can be done, firstly, by presenting individual accounts of men and women on health-related issues. Secondly, by revealing their explanations for illness and their expressions of anxiety. And, thirdly, by reviewing patients' body perceptions and their mental strength or sensibility.
Homoeopathy as the True Key to Healing.
Gustave Van den Berghe (1837-1902) and His Position Within the Belgian Homoeopathic Domain

More than two centuries ago the basic principles of homoeopathic therapy emerged. Since that time, homoeopathy has developed enormously. Originating in Germany at the end of the eighteenth century it did not take long for homoeopathy to spread throughout Europe and into the New World and Asia. Many a physician let go of his traditional medical background to become a homoeopathic practitioner. Non-licensed healers also adopted homoeopathy and numerous ill individuals applied homoeopathic self-treatment.

Belgium did not remain ignorant of this new healing method. The first signs of homoeopathic activity date from the 1820s, when the country was part of the Kingdom of the Netherlands. The 'breakthrough' for homoeopathy in Belgium occurred in the 1870s when the homoeopathic movement accelerated and organised on a more professional basis. One of the people who became involved in the spread of homoeopathy was the physician Gustave Van den Berghe who practised in Ghent from 1869. The development of Belgian homoeopathy will be explored using the example of his life, ideas and activities.
Nowadays, everybody has heard of homeopathy, but many fail to know exactly what it is all about. People refer to it as natural medicine, as naturopathy, and state that it has 'something to do with plants'. Individual sufferers often receive over-the-counter homoeopathic medicines in the pharmacy without knowing that they are making use of homoeopathic self-treatment. In addition, many consider this medical therapy to be of ancient origin.

At the end of the eighteenth century the German physician Samuel Hahnemann developed the homoeopathic healing method as a medical system. Many researchers of homoeopathy, mainly adherents, have argued that homoeopathy already existed long before. Both Hippocrates (5th-4th century BC) and Galen (129-199 AD) are presented as homoeopaths 'avant la lettre'. Even so, the real history of homoeopathy begins at the end of the eighteenth century. In 1779 Hahnemann obtained his orthodox medical degree and started practicing in Dresden. According to tradition, he began studying pharmacology out of dissatisfaction with orthodox medicine. Then,
Hahnemann came across the *Materia Medica* of the English physician William Cullen (1712-1790). Inspired to experiment with *kina*, a medicine prescribed to treat intermittent fever (malaria), Hahnemann ascertained that this medication, taken by a healthy person (himself and friends), resulted in symptoms like that of the disease. In the same manner he tested other medicines, such as mercury, nightshade (*belladonna*), and foxglove (*digitalis*), with similar results, thus becoming aware of the principle of 'similars'. He published his findings for the first time in 1796, but the definite breakthrough dates from 1810, when Hahnemann published his *Organon of the Rational Art of Healing.*

Homoeopathic treatment is based on three inextricably linked basic principles. The first pillar is the notion of *similia similibus curentur*, likes may be cured by likes. In other words, a sick person can be cured with medicines that produce the same illness symptoms in healthy people. Here, homoeopathy distinguishes itself from 'orthodox' (university-taught) medicine, allopathy as Hahnemann labelled it. ‘Allopaths’ employed medication which opposed the symptoms and were thought to suppress or to alleviate the symptoms, without tackling the actual cause. The second principle, directly leading from the first one, is the need to test the functioning of medication on healthy subjects. The last principle is that of the small dosage. Medication should be administered only in a strongly diluted form. The medicinal substance should be diluted with water or alcohol and the smaller the dose the higher its therapeutic effects. This last principle, in particular, has made homoeopathy most susceptible to criticism.

In the 1820s, Hahnemann also published his findings on chronic diseases. All chronic suffering, according to this doctrine, is reduced to three 'miasma' (causes of illness or infections): psora (scabies), syphilis and psychosis. The internal miasmic disease manifests itself via symptoms of the skin but, instead of treating solely these external symptoms, the internal obstacles should be discovered which interrupt the 'Lebenskraft' (life force). Homoeopathy is pre-eminently a healing method in which all symptoms are considered as important as character and appearance. Therefore, decisions on medication are based on the combination of physical symptoms, the medical history of the family (hereditary factors), character (psychological features) and constitution. As a simple example, two people are suffering from exactly the same skin disorder and their families both have a history of asthma. In orthodox medicine they would receive the same medication directed at eliminating the external

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3 Jütte, *Geschichte der alternativen Medizin*, 23-27. See chapter 3 (par. 2) for a further discussion on terminology.
symptoms. However, when the constitutions of the patients differ, they would be treated homoeopathically with different medication.

Hahnemann faced strong resistance from his orthodox counterparts, a struggle which many homoeopaths still confront today. Between 1811 and 1821 Hahnemann practiced successfully in Leipzig and he was a teacher at the Medical Faculty lecturing regularly on homoeopathy. His move to Köthen in 1821 has been mythologised constantly as a forced flight from hostile colleagues. However, he was neither driven away by violence nor prosecuted. The legal position of any physician in Leipzig (prohibition to produce and to provide medication) and Hahnemann’s loss of prestige (leading to a decrease in the number of patients) are more likely reasons. In Köthen, he became the personal physician to Duke Ferdinand of Anhalt. Hahnemann’s first wife died in 1827 and in 1835 he married a former patient, the French-born Mélanie d’Herville. He moved to Paris where he practiced until his death. By that time many, including lay-people, had taken up homoeopathic medicine but already the first signs of internal animosity had come to light.

Followers of Hahnemann regularly discussed the way in which his healing method should be applied. In addition, with the passing of the years, the ‘inventor’ himself became alienated from his pupils. He called homoeopathic practitioners who were slightly at variance with his principles ‘Halbhomöopaten’ or ‘Bastard-Homöopaten’. Moreover, at the end of his life, Hahnemann became a proponent of maximal (very high) dilutions and, finally, he did not prescribe medication at all, but just had his patients have a smell.

Homoeopathic practitioners can be divided roughly into two groups: the classical and the free homoeopaths. The classical homoeopath is a strict follower of Hahnemann, prescribing one medicine at a time, using high potencies and only practicing homoeopathy. The free practitioner determines independently which principles to accept and to practice. Some of the free homoeopaths make use of both homoeopathy and ‘allopathy’ and prescribe compound (complex) medication of low potency.

6 Nys, Geschiedenis van de pioniersfase, 30-31; Jütte, Geschichte der alternativen Medizin, 184.
During the 1820s, homoeopathy expanded considerably beyond the borders of Germany. The United States followed with dedication, a success that is explained usually by the lack of legal or traditional limitations within the country. Yet, the European countries were not deprived of this new therapeutic system. Like Belgium, Austria, Denmark, Switzerland, England, Italy, Poland, Hungary and Russia had their own homoeopathic practitioners at the end of the 1820s and France and the Netherlands followed closely at the beginning of the 1830s. However, homoeopathy developed differently in the various countries. In Russia, for example, mainly non-licensed practitioners provided homoeopathic treatment and, moreover, it had a pronounced characteristic of domestic medicine. In Spain, homoeopaths obtained the creation of a chair in homoeopathy, and Paris would have its official homoeopathic hospital, Saint-Jacques, from 1878. Belgian homoeopaths, conversely, never succeeded in creating a legal and/or academic base for their therapy.

Homoeopathy had been introduced in Belgium in the late 1820s. In 1829, Pierre-Joseph De Moor (1787-1845), physician at Alost (West-Flanders), was the first to open a homoeopathic practice. After Belgium became independent from the Netherlands, his example was followed by some Brussels physicians. The first French translation of the Organon was published in 1824, followed by a Dutch edition published in Amsterdam in 1827. By the 1860s homoeopathic therapy was available in many cities. Throughout Belgium homoeopathic dispensaries, clinics in which free treatment was offered, were set up. In Brussels free help could be obtained at the private dispensary of Dr. Varlez from 1834 and the Hahnemann dispensary offered free treatment from 1855. In Bruges Dr. J. Mouremans (1803-1874) set up a homoeopathic free clinic around 1840. In other cities non-charitable homoeopathic private practices were established. Pierre Dam (1789-1871) became the first homoeopathic apothecary in 1830 in Brussels. Five years later the first, but not long-lasting, professional homoeopathic society was founded, the Société Belge d’Homoeopathie. A decade later a homoeopathic journal was published, the Revue Homoeopathique Belge.

As the number of practitioners increased and homoeopathy became more organised in Belgium, the contacts with representatives of orthodox medicine became more competitive. In 1849-1850 homoeopathy was discussed at length

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in the Royal Medical Academy, where the advantages and disadvantages of homoeopathic treatment for cholera were debated. Homoeopathy was condemned and pushed to the margins of medicine, thus gradually forcing homoeopaths to withdraw from allopathic medical institutions. Delphine Gailliard (1838-1898), a personal friend of Gustave Van den Berghe, for instance, was refused appointment as a poor-doctor by the municipal administration of Bruges because he was a homoeopath. Homoeopaths did not hesitate to denounce the opposition of ‘allopaths’ in the orthodox medical press. Another discussion took place at the Academy in 1860 on the subject of homoeopathic education. Again, the homoeopaths were criticised. The obstinacy of ‘allopaths’ was two-sided. First, they doubted sincerely the efficacy of homoeopathy as scientific evidence was missing. Second, according to many homoeopaths, they wanted to protect their own position and feared the homoeopathic competition in the medical domain. Various homoeopaths were prosecuted principally because of the illegal sale of medication. Physicians were allowed to practice unorthodox therapies like homoeopathy, but the Dutch medical law of 1818 remained in force which stated that the sale of medications was reserved only for apothecaries. Physicians, who provided their patients with medicines, as many homoeopaths did, faced serious sentences. In 1864, the Ghent homoeopath Edouard Van Schauwenberge was convicted for giving medication to his patients, whereas he knew that several pharmacists could prepare homoeopathic drugs. He received a fine of 53 francs.

1.2  Gustave Adolphe Van den Berghe (Zwevegem 1837 - Ghent 1902)

Gustave Adolphe Van den Berghe was born in Zwevegem, in the south-east of the province of West-Flanders in 1837. He was the eldest son of Petrus Joseph Van den Berghe (b. Zwevegem, 1802) and of Joanna Catharina Maes (b. Ootegem, 1805). His father earned a living as a coal merchant and his parents had no involvement in medicine. In the 1840s his mother had worked outside the home as a shopkeeper. Gustave had three brothers and two sisters and he was the only child who attended university. Around 1856 Gustave took up his medical studies, first at the universities of Louvain and Ghent, but graduating eventually from Brussels in 1863. Tradition has it that he left the University of Ghent, upset at being excluded from visiting patients at the Ghent

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10 RAK, Bevolkingsregister Zwevegem 1846 and 1856.
hospital, unlike other students. The academic tradition of professors was to invite only the sons of city acquaintances and not the students from elsewhere.\textsuperscript{12} Zwevegem remained Van den Berghé's legal residence during his years of study and immediately after obtaining his medical degree Van den Berghé set up an orthodox medical practice in his home town. However, within two years, he would completely abandon the orthodox medical tradition to become a convinced homoeopath.

On 29th November 1866 Gustave married Angela Rosalie Vanhoutte, daughter of Joannes Vanhoutte and Rosalie Vantomme, farmers at Beveren. Their daughter Flavie was born in September 1867 and in January 1869 the family moved to Ghent and took up residence in a house in the Muinkkaai, near the city centre. Here, their second child and first son, Samuel, was born. Gustave made a major investment in 1871 by buying a house at Stationstraat 22 (Station street) which included a coach house.\textsuperscript{13} In 1872 Van den Berghé commissioned renovations to the house. The original open space between the coach house and the private dwelling was roofed in, enlarging the actual living quarters, and a separate entrance was created.\textsuperscript{14} It could have been that Van den Berghé wished for this enlargement to meet the needs of his practice as he treated 1124 new patients in 1872 against 828 the year before. Van den Berghé practised and lived in Stationstraat until his death in 1902. The family expanded as between 1871 and 1879 six more children were born, of whom two died prematurely. Irma died within three weeks after birth of an intestinal infection in 1871 and, in 1875, the family was again overtaken by disaster when a son died of cholera. All the other children, Flavie, Samuel, Irma (b.1872), Marie (b. 1874), Fernand (b. 1878) and Louise (b. 1879) grew up to adulthood and Gustave’s interest in medicine and homoeopathy was passed on to some of them.

The Van den Berghé family would develop a homoeopathic tradition, as Gustave’s remaining sons, Samuel (1870-1957) and Ferdinand (1878-1954), studied medicine and became homoeopathic practitioners in Ghent. They were not the only relatives who embraced homoeopathic treatment as Flavie was an ardent user of homoeopathy. Her medical situation and treatment were discussed in several of Van den Berghé’s notebooks which contained case descriptions. She made use also of self-treatment, asking her father for practical advice on certain health problems. In a letter from Van den Berghé, the medications to use in case of common ailments like, fever, headache, a sore

\textsuperscript{12} Kind remark of Mr. Pierre Vermeire, 26-11-1998. Pierre Vermeire (b. 1906) is the son of Marie van den Berghé (daughter Gustave) and Théodore Vermeire.

\textsuperscript{13} Land Registry Ghent, Conservation du cadastre. Actes civils, publics et sous seing privé des jugements etc., report 219.

\textsuperscript{14} Cf. Chapter 6.
throat, a cold, indigestion and diarrhoea and menstrual disorders were given (Figure 2). Ferdinand would continue this self-treatment advice.

Figure 2. Letter by Gustave Van den Berghe to his Daughter Flavie, not dated. Private Archive Gustave Van den Berghe

In 1896 the ‘homoeopathic pact’ was expanded across family lines when Samuel married Maria Bertha Van den Neucker, the daughter of the well-known Ghent homoeopath Pierre Van den Neucker (1826-1909). After his marriage Samuel moved out of his father’s house to start his own household. Van den Berghe also had the pleasure of seeing his daughter Marie (b. 1874) getting married to Théodore Vermeire in January 1902.

When a second daughter married in 1906, Van den Berghe’s absence (he had died in May 1902) was compensated for by Edw. Gailliard, who made a

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15 AVB, Letter by Gustave Van den Berghe with homoeopathic instructions to his daughter Flavie, inv. no. 39, not dated. The archive contains two letters from Ferdinand van den Berghe to his sister, dated: 17-06-1911 and 16-11-1920. ‘Voici, ma Chère Flavie quelques indications médicales pratiques mises à votre portée et qui pourraient vous être utiles à l’occasion’.
speech for the newly-weds. He did so with the words of Van den Berghe who, some forty years before, had delivered the same speech at the wedding of Gailliard’s sister. The introduction is remarkable: Gailliard praised the language used by Van den Berghe, stressing his love for the Flemish language.¹⁶

The words he (Van den Berghe, [AH]) spoke, came from the bottom of his heart and were Flemish, truly Flemish, actually, my friend was a true lover of our beautiful mother tongue, that is very dear to me, to all of us.

This is especially noteworthy, because, as will be demonstrated, Van den Berghe made use primarily of French in his work. When Gustave died, Ferdinand took over his practice and stayed, together with his mother and two sisters, in his parental house. After another reconstruction in 1905, enlarging the whole surface area of the property, the family eventually sold the house in 1912. The premises were demolished in 1974.

Figure 3. Portrait Van den Berghe Family, date unknown. From left to right: Fernand, Louise, Madame Rosalie Van den Berghe-Vanhoutte, Gustave, Flavie and Irma. (Courtesy of Jean-François Vermeire)

¹⁶ AVB, Speech held by Edw. Gailliard at the wedding of Louisa Van den Berghe and Hubert van Houtte, inv. no 53 A+B, not dated [1906]. For the original Dutch text see Appendix 2.
1.3 Van den Berghe’s Career in Medicine: the Change from ‘Allopathy’ to Homoeopathy

Initially, Van den Berghe had been educated in orthodox medicine and had set up a practice of this kind in 1863. His daily events as an ‘allopathic’ physician are more or less unknown. One notebook of Van den Berghe, called ‘Lecture et correspondance’, originated from the period he was still practising orthodox medicine. It can be considered as a medical ‘allopathic’ guide, and seems to have been Van den Berghe’s diary for orthodox practice. The small book consists of 204 pages and is written in both French and Dutch. It reflects on all sorts of ailments and the medicines that should be administered to combat them. It contains also general medical notes and tables, regarding the rates for medical consultations and causes of death, and a list of food products that should be taken in moderation.\(^\text{17}\) It consists primarily of data on orthodox medicine, but also contains notes on homoeopathy, atomism and hydrotherapy. The principles of atomism, Van den Berghe noted, stand midway between allopathy and homoeopathy and that it was practised in Russia. Prophylactics were also described.\(^\text{18}\)

However, although the booklet was intended for ‘allopathic’ practice, Van den Berghe, in time, started to add homoeopathic information. Here, the first signs of Van den Berghe’s self-educated homoeopathic development take shape. For example, notes on the orthodox treatment of whooping cough were adjusted with the remark that homoeopathy gave better results (‘l’homoeopathie fait mieux!’).\(^\text{19}\) An account of the ‘allopathic’ treatment of pneumonia with ipecac was supplemented with a note that it was an excellent medication ‘in small, small dosage or even homoeopathically’.\(^\text{20}\) The adding of homoeopathic findings happened frequently, and the second part of the notebook (from page 112) addresses solely homoeopathic medicine. This notebook does not recount Van den Berghe’s personal experiments or experiences whilst the homoeopathic notes reflect his study and copying of literature.

Van den Berghe titled the notes ‘Lecture homoeopathique’, but it is not always clear from where he copied them. Occasionally dates and sources are mentioned. He included, for example, abstracts on Hahnemann writing to Hufeland (1808), a lecture given by Jahr on the subject of mental and nervous disorders (not dated), Léon Simon reporting on scrofulous ailments (not dated)

\(^{17}\) AVB, Notebook ‘Lecture et correspondance’, inv. no. 26, not dated, 204 pages.
\(^{18}\) AVB, inv. no. 26, 36-46.
\(^{19}\) Ibidem, 10.
\(^{20}\) Ibidem, 24. ‘à petite petite dose, et même homoeopathique il est excellent […]’.
Ipecacuanha influences the digestive organs, the respiratory organs (spastic tickling), and, occasionally, the nerves, nervous system and blood vessels. Hahnemann recommended it as a countermeasure against opium. See: J. Voorhoeve, Homoeopathie in de praktijk. Medisch handboek (Zwolle: La Rivière & Voorhoeve BV; 13th ed., 1972), 105.
and an account of Gueyrard on homoeopathic doctrine (1834).\textsuperscript{21} The notes are made with a fountain pen, supplemented by underlined sentences and marginal notes (usually a cross or a circle) in pencil, indicating which remarks Van den Berghe thought worthwhile reconsidering. Van den Berghe wrote on page 119 (and he made the underlining): 'La médecine symptomatique ne s'attaquait ordinairement qu'à un seul symptôme, tandis que l'homoeopathie s'attaque à tous les symptômes à la fois.' (Symptomatic medicine usually deals with only one symptom, whereas homoeopathy deals with all symptoms at once.). In the margin of page 126, Van den Berghe singled out a discourse on the influence of mental circumstances on the healing process.

‘Lecture et correspondance’ brings slightly to attention Van den Berghe’s development from orthodox to homoeopathic medicine. If he thought homoeopathy gave better results, he amended the notes on ‘allopathic’ treatments advised or used before. This notebook, however, does not give an insight into the day-to-day orthodox practice and the patients are not heard. Only two small notebooks, referring to clinical cases between 1863 and 1865, have been preserved.\textsuperscript{22} These booklets are written in pencil, very legible but, nevertheless, rather cluttered. It is unclear, for example, on which side (front or rear) of the book Van den Berghe started writing because he switched the top and the bottom of the pages. However, the difference between ‘allopathic’ and homoeopathic case-taking becomes abundantly clear. None of the patients is registered by name, only by gender, and ages are hardly given. Although a clear diagnosis is given at the top of the report, patients’ personal features and stories do not appear. The main symptom (supposed illness) is under inquiry rather than the underlying causes of the ailment. For example, several women were diagnosed with hysteria (a diagnosis that Van den Berghe would hardly ever give in his homoeopathic practice), but none of them, apparently, were questioned about their personal circumstances or ideas on the origin of the disorder.

Nevertheless, these ‘allopathic’ patients will have suffered enormously. Most of the cases refer to patients afflicted with severe ailments like tuberculosis, pneumonia, pleurisy, hepatitis and typhoid fever. Moreover, if these people did not suffer from the disorder itself, they would have been very anxious about the potential mortal implications of their ailments. Van den Berghe himself will, at times, have felt powerless as well; occasionally he lost a patient. Interestingly, he carried out personally the autopsies on some of them. These notebooks contain the autopsy reports of people who had consulted him

\textsuperscript{21} Several publications of these homoeopathic practitioners are still present in Van den Berghe’s library, property of J.-F. Vermeire. E.g. H.G. Gueyrard, \textit{La doctrine médicale homoeopathique examinée sous les rapports théorique et pratique} (Brussels: Dumont, 1834).

\textsuperscript{22} AVB, Notebook, (allopathic notes), inv. no 24 and 25, not dated, [Zwevegem].
with scurvy, hysteria, worms, and pneumonia. The notes divulge also that Van den Berghe, besides working at home, was available as a physician in different wards of the hospital St. Pierre, presumably in Zwevegem.23

Van den Berghe started experimenting with homoeopathy in 1864, influenced by his close friend D.L.E. Gailliard.24 The first patient whom he treated homoeopathically was a labourer suffering from a severe inflammation of the mouth. He could not speak, nor swallow, he breathed heavily and had a high fever. Van den Berghe considered an incision of the tongue, but found it uncertain. Then, he prescribed mercury in homoeopathic dosage and the patient’s recovery was obtained within days.25 His definite conversion to homoeopathy dates from 1865 when he acknowledged homoeopathy as the ‘only true healing method’.26 Patients he had treated previously in an orthodox manner now received homoeopathic therapy, and new patients solely got homoeopathic medical advice. Van den Berghe became what he wanted to become most: an adherent of Hahnemann.

Regrettably, Van den Berghe did not leave any personal documents indicating his motives. A historical study on the pioneering stage of homoeopathy in Belgium addresses the grounds for becoming a homoeopath.27 Five general explanations were given based on the accounts of some early Belgian homoeopaths. The decision to join homoeopathy was based on dissatisfaction with orthodox medicine, curiosity provoked by reading homoeopathic publications, encouragement by homoeopaths who were friends, stories of spectacular recoveries thanks to homoeopathic treatment and, finally, family inducement.

As previously noted, Van den Berghe was both the first physician in his family and the first one to adopt homoeopathy. He was not preceded by anyone in the homoeopathic field but, certainly, he inspired his descendants. It is more than likely that he became interested in homoeopathy during his medical studies. Brussels was the centre of Belgian homoeopathy during the entire nineteenth century and, probably, this influenced Van den Berghe’s wish to change universities. Official homoeopathic educational institutions did not exist in Belgium and the first generation of Belgian homoeopaths had its

24 Delphine Louis Ernest Gailliard (1838-1898) completed his medical studies in Brussels in 1863 and, thereafter, followed homoeopathic classes in Brussels. He would become one of the most ardent protagonists of homoeopathy in Belgium and for this goal he, amongst others, launched the periodical l’Homoeopathie Militante (1878-1882). Cf. Van Praet, De receptie van de homeopathie, 167-168.
25 Dr. G. Van den Berghe, De homoeopathie en hare tegenstrevers (Bruges: Edw. Gailliard, 1881), 160.
26 ‘Mort du Docteur G.A. Van den Berghe, père’, JBH 9 (1902), 81-88, q.v. 85
27 Nys, Geschiedenis van de pioniersfase, 111-114.
education in France or Germany. When homoeopathic courses became available homoeopathic physicians gave them privately. From 1861, for example, Dr. Mouremans gave clinical lessons at the Hahnemann dispensary in Brussels.\textsuperscript{28} Furthermore, Van den Berghe studied with some later well-known homoeopaths who were descended from a homoeopathic family tradition. The brothers Leon and Jules Gaudy, for example, who would become physicians in the Hahnemann dispensary in the 1870s, were the offspring of a homoeopathic veterinarian and fellow students of Van den Berghe.\textsuperscript{29}

Encouragement from other ‘candidate’ homoeopaths and the positive results of homoeopathic experiments in his early practice will eventually have convinced him. More so, Van den Berghe did not hesitate to experiment continuously with medication on himself, one of the three pillars of homoeopathic therapy. His colleagues praised him for this unflagging zeal for testing: ‘his arduous labour of studying medical pathology had given him the courage to completely reject his allopathic science’.\textsuperscript{30} According to homoeopathic principles, determining each medication’s selective action simplified both the study of pathology and the application of homoeopathic treatment. Van den Berghe, as did many homoeopaths, stated that, natural, simple, special or specific instances of illness often touch upon selectively a particular organ or region of the body, just like medicines. It is incontestable, therefore, Van den Berghe continued, that knowledge with respect to the selective pathogenetic functioning will add to both the speeding up and improving of diagnostics.\textsuperscript{31}

Van den Berghe’s change to homoeopathy was based initially on personal experience and the study of homoeopathic publications. At the beginning of the 1870s he would receive eventually theoretical homoeopathic education. In 1870, the homoeopathic physician G.H.G. Jahr (1801-1875) arrived at the Hahnemann dispensary in Brussels. As a German, Jahr had been forced to leave Paris on the outbreak of the Franco-Prussian war. He provided theoretical and practical education for young homoeopaths, twice a week between 1870 and 1875.\textsuperscript{32} In March 1871, Van den Berghe started to attend Jahr’s classes. As these lectures were on Wednesday, an ordinary working day

\textsuperscript{28} Nys, Geschiedenis van de pioniersfase, 92-93.
\textsuperscript{29} Van Praet, De receptie van de homeopathie, 168. Jules Gaudy (1835-1899) and Léon Xavier Gaudy (?-1888) had both been working as medical personnel in the army.
\textsuperscript{31} Docteur Van den Berghe, ‘Le Kali Carbonicum dans le traitement de la coxarthrocace’, \textit{HM} 1 (1878), 257-260.
Gustave Van den Berghe (1837-1902)

for Van den Berghe, it is likely that he attended evening classes. Lecture notes left by Van den Berghe showed which courses were available: he participated in lectures on mental and cerebral affections, ailments of the head and disorders of the eye, ear and nose.33

Although other homoeopaths sometimes continued the partial use of allopathic treatment, Van den Berghe irrefutably rejected allopathy. His colleagues considered him as one of the truest followers of Hahnemann. On the title page of his book De homoeopathie en hare tegenstrevers ('Homoeopathy and its opponents') Gustave quoted Hahnemann.34 Medical science, according to Van den Berghe, had failed to develop in the way that other sciences had done for centuries. Despite the efforts of great scientists like Hippocrates, Galen and Paracelsus, the medical sciences had never succeeded in finding the true key to curing. This all changed with Hahnemann's knowledge of the effects of medication and the 'old' school should take note.35 Hahnemann's instructions on case-taking procedure were of the utmost importance and should be followed carefully.36 Van den Berghe emphasised the recommendations made by Hahnemann on individual diagnostics. Account should be taken not only of the origins of the disorder, it was even more relevant to consider age, personal circumstances, profession, and constitution etc.37 Van den Berghe, besides written declarations of admiration, also expressed, at a memorial banquet, his great respect for Hahnemann:

Our hearts are filled with love and our minds are pervaded with admiration for the one most sympathetic person, our venerated Master, the physician Samuel Hahnemann. It is he who initiated us in the true medicine and he was the source of our success; it is he who through his homoeopathy provided the suffering humankind with ineffable benefaction. [...] permits us to declare him to be one of the greatest benefactors the world has ever seen.38

33 AVB, Notebook 'Leçons sur l'homoeopathie par le Dr. Jahr au dispensaire Hahnemann a Bruxelles', inv. no. 28 B, March 1871, 182 pages; Docteur Gustave van den Berghe, 'Leçons sur l'homoeopathie données par le Docteur G.H.G. Jahr (1801-1875) au dispensaire Hahnemann de Bruxelles, les mercredis 1er, 8, 15, 22 et 29 mars 1871', RBH 10 (1958), 381-386.

34 See page 40. 'The first and sole vocation of the physician is to restore health to the ill. This is called curing.'

35 Van den Berghe, De homoeopathie, 7.


38 Un convive, 'Banquet commémoratif de la naissance de Hahnemann donné par le Cercle homoeopathique des Flandres', Union 2 (1887-1888), 119-122, q.v. 119. 'La figure la plus sympathique pour laquelle nos cœurs sont remplis d'amour et nos esprits pénétrés
Van den Berghe held uncompromising views about the attitude of allopathic physicians towards homoeopathy and the possibilities of allopathic treatment. He detested the open doubts allopathic physicians expressed on the efficacy of homoeopathic therapy, particularly as they were unwilling to investigate impartially the 'homoeopathic facts'. Moreover, he reproached their ignorance, as allopaths sometimes used homoeopathic healing unknowingly. The allopathic practice of administering purgatives, furthermore, was inefficient. It could never result in long-lasting or permanent recovery and was accompanied often by unpleasant or even dangerous side effects. He exemplified this statement with the allopathic treatment of skin disorders. The external use of medication usually stops the initial eruption, but will lead to internal ailments that undermine strength and could be lethal. Van den Berghe persistently advocated administering one medicine at a time, because the allopathic mingling of medications could only diminish or even destroy the power of the remedy. A mix of medications should never be employed on patients and should have been banned a long time ago.

This did not mean, however, that alternation between medicines was not acceptable. Van den Berghe was one of the first homoeopath in Belgium to apply the method of interchanging in case one remedy did not obviate the complete set of symptoms. He acknowledged that alternation should be avoided, but experience had shown that, in some cases, variation between two different medicines was necessary especially in instances where both the physical and constitutional circumstances of the patient were at stake. In 1870, for example, Van den Berghe met the desperate parents of a three-year-old child with hydrocephalus (water on the brain). He began the treatment by prescribing fifteen globules of calcarea carbonica C30 dissolved in 150 grams of water. A month later the dilution changed to C200. After two months the volume of the head had diminished and Van den Berghe decided to continue the treatment by alternating between calcarea and sulphur. Within a year the fontanelle had closed and the child's walking ability and speech had improved. Although the head remained large, it did not hinder the child from going to
Gustave Van den Berghe (1837-1902)

school. Van den Berghe used this case to underline the incapacity of allopaths to combat this illness and to denounce again their dismissal of homoeopathy.

Van den Berghe also countered the al­lopathic criticism of the homoeopathic functioning of the small dose. In his book, intended for Dutch speaking lay-people, he gave a clear cut example that appealed to the imagination of his readers: the contagious miasma that led to diseases such as cholera, typhus, and smallpox. Everybody knew that these infectious ailments were carried by air, even though, like miasma, they were not visible. Van den Berghe, like Hahnemann, clearly preferred some dilutions to others. Generally, he prescribed the 30th dilution; sometimes he made use of the 6th dilution. He preferred to administer C200 for chronic ailments. Van den Berghe was of the opinion that the choice in favour of a particular dilution should be related primarily to the affected organ rather than to the nature of the ailment. He employed, for example, small doses of ipecac for abdominal affections and high dilutions for ailments of the chest. Whereas, according to Van den Berghe, the dilutions depended on the type of organ, the choice of the medication corresponded with the characteristics of the patient. If a patient responded well to a specific medication for a particular ailment, it was often the case that several other disorders could be cured with the same remedy. In the final years of his practice, Van den Berghe also started experimenting with the high dilutions of Skinner. Although sceptical at first of the efficacy of these dilutions, he used it in chronic and tough cases from 1895. He was inspired by the positive clinical results that his son Samuel had witnessed during his studies in the United States and in London. Moreover, Van den Berghe was convinced that high dilutions had a longer effect persisting for five to six

44 Van den Berghe, De homoeopathie, 106-132.
45 Anonymous, 'Cercle Médical Homœopathique des Flandres', JBH 2 (1895), 156-162, q.v. 159-160.
46 Ibidem, 43-46, q.v. 44-45. 'Si une maladie se trouve bien d’un remède dans une maladie donnée, bien souvent le même remède le guérit dans les affections les plus diverses’.
47 Thomas Skinner (1825-1906) was a British physician of Scottish origin. After an American homoeopath living in Liverpool, Edward Berridge (1844-1920), successfully treated Skinner, he took up homoeopathy himself. He had been treated with one single dose of medicine of high potency. Its effect was so profound and unexpected on the part of Skinner, that he became a strong advocate of high dilutions. He went to the U.S. in the 1870s where he developed a fluxion machine supplying for high potencies.
48 Samuel most probably was educated according to the Kent school. The American James Tyler Kent (1849-1916) initially was a professor in anatomy. He converted to homoeopathy after his chronically ill wife had been cured in a homoeopathic manner. The Kent school strictly follows Hahnemanns’ writings, except in using high dilutions: H. Bodde, O. Goetz and E. de Lange-de Klerk (eds.), Leerboek homeopathie (Utrecht/Antwerp: Bohn, Scheltema & Holkema, 1988), 22, 118-119.
He continued to innovate as, even before Koch's discovery of the tubercle bacillus (1882-1883), he administered tuberculinum against tuberculosis. Adult patients suffering from consumption did not seem to benefit, but the condition of consumptive children improved after eight days and they were cured usually within two months.50

Besides the medication, the treatment usually included also a diet. Unfortunately, Van den Berghe barely noted anything on dietary rules in his casebooks, although remarks on the usage of coffee, tobacco and alcohol may be found. However, diet must have been an important part of the treatment as it is regularly referred to in his published cases and in his book. However, Van den Berghe emphasised that it was not always possible to uphold the homoeopathic regimen and that recovery was not completely dependent on it. Even so, people who did follow the diet were more likely to get better results from the treatment.51 The homoeopathic lifestyle, like contemporary orthodox medical advice, prohibited intemperate activity in work and other pursuits as excesses of all kinds were damaging to health. The use of coffee, medication, purgatives, menthol and tooth powders was strongly advised against. Caution was advised with meat, fish, vegetables, herbs and fruit. The internal and external use of allopathic medication to stimulate stools, of expectorants or of breast cleansing drugs was strictly forbidden, as were leeching and bleeding.

Van den Berghe, like many of his colleagues, was a 'self-made' man whose unflinching acceptance of homoeopathy was founded initially on personal experience and self-study, supplemented by some theoretical education. He became a classical homoeopath, closely following Hahnemann's recommendations but, at the same time, deviated from the 'Master' in parts of his medical practice. There was, for example, no use of placebos and only one form of treatment was offered, homoeopathy, whereas Hahnemann also made use of mesmerism.52 Van den Berghe was a strong advocate of the study of the science of pathogenesis; he rejected the intermingling of medications, unlike some of his homoeopathic colleagues, and, over time, took up experimenting with high dilutions. He maintained seriously the homoeopathic principle of testing medications on healthy subjects by performing it on himself. The treatment was accompanied always by a homoeopathic diet, although Van den Berghe did not consider it of vital importance, as it ensured the functioning of the homoeopathic medication. The way in which he approached and treated

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50 Ibidem, JBH 2 (1895), 422-425.
51 Van den Berghe, De homoeopathie, 164-169.
Gustave Van den Berghe (1837-1902)

his patients with regard to diagnostics, physical examination and the use of stethoscope etc. will be discussed later. Throughout his life as a homoeopathic practitioner, Van den Berghe continued the study of the functioning of medicines. He did not hesitate to challenge allopaths and to propagate the hopeful message of homoeopathy as the true key to curing at a time when orthodox medicine was still 'ignorant and arrogant'.

1.4 Van den Berghe's Commitment to the Belgian Homoeopathic Movement

On Van den Berghe's death, his colleague Eugène De Keghel (a homoeopathic physician in Ghent, d. 1914) commemorated him in military language stating that, after his settling in Ghent, he became quickly the 'porte-étandard' (flag-bearer) of homoeopathy:

Rejecting the entire therapeutic baggage of the old school, he defied all his clinical cases with the powerful arms within the homoeopathic arsenal. With this constant practice he acquired solid experience and he obtained glorious victories in cases that left his allopathic colleagues powerless.

The use of terms like ‘arms’, ‘arsenal’ and ‘victory’ in relation to Van den Berghe suggests that he noticeably and, perhaps, even aggressively fought for the homoeopathic ‘cause’. Undoubtedly, Van den Berghe participated unhesitatingly in the organisational structures of the homoeopathic movement. His contributions to periodicals and his active involvement in homoeopathic societies indicate irrefutably his energetic passion for the cause. Whether Van den Berghe's engagement indeed was of a militant character will be examined later.

Although practising in a homoeopathic manner since 1865, Van den Berghe did not become involved immediately in the homoeopathic movement in Belgium. Apparently, he gave himself time at first to explore further the possibilities of homoeopathy and to create a steady clientele and practice. He took the first careful step towards participation in 1874, when he signed up as a corresponding member of the Société du Dispensaire Hahnemann in Brussels, though he never attended any meetings. This society was founded in November 1874, but probably disappeared one year later. Jahr filled the

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53 See Chapter 6.
54 Van den Berghe, De homoeopathie, 98-99.
55 'Mort du Docteur G.A. Van den Berghe', 85. 'Rejetant tout le bagage thérapeutique de la vieille école il affronta tous ses cas cliniques par des armes puisées dans le seul arsenal d'homoeopathie. Cette pratique constante lui fit acquérir une expérience solide et lui valut des victoires éclatantes là où des confrères allopathes [sic] étaient restés impuissants'.
56 Van Praet, De receptie van de homeopathie, 26, 132.
In Search of a Cure

chairmanship and some of Van den Berghe’s university friends had become members. Three years later, in 1877, Van den Berghe’s commitment to the homoeopathic movement became more pronounced. He took part in the foundation meeting of the Société Belge de Médecine Homéopathique in Brussels and remained a member until its closure in 1882. The Société Belge was a small society, like the Société du Dispensaire, with only seven ordinary members. At the first meeting a Hahnemann fund was created with the aim of setting up local dispensaries and establishing hospitals or wards reserved specifically for homoeopathic treatment. The monthly gatherings, at which Van den Berghe was almost always present, took place in Brussels on the second Monday of the month and started at 16.00. The minutes for the first two years were published in l’Homoeopathie Militante (HM) (Brussels, 1878-1882) to which Van den Berghe was a contributor.57 The minutes and Van den Berghe’s publications confirm his increasing participation in the homoeopathic organisation.

Between 1878 and 1880 Van den Berghe wrote ten articles for HM most of which consisted of practical experiences in the way of case descriptions. Sometimes, the basis of the article was the medication, in others the ailment was taken as the starting point. In an article on the application of *rhus toxicodendrum*, he dwelt upon the possibilities and limitations of this specific medicine beginning with summarising situations where *rhus* is most convenient and ending with a condition in which it most certainly is not.58 In 1874 an accident had happened in the Van den Berghe household when white spirit had caught alight and Gustave and his wife suffered burns on their hands and wrists. Although, in some cases, *rhus toxicodendrum* appeared to be the proper medication, in theirs it was not, as it did not relieve them. Other articles were concerned with general topics intended to improve the general public’s knowledge of homoeopathy. Van den Berghe, for instance, emphasised the importance of publishing Hahnemann’s correspondence for the diffusion and understanding of homoeopathy.59

Most of Van den Berghe’s publications were of a medical scientific nature and, therefore, not primarily accessible or, perhaps of interest, to the general

58 *Rhus* is applied in case of both chronic and acute conditions resulting from physical labour (like wrenches), typhoid fevers and skin ailments that are characterized by burning pains and the occurrence of vesicles. Docteur Van den Berghe, ‘Quelques applications cliniques du Rhus Toxicodendron’, *HM* 1 (1878), 119-120.
59 G. van den Berghe, de Gand, ‘La correspondance de S. Hahnemann. Sur l’utilité de sa publication’, *HM* 1 (1878), 63-64. ‘Cette correspondance nous ferait connaître Hahnemann comme médecin praticien; elle enlèverait bien de fausses interprétations de ses écrits en révélant ses pensées intimes; elle nous ferait la lutte héroïque qu’il eut à soutenir contre les allopathes, elle nous dirait ses déceptions et ses peines, mais aussi ses consolations et ses joies’.
Gustave Van den Berghe (1837-1902)

public. Usually, they were published after the conditions and the most suitable treatment had been discussed during one of the society's meetings. Although the statutes of the Société Belge proclaimed dedication to the spread of homoeopathy by founding dispensaries and hospitals, the society primarily was a platform for professional discussion. Van den Berghe's articles suggest that he was more concerned with strengthening the scientific base of homoeopathic treatment than with making homoeopathy known amongst a broad spectrum of the population. However, from the day he opened his Ghent practice, Van den Berghe made homoeopathy available to everyone by offering free treatment for the needy. An advertisement announcing the opening of his practice stated:

Homoeopathic medicine
Doctor Vandenbergh [sic.], Muinkkaai 2, in Ghent, announces that his practice for the needy will be open every day from 7 to 9 o'clock in the morning. He will give his special consultations from 11 to 1 o'clock.60

He made a distinction in his practice, therefore, between a free dispensary for the poor and a private practice for people with means. An examination of the advertisements in homoeopathic periodicals about the existence of dispensaries suggests that Van den Berghe was the only homoeopath in Ghent who offered free treatment in a private practice.61 Van den Berghe's effort to make homoeopathy accessible to the general public found its climax in 1881, with his decision to write a book on homoeopathy in Dutch. As he stated, this was necessary not because publications on homoeopathy were rare, but because the mono-lingual Flemish were deprived of knowledge of this only true medical system to find restoration to health, as nothing had been published ever in their native language. Van den Berghe wanted to fill the gap with De homoeopathie en hare tegenstrevers.62 It would remain the only nineteenth-century publication in Dutch on homoeopathy printed in Belgium (Figure 4).

However, the book is not as readable as might be expected given the target group. It contains a thorough description of the principles of homoeopathy and their accuracy in comparison with the errors of allopathy. There is an opening chapter on Hahnemann, to whom Van den Berghe

60 Gazette van Gent, Sunday 17 January 1869, unpaged. For the original Dutch text see Appendix 2.
61 See, for example, JBH 1 (1894).
62 Van den Berghe, De homoeopathie, 5-6. This deprivation was only relative. Dutch (-language) publications on homoeopathy indeed were available, however not from Belgian origin, but for example published in the Netherlands. Nevertheless, the total number of books, brochures and leaflets in Dutch on homoeopathy remained small.

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constantly refers as the Master. This is followed by outlines of the three existing healing methods: allopathic medicine, antipathic medicine and, finally, homoeopathy, arguing why homoeopathy offers the only proper treatment in case of illness. Antipathic medicine is based on the principal of the opposite curing the opposite and as the opposite of illness is health, health should be treated thereby making this system incomprehensible and ‘false’.63

Furthermore, Van den Berghe discusses the effects of medication on healthy people and the truth of the infinitely small dose. These chapters are all accompanied by testimonies and quotations from both ‘allopaths’ and homoeopaths to underline the scientific base of homoeopathic principles and to criticise orthodox medicine. Van den Berghe included also information on the homoeopathic movement around the world, discussing among other things, the

63 Van den Berghe, De homoeopathie, 24-46.
fruitless attempts by Belgian homoeopaths to obtain official recognition for homoeopathy. The final chapter, contains some practical advice on the proper preparation and use of homoeopathic medications with regard to particular ailments. However, Van den Berghe makes it abundantly clear that this advice is meant for allopathic physicians willing to take a first step on the path of homoeopathy. He concludes with a general overview of the characteristics of a homoeopathic regimen, but only in summary. Van den Berghe referred people who wanted more information to a publication of his colleague Pierre Van den Neucker, the future father in law to his son Samuel.

De Homoeopathie en hare tegenstrevers, thus, was not a self-help guide that aimed at providing Dutch-speaking Belgians with the necessary knowledge to employ homoeopathy at home. It neither offered advice on how to improve health nor on how to maintain it by means of hygienic measures. The book, therefore, shows interesting similarities with the contents of Van den Berghe's articles in homoeopathic periodicals; a reinforcement of the appropriateness of homoeopathy for a medical public. The book might have enlarged homoeopathic knowledge of ordinary people but its predominant purpose was to defend homoeopathy and to persuade allopaths to embrace it as well. Nevertheless, the book was available in public libraries and it is said that many a labourer had had it in his hands.

As noted, Van den Berghe participated in the Société Belge until its dissolution in 1882 and he must have been very busy during these years. Besides developing a continuing growing new clientele, he still found time to write a book and to publish case histories. Meanwhile, a new professional society had emerged in Brussels in 1879, the Association Centrale des Homoeopathes Belges founded by Louis Martiny (1839-1902) and dissolved at his death in 1902. The society attracted mostly members from the city of Brussels and the Walloon provinces in Belgium and grew from 23 members in 1879 to 47 in 1897. Van den Berghe did not join his Brussels colleagues but, instead, became a member of the Flemish Cercle Medical Homoeopathique des Flandres

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64 This is rather remarkable as this publication was in French: P. Van den Neucker, Ce qu'est l'homoeopathie, ce qu'elle n'est pas. Du régime homoeopathique (Harelbeke: Carlier-Debrauwer, 1878).
66 See Chapter 2.
67 Henri-Louis Martiny (1839-1902) initially worked as a physician in the army, where he first became acquainted with homoeopathy. Martiny published various books and articles regarding homoeopathy and was the founder of the aforementioned society and he was the initiator of the Revue Homoeopathique Belge. Martiny was not a close follower of Hahnemann; he pleaded in favour of the medical science and therapy of common sense. Van Praet, De receptie van de homeopathie, 175.
In Search of a Cure

(Cercle). A group that probably best underlines Van den Berghe’s involvement in the homoeopathic movement.

The idea of founding the Cercle in 1872 originated from a group of homoeopaths that had attended Jahr’s classes in Brussels, then travelling home by train. Apparently, Van den Berghe had not been present in Brussels on this particular date as he did not take part in the inaugural meeting and his absence was regretted sincerely. The cause had been a communication failure as one of his colleagues, Van Peene who also lived in Ghent, had agreed to invite Van den Berghe but had forgotten to do so.

The minutes of the Cercle were published, at first, in the Revue Homoeopathique Belge (RHB). They were printed in l’Homoeopathie Militante (HM) between 1878 and 1880 but, after its closure, the minutes ceased to be distributed in print until the publication of l’Union Homoeopathique (1886-1892) (Union) provided a new distribution channel. The transfer from the RHB to HM led to some animosity between members. Rivalry and, perhaps, jealousy were not uncommon. When a colleague of Van den Berghe suddenly decided to denounce homoeopathy, he was accused of envying Van den Berghe who had superior knowledge and practical experience with regard to the Materia Medica. In April 1882, Van den Berghe finally joined the Cercle at a memorial banquet to Hahnemann. He would be President from 1887 until 1897. Van den Berghe even had the pleasure of welcoming his son Samuel, who had just obtained his medical degree, as a member of the Cercle in 1893. When Gustave stepped down as President Eugène De Kehgel succeeded him and Samuel became Secretary. Van den Berghe continued to attend meetings but from 13th September 1898 his name was no longer mentioned in the minutes.

The homoeopathic movement faced both its flourishing era and its decline during the period of Van den Berghe’s Ghent practice. In terms of the number of practitioners, 1875 witnessed the peak: fifty-five to fifty-nine medical doctors practised as homoeopaths in Belgium. In 1894, their numbers had declined to forty-seven to fifty-one, with the lowest point in 1904: thirty-four to thirty-six practitioners. Most of them resided in the province of Brabant.

69 Van Wassenhoven, ‘Geschiedenis van de homoeopathie (deel 2)’, 11.
70 AVB, Notice historique du Cercle Médical Homoeopathique des Flandres, 1872-1897, inv. no. 50, dated 30 April 1922. Manuscript ‘history’ of Belgian homoeopathy by Dr. E. de Kehgel, read on 30 April 1922. ‘Le Dr. Van Peene s’était chargé de prévenir ce dernier l’homoeopathie le plus en vue en ce moment à Gand; mais il avait oublié de remplir cette mission. Le Dr. DeKehgel se charger de réparer cet oublie. Seulement malgré de vives instances le Dr. Vanden Berghe refusa son concours’.
71 Martiny and Emile Seutin terminated their membership of the Cercle. Seutin (1811-1895) was a homoeopathic pharmacist in Brussels.
72 AVB, inv. no. 50. ‘[…] les connaissances en matière médicale comme l’expérience pratique en homoeopathie […] beaucoup supérieures’.
followed by, respectively, the provinces of East-Flanders, Antwerp and West-Flanders. Within these provinces homeopaths preferred the city to the countryside.\textsuperscript{74} Between 1874 and 1914, furthermore, no less than five homeopathic societies were founded of which four had their origin in the 1870s. Some of these institutions disappeared as fast as they emerged. Although the purpose of the various societies basically was the same, they were never able to come together. During the nineteenth century the Belgian homeopathic movement remained scattered and initiatives to combine forces never succeeded. This lack of cohesion and solidarity was one of the reasons for the decline of homeopathy at the end of the nineteenth century. It was principally Brussels homeopaths who hindered the creation of one Belgian federation. Other reasons for homeopathy’s decline were the progress of ‘orthodox’ medical science, a failure to recruit new homeopathic physicians, the improved living standards, the absence of a charismatic leader and, finally, the refusal of the Belgian government to officially acknowledge homeopathy.\textsuperscript{75}

In the same period, eight, sometimes short-lived, periodicals were published and at least twenty dispensaries, including private ones, were set up. Lay commitment to the homeopathic movement in Belgium had not yet been established. The only known pledge for homeopathy by lay-people dates from 1874 when several inhabitants of the municipalities of Durby, Waver and Tubize petitioned the parliament.\textsuperscript{76} In contrast with developments in Germany and the Netherlands no lay-societies were founded in Belgium.\textsuperscript{77} It would take until the 1970s before a society of lay sympathisers, ‘The Friends of Homoeopathy’, was established.\textsuperscript{78} Nevertheless, the growth of homoeopathy in the nineteenth century could not have taken place without any lay interest, namely that of sufferers consulting homoeopathic practitioners. Moreover, some dispensaries were set up with the financial aid of charity committees.

\textsuperscript{74} Van Praet, De receptie van de homeopathie, 11-23.
\textsuperscript{75} Ibidem, 28-29, 123-125.
\textsuperscript{76} Ibidem, 25-42, 97.
\textsuperscript{78} K. Van Wassenhoven, ‘Geschiedenis van de homeopathie in België (deel 4)’, Homeopathisch Bekeken 48 (2000), 12-17, q.v. 16.

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The organisation of the Cercle and the contents of its meetings are comparable with that of other societies. Homoeopathic professionals gathered to exchange knowledge and practical experiences, to commemorate their founding father and to strive for official recognition of their therapy. As president of the Cercle, Van den Berghe's role became more public, for example, by twice petitioning the Belgian parliament on behalf of the society. The first petition aimed at the prohibition of the usage of lead pipes for beer production to prevent lead intoxication. In imitation of French legislation, lead pipes should be replaced with tin pipes. The use of leather and zinc should be prohibited also as they constituted a hazard to public health no less than that of lead.79 The second petition fulminated against the laws on the sale of medications.80 Van den Berghe was chosen also to represent the Cercle at the International Homoeopathic Congress that took place in Paris in August 1889.81

At the end of the 1880s Van den Berghe picked up writing again. He published on the treatment of shingles, angina pectoris, cholera, and ailments resulting from childbirth, ear infections, inflamed glands and furonculosis. Van den Berghe was still very productive at the end of his life. In 1900 he wrote on influenza - 'petite peste des anciens' as he called it - based on practical observations. It was published in the Journal Belge d'Homoeopathie and independently in Brussels.82 During the last years of his life Van den Berghe worked on another book titled 'Médecine des régions' or 'Thérapeutique des régions'. He would not be able to complete it, but the manuscript has been preserved.83 This, again, is a small format notebook written in French and its contents are based on each part of the body (région). The possible ailing situations (the symptoms) for each part or organ and the proper medication were described. However, not all body parts had been discussed by the time of his death. His colleagues knew that he had been working on it and, at his grave-side, the wish was expressed that one of his sons would finish and publish the work posthumously.84 This wish has never been fulfilled.

Van den Bergh clearly committed himself to the homoeopathic 'cause'. His (sometimes long) membership of different societies and his publications attest to this. His activities express a two-sided attitude. On the one hand, he was a scientist whose only goal was to 'prove' the truth of homoeopathic

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79 AVB, Letter by Gustave Van den Berghe to the house of parliaments regarding lead-intoxication, inv. no. 36, not dated.
81 Ibidem, Union 3 (1888-1889), 116-120.
82 For a survey of Van den Berghé's published works see the bibliography.
83 AVB, Manuscript Médecine des Régions, inv. no. 33, not dated, 123 pages.
84 AVB, A la Mémoire du Dr. G.A. van den Berghe, père, homoeopathe à Gand, inv. no. 54, 1902, 9 pages, 8.
treatment and to convince allopaths that their medical science was based on error. He considered it important to share his experiences with his colleagues and with his Presidency the Cercle took a new turn. His medical kindred spirits considered his lectures as lessons in lucid diagnostics. 'The observations he presented constituted a compendium of experience of the utmost advantage'. Furthermore, precisely his involvement in the Cercle made Van den Berghe's input publicly visible. On the other hand, Van den Berghe expressed social commitment by ensuring that homoeopathy was available to all. His Dutch-language publication on homoeopathy, although perhaps not easily readable to the layman, enlarged the possibility for the Flemish to gain knowledge on homoeopathy. Moreover, by establishing a free dispensary for the impecunious from the day he opened his Ghent practice, Van den Berghe greatly dedicated himself to offer homoeopathic treatment to whoever was interested or in need.

Nevertheless, Van den Berghe's participation in the homoeopathic movement does not reveal any militancy in his activities. Although he contributed to periodicals with militant tendencies, he never engaged in public polemics with his allopathic colleagues. This is not to say that he never would have wanted to. Indeed, in one case, Van den Berghe sought to enter a debate. Among the papers Van den Berghe left behind, there is one essay entitled 'Homoeopathie. Réponse à Monsieur le Docteur Dossel'. At the beginning of the 1880s, this Ghent allopathic physician published an article criticising homoeopathy. Dossel began with outlining the basic principles of homoeopathy and the role of Hahnemann and, thereafter, expounded his arguments against this medical system. The existence of numerous cures obtained through homoeopathy were explained as resulting from the personal qualities of the practitioner rather than from the therapy itself. Moreover, the popularity of homoeopathy was mainly due to its suitability for personal employment. 'It permits anyone to somewhat be his own physician'. Apparently, Van den Berghe thought a response was appropriate and he wrote one of 26 pages. Van den Berghe stated that he found it necessary to give a clear exposé of the contents of homoeopathic medicine and to refute some erroneous assertions. However, it was not published. A month later, the

85 AVB, A la Mémoire du Van den Berghe, 4. 'Chaque causerie du président était une leçon, non seulement d’expérience heureuse, mais aussi de diagnostic sagace et d’application scrupuleuse de nos pathogénèsies. En parcourant les procès-verbaux des travaux du Cercle, les observations présentées par le président Van den Berghe constituent un compendium de renseignements de la plus grande utilité'.
86 Dr. Dossel, 'Homoeopathie et allopathie. Causerie médicale', Revue Générale 17 (1881), 915-934.
87 Dossel, 'Homoeopathie et allopathie', 931. 'Elle permet à un chacun d’être un peu son propre médecin [...]'.
88 AVB, Homoeopathie réponse au docteur Dossel parvue dans la Revue Générale, inv. no. 35, not dated, 26 pages.
editorial staff of the *Revue Générale* wrote that Dossel’s article had stirred up some emotions and to regain general calmness amongst the subscribers they handed over the issue to one of the respondents, the homoeopath Martiny.\textsuperscript{89}

Other Belgian homoeopaths were, in contrast to Van den Berghe, much more actively searching for confrontation. Gailliard, for example, disputed continuously with anyone who dared to judge negatively homoeopathy.\textsuperscript{90} Van den Berghe’s fighting spirit, conversely, seems more to have been ventilated internally. His dedication to homoeopathy as the only true key to healing concentrated primarily on ensuring its proper application. Van den Berghe’s struggle aimed at protecting the therapy from practitioners who did not subscribe to the instructions given by the ‘Master’.

\textsuperscript{89} Dr. Martiny, ‘Homoeopathie et le “gros bon sens”, *Revue Générale* 17 (1881), 154-158. See for the editorial remark footnote 1. Martiny’s response was much shorter than that of Gustave!

\textsuperscript{90} Van Praet, *De receptie van de homeopathie*, 86-87.
2

Patients from Everywhere:
Gustave Van den Berghe’s Overall Clientele, 1865-1902

On Friday 28th July 1865 Gustave Van den Berghe is sitting in his surgery in Zwevegem, he opens Casebook One and files the first patient whom he treats officially with homoeopathy. The homoeopathic practice has started. However, unofficially, Van den Berghe had started the day before. On July 27th a patient from Moeskroen, a village nearby, had received medical attention, but he was not registered until August. Presumably, Van den Berghe had visited the patient at home and only enrolled him as a client when the patient appeared physically in his practice.

Although Ghent citizens consulting Van den Berghe are at the heart of this study, a general overview of his entire clientele is appropriate. After all, the material left by Van den Berghe offers a splendid opportunity to gain insight into the socio-historical aspects of a homoeopath’s entire clientele. A social analysis is the more interesting since, apart from a few exceptions, data on the composition of homoeopathic clientele in the nineteenth century are hardly available. This chapter does not involve people’s experiences with health, illness or previous experiences with health care, but aims at unravelling the general features of Van den Berghe’s clientele. Nor does it profoundly deal with questions regarding personal motivations for turning to Van den Berghe.\(^1\) It serves, on the other hand, to provide for an overview of changes occurring in Van den Berghe’s entire clientele. First, the development of the practice, based on the total number of patients treated by Van den Berghe, will be explored. Next, the social features of the clientele, during three different periods in time at the beginning, the middle and the end of the practice will be studied to verify whether its composition underwent any profound changes. The results will be compared to practices of other homoeopaths to establish whether Van den Berghe’s clientele exhibited any specific peculiarities. Finally, the presence of ‘foreign’ patients in the clientele will be examined to consider if any differences existed with the Belgian clientele and why ‘foreigners’ may have consulted a homoeopathic physician far away.

2.1 From Zwevegem to Ghent: the Total Number of Patients Treated by Van den Berghe

Van den Berghe treated more than 22,000 people in thirty-seven years of homoeopathic practice. He treated an average of 595 new patients per year but,

\(^1\) These matters will be touched upon in the next five chapters.
as will become clear, in some years he welcomed more new patients to his practice than in others. Most of Van den Berghe's patients lived in Belgium and even resided in Ghent or the immediate environs. Some were willing to travel considerable distances and lived on the other side of the country. Yet others came from abroad, mostly living in the nearby Dutch province of Zeeland or in the North of France. Most of his patients (84 per cent) were men and women older than sixteen, sixteen per cent of his clientele consisted of children age sixteen or younger. Graph 1 shows that of all patients, 1,753 (8 per cent) were treated for free, but that relatively more children than adults received medical care free of charge. Almost one out of five children consulted Van den Berghe without their carers ever paying, against one out of sixteen adults.

Graph 1. Composition of Van den Berghe's Clientele: Total Number of Patients, Adults and Children and their Numbers Treated for Free, 1865-1902

Van den Berghe practised for the first four years in Zwevegem. The practice was small; treating a total of 693 people, an average of 173 new patients per year. This is not surprising as Van den Berghe still had to establish his reputation and he continued his professional re-orientation as a homoeopath. The quiet days were over with his move to Ghent. In 1869 nearly seven hundred sufferers called upon his help for the first time. Unfortunately, nothing is known about the way Van den Berghe publicised his existence during his Zwevegem practice. The opening of the Ghent practice, conversely, was accompanied by a true advertising 'campaign' in a Ghent newspaper: the Gazette van Gent. Van den Berghe, on 17th January 1869, let it be known that he had established a homoeopathic practice. He repeated the advertisement thirty-eight times until mid-April, though the text slightly changed after three weeks.
Whereas he had announced previously that he would work seven days a week, subsequently, he excluded Mondays. Furthermore, the office hours of his dispensary were reduced to between 7 a.m. and 8 a.m.\(^2\) It is unknown whether it was exceptional to work on the Lord’s Day though, for many of Van den Berghe’s working-class patients, it will have been a blessing as it was their only day off in the week.

\[\text{Graph 2. Number of New Patients (adults and children) per Year, 1865-1902}\]

Graph 2 shows the number of new patients who consulted Van den Berghe each year. Again a division has been made between adult and child patients. In 1869 Van den Berghe saw 675 new patients and the size of his new clientele fluctuated greatly between this year and 1873. In 1870 he welcomed 1,432 new patients, but the number dropped considerably to 828 in 1871. Then his new clientele grew again: in 1872 more than 1,100 new patients consulted him. In 1873 nearly 700 new sufferers called upon Van den Berghe’s aid. The last peak occurred in 1882: 838 new patients. Thereafter, the size of Van den Berghe’s new clientele gradually decreased until it stopped in May 1902 when Van den Berghe died.

It must be kept in mind that the above numbers refer to the number of new patients Van den Berghe treated each year. New patients consulted Van den Berghe alongside old ones; the total number of patients Van den Berghe saw each year was higher. Therefore, it is understandable that, with the continuation of treatment of regular patients, Van den Berghe could not take on as many new patients as he may have wanted. When he just had started in Ghent he did not have an established clientele and, therefore, welcomed everybody who applied for medical advice. The remarkable drop in the

\(^2\) Gazette van Gent, 12 February 1869, unpaged.
number of new patients visiting Van den Berghe in 1871 could well be explained by the move to Stationstraat which had not been accompanied by an announcement of the change of address in a newspaper. Clearly, he had already an established reputation by that time and publicity through personal recommendations had paved his way. However, it is not unlikely that some 'potential' patients fell between two stools. In addition, the preparations for the move took up Van den Berghe's time, thus leaving him less opportunity to give consultations.

Comparison of Graphs 2 and 3 shows that a correlation between an increase in the number of new patients and a growing number of people treated for free did not exist. In 1870, the year in which Van den Berghe treated the largest number of new patients, only four patients received gratis treatment. Moreover, the peak in Van den Berghe's dispensary, a clinic for free treatment, dates from 1877; but a remarkable growth of new clientele overall is not visible. The last peak in the number of new patients and in the number of non-paying patients occurred in 1882. In that year 838 new patients were registered of whom fourteen per cent received free medical advice. It might be assumed that with the publication of De Homoeopathie en hare tegenstrevers in 1881, Van den Berghe gave a new boost to the interest in homoeopathy. Furthermore, the usual distrustful attitude of ordinary people towards doctors could well have been diminished because of the use of Dutch.3

Patients from Everywhere

The use of the Dutch language was unique in Belgian homoeopathic publications. Fifty-eight works on homoeopathy were printed in Belgium between 1850 and 1900 and Van den Berghe’s book is the only Belgian homoeopathic guide in Dutch. Van den Berghe explained that he felt the vocation to publish in this language, because many patients repeatedly asked questions regarding the subject. Yet, he did not run an entirely Flemish practice. Although Van den Berghe, if needed, spoke Dutch with his patients, he held on to the medical tradition where all education had been in French of case-taking in French. Consequently, he translated the information that Dutch-speaking patients shared with him. Sometimes, he remained with the initial language patients used, as not all those visiting Van den Berghe spoke Dutch. Some letter-writers addressed him in French, not only inhabitants of France, which shows that French was, indeed, their first language.

Van den Berghe started quietly in the early years in Zwevegem but, in Ghent, he soon became a busy man. He treated 21,340 patients between 1869 and mid-1902, an average of 647 new patients per year and 54 per month. As Van den Berghe worked a maximum of six days a week, the number of new patients per day is reduced to between two and three. Yet, the questions remain whether the surge of people to his practice was extraordinary or whether Van den Berghe’s working days reflected those of his homoeopathic and ‘allopathic’ colleagues. Data on the practices of his Ghent allopathic and homoeopathic colleagues are not available. There are figures on Belgian

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4 The number of fifty-eight publications is based on Wim Van Praet, De receptie van de homoeopathie in België 1874-1914. Unpublished licentiate thesis (University of Ghent, 1986-1987), 96-97; Karel Veille, ‘De homoeopathie in België in de 19de eeuw’, Geschiedenis der Geneeskunde 2 (1994), 18-27, q.v. 25-26. However, Van Praet’s list of publications is incomplete and is lacking at least five titles, e.g. H. Richald, Les affections diarrhéiques des enfants et leur traitement homoeopathique (Brussels: Manceaux, 1878); Dr. Gailliard, Mercurisme et syphilis. Ma réponse à une critique de M. le professeur Crocq (Brussels: Mayolez, 1891); Dr. Lambrechts, Notice sur le dispensaire homoeopathique du Bureau de Bienfaisance d’Anvers (Antwerp: Dela Montagne, 1892); Dr. De Cooman, Rapport adressé aux dames de la Charité sur le 1er année de fonctionnement du dispensaire des sœurs de St. Vincent de Paul à Bruges (Brussels: L. Wintraecken & Cie, 1895); Un partisan de l’homoeopathie, Essai du synthèse du composé humain ou aphorismes justifiant l’opportunité d’établir des chaires d’homoeopathie dans les universités Belges (Brussels: Schepens, 1899). In the Netherlands several (translated) homoeopathic works in Dutch had been published by 1881, such as homoeopathic house doctors’ meant for lay-people. Cf. Marijke Gijswijkstra, ‘Homeopathie in de negentiende eeuw: het Nederlandse debat’, in: Willem de Blécourt, Willem Frijhoff and Marijke Gijswijkstra (eds.), Grenzen van genezing. Gezondheid, ziekte en genezen in Nederland, zestiende tot begin twintigste eeuw (Hilversum: Verloren, 1999), 274-310, q.v. 292-293, footnotes 53 and 54.

5 Dr. G. Van den Berghe, De Homoeopathie en hare tegenstrevers (Bruges: Edw. Gailliard, 1881), 5-6.

6 It would be interesting, therefore, to study the patient material left by Van den Berghe’s son, Ferdinand. He practised in Ghent between 1902 and WW II. Though incomplete, these casebooks have been preserved and constitute an interesting source for comparison over time.
dispensaries but they are difficult to interpret. These dispensaries were set up mainly to promote the spread of homoeopathy and aimed mostly at providing free treatment for the poor. The numbers were published by the institutes themselves and, probably, are biased. The figures show primarily the number of prescriptions issued per year and, thus, barely represent the precise number of patients visiting the dispensaries. Finally, most published figures concern 'public' dispensaries where several homoeopaths were available and not private dispensaries with only one homoeopath, as in the case of Van den Berghe.7

Therefore, to establish the relative size of Van den Berghe's practice, it is necessary to look outside Belgium's frontiers and principally to Germany, the cradle of homoeopathy. However, data are still rare, illustrating that research into homoeopathic practitioners' clientele is highly desirable. The clientele of Hahnemann has been studied in depth and at different periods. In 1801-1803, Hahnemann practised in the small rural town of Eilenburg where he treated 997 patients. In 1820, the year that is considered to be one of the busiest in his Leipzig practice, he treated nearly 407 new patients. Three hundred old and new clients were served in Köthen between February and August 1830.8 Georg Rapp, a German contemporary of Van den Berghe, treated a total of 618 new and old patients in Stuttgart in nearly two years.9 The data on Rapp's clientele are especially interesting because the years of his practice correspond with those of Van den Berghe. Rapp, in total, treated fewer patients per year than just the new patients of Van den Berghe. The German homoeopath offered free treatment in the earlier years, but it seems unlikely that he did in Stuttgart which might have resulted in fewer patients. Although comparisons are hardly

7 E.g. De Cooman, *Rapport adressée aux dames de la Charité*; Lambreghts, *Notice sur le dispensaire homoeopathique*. De Cooman, physician at the homoeopathic dispensary in Bruges, reported on the free treatment given between November 1894 and December 1895. In that year 1256(!) patients had been treated, of whom a quarter were children. A dispensary in Antwerp, that was only open for three hours a week, reported the number of 2313 consultations and 609 house calls in the year 1892.
9 Christa Maria Held, *Medizinisches Außenseiterum in der Frühzeit der naturwissenschaftlichen Medizin, dargestellt an Leben und Werk von Prof. Dr. Georg Rapp (1818-1886)*. Unpublished PhD-thesis (University of Frankfurt am Main, 1999), 82.
fair to make, for instance as Hahnemann enjoyed prominent protection in Köthen, it is still beyond doubt that Van den Berghe worked very hard. His taking on of 647 new patients on average per year was not equalled by any of the early nineteenth-century German homoeopaths.

2.2 The Social Features of the Entire Clientele over Time. Patients' Age, Gender and Residence: A Changing Composition?

A comparison has been made between three different casebooks to make some general statements about the personal features of the clientele and practice over the years. These casebooks contain a total of 2,552 patients who consulted Van den Berghe in his Ghent practice (Table 1) which enables comparisons over time to be made.

Table 1. Number of New Patients from Belgium and Abroad per Casebook Based on Ghent Practice

<table>
<thead>
<tr>
<th>Casebook</th>
<th>Total</th>
<th>Female</th>
<th>Male</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (1869)</td>
<td>329</td>
<td>186</td>
<td>143</td>
<td></td>
</tr>
<tr>
<td>8 (1881-1882)</td>
<td>1,120</td>
<td>628</td>
<td>482</td>
<td>10</td>
</tr>
<tr>
<td>17 (1898-1901)</td>
<td>1,103</td>
<td>639</td>
<td>454</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>2,552</td>
<td>1,453</td>
<td>1,079</td>
<td>20</td>
</tr>
</tbody>
</table>

The first casebook describes the first months of the Ghent practice. The eighth casebook concerns the practice twelve years later, the time of publication of Van den Berghe’s book. The seventeenth casebook covers the turn of the century, when orthodox medicine was in the ascendancy and homoeopathic medicine was declining.

The first casebook reveals the stories of 329 people who became patients in Ghent over a period of approximately eight and a half months. It was not until the end of this casebook that Van den Berghe switched from Zwevegem to Ghent and, thus, began to register patients consulting him in Ghent. Casebook Eight (1881-1882) contains 1,120 new patients over one and a half years; an average of 748 new patients a year. The last casebook (1898-1901) has 1,103 new patients over a period of 2.2 years, an average of nearly 501 per year.

Age, Gender and Residence of Patients from Home and Abroad

Graph 4 shows that Van den Berghe was consulted by sufferers of all ages, but more than half of the patients (1,408 or 58 per cent) were between 21 and 50 years old.\(^\text{10}\) No significant differences were found considering the age per

\(^{10}\) It was possible to establish the age of 95 per cent (or 2,434 out of 2,552) of Van den Berghe’s patients.
gender. Female patients only slightly dominated among children age ten or younger. If the same calculation is made for the patients not living in Ghent again no significant differences occurred; Ghent and non-Ghent patients were of comparable age.\(^\text{11}\)

![Graph 4. Numbers and Percentage of New Patients from Belgium and Abroad per Age Category (1869; 1881-1882; 1898-1901)](image)

The male and the female patients overall had an average age of nearly thirty-five at their first consultation, but the women were, in general, two years younger. This average fluctuated slightly over the years, with a maximum in 1869 (36.5) and a minimum of 33 in 1881-1882. In 1898-1901, the new male and female patients were, on average, 34.5. The variations in average distribution of age are because of the number of children treated. In 1869, he took care of less children in terms of percentage than in later periods.\(^\text{12}\) The age of Van den Berghe’s patients does not notably deviate from that of other homeopaths. As in other homoeopathic practices, people between 20 and 60 years of age made up the majority of the patient population, thereby reflecting the age-structure of the general population.\(^\text{13}\)

While the women were, on average, younger than the men, they also exceeded them numerically. Van den Berghe’s entire clientele showed a slight

\(^{11}\) Chapter 4 discusses the features of the Ghent patients, cf. Chapter 4, Tables 1. and 2.

\(^{12}\) In 1881-1882 the number of children treated was 194 against 154 in 1898-1901. On average, the children in the first period were one year younger than the ones in the latter. More so, those children were on average 9.3 years old; at least 2.5 years older than the children visiting Van den Berghe later on.

female predominance. Fifty-seven per cent of all patients were women. If children (16 and younger) are excluded the percentage of female patients increases to 62 per cent against 38 per cent for male patients. The gender ratio (the number of males per 100 females), however, declined over the years. In 1869 and 1881-1882 the gender ratio was the same at 77; but it had declined to 71 by the end of the century. Women were only in the minority in the age categories 61-70 and 71-80. However, the data of the non-Ghent patients reveals a rather different picture as the female majority is less: 54% women against 46% men. Exclusion of the children does not have any impact on the percentages. The exact ratio of male to female patients is shown in Table 2.

Table 2. Gender Ratio (= males per 100 females) of Van den Berghe’s New Clientele from Home and Abroad (1869; 1881-1882; 1898-1901)

<table>
<thead>
<tr>
<th>Casebook</th>
<th>Entire clientele</th>
<th>Non-Ghent clientele (including ‘foreigners’)</th>
<th>Ghent clientele</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (1869)</td>
<td>77</td>
<td>67</td>
<td>80</td>
</tr>
<tr>
<td>8 (1881-1882)</td>
<td>77</td>
<td>93</td>
<td>68</td>
</tr>
<tr>
<td>17 (1898-1901)</td>
<td>71</td>
<td>84</td>
<td>58</td>
</tr>
<tr>
<td>Average</td>
<td>75</td>
<td>81</td>
<td>69</td>
</tr>
</tbody>
</table>

Men were in the minority in both the entire clientele and in the Ghent clientele. The number of men in the non-Ghent clientele fluctuated and was, more so, the highest. Eventually, the Ghent clientele would consist of considerably fewer men than at the beginning of the Ghent practice, whereas the non-Ghent clientele would become composed of more men at the end than at the beginning. Thus, the Ghent clientele consisted of more women.

Nowadays, an over-representation of women as patients in homoeopathic practices is common as women tend to choose homoeopathic remedies more often than men. The homoeopathic practice of L. Vannier (1880-1963) in the first half of the twentieth century supports this view. The

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14 It was impossible to determine the gender of eighteen patients. They had sexually ambiguous names and their sex could not be guessed from the language used by Van den Berghe.

15 This will be discussed further in Chapter 4.

majority of his patients were women and their number increased over the years as in Van den Berghe's practice. However, female predominance in nineteenth-century homoeopathic clienteles is not obviously clear. At the beginning of the century (1801-1803), Hahnemann treated slightly more women than men in his rural practice in Eilenburg but, nearly thirty years later, the percentage of male and female patients was more or less the same. His practice in Paris revealed a slight male majority but, when his second wife Mélanie took over after his death, more women than men became patients. The Dutch clientele of Clemens von Bönninghausen, homoeopath at Münster (Germany), were also predominantly male. Rapp gave medical support to sixteen per cent more men than women. The statistical male over-representation within Von Bönninghausens' clientele has been explained by the distance to his practice. His patients had to travel to the German border to undergo treatment and travelling was especially problematic for women. The places of origin of Rapps' patients were not always clear, most of them resided probably in Stuttgart itself. In this case, the preponderance of men over women cannot be explained by the need to travel.

Thus, in terms of gender, Van den Berghe's clientele deviated from that of other earlier nineteenth-century homoeopaths. Later, the proportion between male and female patients shifted towards the picture left by Vannier's clientele. Van den Berghe's clientele may therefore be considered as representing a transitional period in terms of gender, in between the 'old' (more men) and the 'new' (more women) homoeopathic practice. Still, why did the number of male visitors decrease and that of women increase to this extent? Seventeenth-century medical behaviour of sufferers in England suggests that a female predominance was more overt in the cities because women could easily find work as domestic servants. This picture is confirmed by the situation in

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17 These findings are based on three years of Vannier's practice: 1928, 1941 and 1948. Leon Vannier was not a classic homoeopath. Besides practising homoeopathy, he had esoteric tendencies also and made use of other unorthodox methods such as iriscopy, chiroscopy, graphology and so on. See: Faure, 'La clientèle d'un homéopathe Parisien', in: Faure (ed.), Praticiens, patients et militants, 175-196.


20 Held, Medizinisches Außenseitertum, 83.

nineteenth-century Ghent where women, indeed, were attracted by the city because of the availability of work in industrial or domestic service.\textsuperscript{22}

\begin{figure}
\centering
\includegraphics[width=\textwidth]{map}
\caption{Number of Van den Berghe’s New Patients per Belgian Province (1869; 1881-1882; 1898-1901)}
\end{figure}

Analysis of the places of residence of Van den Berghe’s patients, based on Casebooks One, Eight and Seventeen, shows that at least ninety-five per cent of his patients lived in Belgium.\textsuperscript{23} The great majority of the 2,423 Belgian patients lived in East Flanders, the next was West Flanders (Figure 1). There were no patients from Belgian Luxembourg and only one patient from the province of Liège. Patients from the regions of Brabant, Hainault and Antwerp did travel but, only on a few occasions, to Ghent. An explanation for the small number of

\textsuperscript{22} See Chapter 3, 76-77. Women outnumbered men, especially in the Ghent clientele, and this preponderance of women in Van den Berghe’s clientele will be examined in depth in Chapter 4.

\textsuperscript{23} Of the 2,552 patients, 2,423 patients (or 95 per cent) for sure lived in Belgium. Of 34 patients the places of residence were illegible.
patients from these areas might be that many homoeopaths were practising in Brabant and Antwerp.

The 2,297 patients who were living in East Flanders lived primarily in its provincial capital, Ghent (1,456 or 63 per cent). If they did not live in Ghent they often came from the direct vicinity. Other East Flemish patients had to travel fairly long distances considering the size of this province and the relatively poor travelling conditions. The one patient from the province of Liège was a 26-year old married woman living in Liège itself, about 145 kilometres away from Ghent. She visited Van den Berghe only twice, once at the end of July 1882 and once in October of that same year. However, her sister was a Ghent citizen and the Liège patient probably consulted Van den Berghe when she was visiting her. In the meantime, she possibly had returned home to her husband. The difference in the number of men and women travelling from other provinces than East Flanders is minimal. It is unlikely, therefore, that women were discouraged from undertaking such journeys. However, few women travelled alone to Ghent. Most women made the journey with friends and relatives and not just with men. Nevertheless, some female patients stopped their treatment when their husbands were no longer able to accompany them.25

The Development of the Non-Ghent Belgian Clientele

More than half of Van den Berghe’s patients lived in Ghent and they will be analysed in depth later. Here, firstly, the presence of non-Ghent sufferers will be considered and, secondly, the foreign patients. Patients did not always consult Van den Berghe in person at his practice in Ghent. The number of preserved letters from patients living in Belgium is negligible, but Van den Berghe occasionally copied parts of letters in his private notebooks or casebooks. These letters make clear that, sometimes, discrepancies crept into the accuracy of his casebook notes; he did not always make a clear distinction between a written or personal consultation. Some people who had first started to consult Van den Berghe in writing did not receive their own file in the casebook until they appeared in person at the practice in Ghent. Jules Lemaire from Tournai, became a patient in 1898, but his first file notes date from 1900. He had corresponded previously with Van den Berghe and the physician

25 Apparently, Van den Berghe had made another appointment with Mrs. Irma Van Caemelbeke and her husband to consult him in Ghent. Mr. Van Caemelbeke wrote: ‘Je regrette de ne pouvoir vous rendre la visite que vous me demandez, surtout dans les circonstances actuelles: ...‘. Irma would consult Van den Berghe no more. Cf. Appendix 1. Second letter by Mr. Van Caemelbeke to Dr. Van den Berghe.
Patients from Everywhere

copied the accounts of his state of health in a small notebook. Lemaire called upon Van den Berghe’s help with hearing difficulties. He was deaf in his right ear and a Brussels orthodox physician had diagnosed ear congestion and stated that there was little hope of recovery.

Van den Berghe made notes of two letters from Lemaire, dated 29th October 1898 and 13th November. Firstly, these notes reveal that Lemaire had made use also of homoeopathic self-treatment. He did not feel any hesitancy in telling Van den Berghe and, hence, demonstrated his knowledge on which precise medication he had taken. Secondly, he more-or-less advised Van den Berghe on the proper treatment. He had developed a crust on his cheek after a homoeopathic prescription. This crust, according to Lemaire, was similar to another skin ailment he had suffered in his beard and he had taken successfully *hepar* and *graph*. The letter in which Lemaire gave this 'advice' revealed also that he generally felt better; that his appetite had improved considerably, but that, nevertheless, he still had haemorrhoids. However, regarding the main ailment, the deafness, Lemaire did not mention anything and Van den Berghe felt the need to make some additional remarks: 'I have to add that before taking sulphur he had had dizzy spells when he walked; this was also cured at the same time as the ringing in the ear and the deafness'.

Lemaire’s second letter makes clear that Van den Berghe, in contrast with Hahnemann’s approach, informed his patients of the contents of the prescriptions. Furthermore, as is evident from this letter, Van den Berghe replied to the consultation letters without delay. Lemaire wrote and Van den Berghe cited: ‘Following your letter of October 31th, I have from 1 to 8 [the 1st to the 8th of November] daily taken 2 granules of sulphur 40 (magistral) evenings and mornings and have the pleasure to tell you that I am very well [...]’.

The further people lived away from Ghent, the more likely it was that they consulted Van den Berghe via correspondence. Hypothetically, it would

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26 AVB, Symptomes médicamenteux observés sur mes malades et observations clinique, inv.no. 30, from 1871, 197 pages, 179-181.
27 AVB, inv. no. 30, 181. *Hepar* combines the effects of calcium and sulphur and works on blood, glands, skin, respiratory organs and the nerves. It functions particularly well during infections tending towards suppuration. *Graphite* is used usually by people with sensitive skins who suffer from moist encrusted rashes. ‘[...] il m’est venu au milieu de la joux une dartre d’un centimètre carré, de même nature que celles que j’ai dans la barbe. J’ai ds [dans, AH] le temps pris pour me guérrir de ces dartres hepar & graph."
28 AVB, inv. no. 30, 181. ‘Je doit ajouter qu’avant la prise de sulp il avait des vertiges qd il marchait; ceci aussi guéri en même temps que les bourdonnements & la ½ surdité.’
30 AVB, inv. no. 30, 181. ‘En suite de votre lettre du 31 Octobre j’ai pris du 1 au 8 courant 2 globules de sulp 40 (magistral) soir et matin et ai le plaisir de vous dire que je m’en suis très bien trouvé [...]’.
not be surprising also if the patients living far away from the practice consulted Van den Berghe less often than Ghent citizens. Some journeys took a whole day and the financial consequences could be substantial. Tables 3 and 4 give an insight into the number of new patients not living in Ghent and their average number of consultations.31

<table>
<thead>
<tr>
<th>Casebook</th>
<th>Total number of new patients</th>
<th>Non-Ghent clientele</th>
<th>Ghent clientele</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>?</td>
</tr>
<tr>
<td>1 (1869)</td>
<td>143</td>
<td>182</td>
<td>?</td>
</tr>
<tr>
<td>8 (1881-1882)</td>
<td>469</td>
<td>611</td>
<td>10</td>
</tr>
<tr>
<td>17 (1898-1901)</td>
<td>404</td>
<td>594</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>1,016</td>
<td>1,387</td>
<td>20</td>
</tr>
</tbody>
</table>

The longer Van den Berghe was in practice he treated more men and women from elsewhere (Table 3). The non-Ghent Belgian clientele grew steadily; the new Ghent clientele had diminished again at the turn of the century. Although, in earlier periods, the number of new Belgian patients not living in Ghent was smaller than that of Ghent patients, by 1898-1901 new non-Ghent patients were slightly in the majority (504 against 494) as there was a serious fall in the number of Ghent citizens becoming patients at the end of the century.

<table>
<thead>
<tr>
<th>Casebook</th>
<th>Total number of consultations men and women</th>
<th>Average number of consultations men</th>
<th>Average number of consultations women</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (1869)</td>
<td>420</td>
<td>6.3</td>
<td>6.3</td>
</tr>
<tr>
<td>8 (1881-1882)</td>
<td>2,957</td>
<td>6.6</td>
<td>7.9</td>
</tr>
<tr>
<td>17 (1898-1901)</td>
<td>3,975</td>
<td>7.9</td>
<td>7.4</td>
</tr>
<tr>
<td>Total</td>
<td>7,356</td>
<td>6.9</td>
<td>7.4</td>
</tr>
</tbody>
</table>

In absolute numbers, both the non-Ghent and Ghent clientele consisted of more women than men though the gender ratio differed within the two clienteles. The proportion between men and women in the non-Ghent clientele was 85 per cent (440 against 518), the gender ratio within the Ghent clientele was 66 per

31 The Ghent practice has again been taken as the basis.
Patients from Everywhere

cent (576 against 869). Thus, relatively more men from outside Ghent consulted Van den Berghe. Although the size of the non-Ghent Belgian clientele continued to expand, its consultation behaviour may have not. How often did these men and women consult or visit Van den Berghe? Table 4 gives an overview of the average number of consultations of male and female patients living outside Ghent.

It is clear that, on average, women received treatment, via correspondence or not, slightly less often than men; except at the turn of the century when the averages were the same. The average of the male patients in Casebook One is higher than the 6.3 in the table. Twenty male patients living outside Ghent visited Van den Berghe for the first time in 1869. Four of them had 154 consultations in total. Their exceptional consultation behaviour causes a non-representative high average and, therefore, has been omitted. Seventy-two year old Mr. Dewinter, from Baerle north of Antwerp, consulted Van den Berghe fifty-eight times during less than three years. Francois DeKeijzer (19), from Neukerke, was a patient between 1869 and 1873 and was treated on forty occasions. His sister Hortence (24) joined him, but would be less persistent. J.B. Piens (44) consulted Van den Berghe twenty-eight times in less than a year. The effort for him was negligible as he lived in Gentbrugge, a bordering municipality. Camille Vermaele was only twelve years old in September 1869 when he first consulted Van den Berghe about abdominal ache, vague pain in his arms and vomiting. The suffering was relieved within eight treatments and, in the 1870s, Camille returned twenty more times.32

The frequency of consulting Van den Berghe increased for both men and women from outside of Ghent and grew more rapidly for the men than for the women. These behavioural patterns do not deviate substantially from those of the Ghent patients. The average number of consultations of men and women hardly diverged for both Ghent and non-Ghent patients. The averages increased in the non-Ghent patient group, but not in the Ghent group where, conversely, averages fluctuated substantially. The behaviour of Ghent patients who started their treatment in 1881-1882 differed considerably, with the female sufferers consulting Van den Berghe, on average, nearly six times less often than the men. However, taking both the sexes together the divergence in the average number of consultations of people living in Ghent and of Belgian patients living elsewhere is not significant.

Thus, although an appreciable deviation in the average number of consultations could have been expected between Ghent and non-Ghent patients - based on the time-consuming and, for some, costly need to travel to Ghent - this was not the case. Therefore, non-Ghent patients may have been comparatively more motivated or dedicated to test Van den Berghe. To meet

with him in person they had to take more trouble. This suggests that patients from further away were potential 'believers', yet whether they believed in the physician or in his cure is hard to determine. However, it should also be noted that Van den Berghe, at times, was not very precise in taking notes. The notes only reveal specifically that physician and patient corresponded in two types of events. The first refers to notes about not having received letters. The second are notes directly quoting from letters of patients. The busier Van den Berghe's practice became, the less he made extensive notes and, possibly, the more incomplete or even inaccurate the files. Van den Berghe, for instance, noted sometimes that patients were residing in Ghent, whereas they were living elsewhere. Jean Herrry (33) and his daughter Caroline were registered as living at the Coupure in Ghent. The only people registered officially at this address were Jean's brother George and his family who had as their domicile Steenhuyze-Wijnhuyze. Thus, occasional incompleteness and inaccuracy of the files is incontestable. It would be possible, moreover, that Van den Berghe did not always note that he had given a written consultation. This might explain, therefore, why the expected difference in the average numbers of consultations of Belgian people from and outside of Ghent is not supported by evidence from the casebooks.

In one case it is exceedingly clear that the patient hardly visited Van den Berghe in Ghent. Madame Beke-Crombet (60) lived in Courtrai, fifty kilometres southwest of Ghent. All notes are quotations from letters she sent regularly to Ghent, sixteen in total. Van den Berghhe received the first on 18th December 1898 and these letter consultations lasted until August 1899. She wrote to him in French, but she also was proficient in Dutch. In her first letter she describes her suffering from severe pain in her left knee and leg. This condition had existed for a couple of months, but it had been accompanied by a heel complaint immediately prior to her first appeal. She wrote that other people had told her that, eventually, it would probably go away, but she had strong doubts. Madame Beke-Crombet was convinced that the heel condition was due to 'always the same thing, my legs are worn out'. Another disorder she suffered from, she herself called it another great misery, 'une autre grande misère', was that she could not retain her urine. Furthermore, she considered that it was very unpleasant that she was hardly able to walk, not only because of the pain and the breathing difficulties, but also because she was worried about her weight. '[..] j'ai besoin de marcher pour ne pas devenir plus corpulent [...]. Je voudrais bien maigrie un peu' (I need to walk to avoid becoming too corpulent and I would really like to lose some weight). She always referred in

33 Casebook 5 (1873-1876): pp. 1017, 1036. The information on his brother is based on data derived from: DSG, Straatnamenregister 1867-1880: Coupure 4-3, district 2.
34 Casebook 16 (1896-1898): p. 435. [...] c'est tjs. la même chose 'mijne beenen zijn afgesleten'.

62
subsequent letters to what she considered her main conditions: pain in knee and leg, breathing difficulties and incontinence. She developed a cough, ‘like that of an old man’, and she filled out. Madame Beke-Crombet was concerned mostly with her mental state in the last letter Van den Berghe copied (July 12th, 1899). The homeopathic medication she had taken had caused complete amnesia for a whole day. Then she developed weak sight, she became inconsolably sad and nervous and cried constantly. The earlier conditions were not discussed and this is the last known about her physical and mental state.

Madame Beke-Crombet, obviously, preferred to stay at home and to wait for Van den Berghe’s written advice. Other patients travelled to Ghent, but little is known about their stay in the city. Hahmann’s patients from a distance consulting him in Köthen, usually stayed a couple of days or weeks in town and, afterwards, would briefly continue the treatment. Thus, it can be assumed that people who were expected to return to Van den Berghe in the next couple of days normally spent some nights in Ghent. The aforementioned Jean Herry, for example, probably stayed with his brother. He brought his daughter to Van den Berghe on 28th January 1875 with an eruption over her whole body. At her second consultation on 6th February, Jean asked for advice for himself because he was suffering from an abdominal ailment. Van den Berghe saw them both, for the last time, ten days later; they were relieved from their ailments and would never return.

2.3 Renowned Across the Border: Patients from France and the Netherlands

Besides the large group of Belgian patients to whom Van den Berghe rendered his services in Ghent, sufferers living abroad also occasionally approached him. They came from far and wide, using time and energy to be cured. Who were these ‘foreigners’ and why did they make such an effort?

In July 1898, Emile Blaise, an office clerk in his thirties, decided to write a letter to Van den Berghe, to ask for help. He lived in Billy-Montigny, Pas de Calais, in the North-West of France. Blaise began his letter with a short and rather complimentary introduction to explain why he appealed to Van den Berghe:

To Monsieur Vandenberghe, homoeopathic physician

Monsieur

Having heard of numerous recoveries you have achieved with your homoeopathic treatment, I have the honour to ask you if you would

36 Casebook 5 (1873-1876): pp. 1017, 1036.
In Search of a Cure

be so kind as to consider whether you could do something about the type of illness that I will describe to you.37

This letter is one of the few sources that provide the personal voice of the patient and the reasons for consulting Van den Berghe; in this case the stories of successful treatment. Emile continued with the description of his suffering:

I am thirty-eight years old. At the age of 12, I contracted a severe illness of the eyes; I have been treated by various physicians who, all in all, have done me more harm than good, because they have given me several liquids that, as I recall, made me suffer horribly. It was only 8 or 10 months later and through milder remedies that the recovery was obtained. [...] since that moment my sight has never been well [...].38

Blaise had been suffering for many years and had tried various physicians who, eventually, had improved his condition but, at the same time, had created a new complaint. Thereupon, Emile consulted an oculist who advised him to wear glasses but they did not improve his sight: 'he could not give me any pair of glasses that were of use, because I did not see better with than without'.39

After Emile had asked repeatedly why the glasses did not improve his sight, the oculist diagnosed an untreatable disorder: infinitely small, hardly perceptible blotches in his eyes. Emile wrote that he had never had any other health problems, he had never taken medication and he considered himself to be in perfect health, santé parfaite. His appeal for Van den Berghe's services was completed by asking if he could improve the affection and if it would be possible to send him the treatment. Although he had complete confidence in Van den Berghe, this French-language patient was not completely positive that

37 Casebook 16 (1896-1898): p. 714. Letter by Mr. Emile Blaise to Gustave Van den Berghe, 23-07-1898. 'Entendre parler des nombreuses guérisons qui vous obtenez [sic.] par votre traitement par l'homéopathie, j'ai l'honneur, de vous demander, d'être assez bon, de voir si vous pouvez faire quelque chose dans le genre de maladie que je vais vous décrire.'

38 Ibidem. Letter Blaise to Van den Berghe, 23-07-1898: 'J'ai trente-huit ans. Dès l'âge de 12 ans je contractai une forte maladie des yeux; je fus traité par plusieurs médecins qui, en somme, me firent plus de mal que de bien, car, on me mit dans les yeux divers liquides qui je me souviens, me faisaient horridement souffrir et ce ne fut qui au bout de 8 ou 10 mois et par de moyens plus doux que la guérisons se fit. [...] depuis ce moment ma vue ne fait plus jamais bien nette [...].'

39 Ibidem. '[...] il ne peut m'en procurer aucunes qui puissent m'être utiles car je ne distinguiai pas mieux avec que sans'.
Patients from Everywhere

Van den Berghe would accede to his request. He carefully expressed the hope, in the last paragraph, that the homoeopath would favourably answer the plea.40

The casebook reveals that Van den Berghe did answer on July 26th, Emile’s letter was dated July 23th. Van den Berghe noted that he prescribed aur. mur.41 However, this is the only note made and the only consultation mentioned. Thus, it is known that Emile Blaise never travelled to Ghent to consult Van den Berghe and that their contact only took place via mail. However, the casebook does not make this clear distinction between a personal or a written consultation, a problem discussed previously.

The writing of letters reflected the lack of medical personnel during the eighteenth century, particularly in the countryside. However, new medical ideas at the beginning of the nineteenth century, focusing on pathology and anatomy, diminished the suitability of written consultations for the healing process. Moreover, the accessibility and proximity of medical care expanded with the growth of the medical profession. Yet, practitioners of unorthodox medicine were far less numerous and, for patients who preferred such therapies, written consultations were indispensable.42 Letters written to doctors are a precious source in writing patients’ history as they give direct insight into the perception and experience of illness, whether written by the sufferer or someone close to the sufferer. Hahnemann, for instance, gave written medical advice, would send medication to the patients and also required patients to keep a diary of symptoms and alterations in sensations.43 Unfortunately, this type of source has not always survived. Van den Berghe also gave letter consultations yet, in his case, only fifteen letters, of which six were sent from France, have been preserved. The remaining nine authors lived in Belgium and two of them even resided in Ghent or its vicinity. All but one of the six letters from France were written in French. It seems that Van den Berghe was

40 Letter Blaise to Van den Berghe, 23-07-1898: ‘Dans l’espoir que vous accueillerez favorablement ma demande ...’.
41 Aurum muriaticum is a gold compound, and is used mainly for ailments of glands, bones and genitals. It is applied also with regard to eye-disorders, such as an inflammation of the eye-lids, keratitis (inflammation of the cornea) and photophobia. See: J. Voorhoeve, Homoeopathie in de praktijk. Medisch handboek (Zwolle: La Rivière & Voorhoeve BV; 13th ed., 1972), 74-75.
42 However, it is known that renowned psychiatrists, such as Krafft-Ebing, were consulted also in writing in the nineteenth century. Cf. Oosterhuis, Stepchildren of Nature.
extraordinarily aware that letters could easily be lost or destroyed. He made it a habit to copy or quote from the letters and distinguished these pieces with remarks such as 'style du malade' (style of the patient). What Van den Berghe meant was that he had copied directly from a patient's letter. However, the information and formulations in the letters hardly diverge in content or style from Van den Berghe's own notations, as the information in the patients' files are recorded directly from the sufferers' own words. In this sense, the letters are as interesting as the casebooks regarding individual concepts of the body, illness and suffering.

These distinguishing remarks are quite often present relating to 'foreign' patients and corroborate the proposition that many patients made use of Van den Berghe's written advice. Two per cent, 468 adults and children, of his entire patient population lived in countries other than Belgium. Most of these 'foreign' patients (290) came from France, 166 people lived in the Netherlands and twelve people lived in other countries; three from Germany; two from Ireland, Austria and Great Britain; Poland, Turkey and Switzerland each one patient. The label 'foreign' should be used with caution, as it is uncertain whether people living outside Belgium were, indeed, of different nationality. The one patient from France, writing in Dutch, indicates that Belgians for one reason or another occasionally moved abroad. This male patient, Emile Bollaert (33), lived in Roubaix and consulted Van den Berghe regarding an ailment of his sexual organs and abdominal feebleness. Emile had Belgian nationality and only had his domicile in France.

Graph 5. The Total Number of Patients Living in France, the Netherlands and other Foreign Countries within Van den Berghe's Clientele, 1865-1902

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44 This number, thus, includes foreign patients consulting Van den Berghe when he was practising still in Zwevegem. All together six patients living in France requested his treatment between 1865 and 1868.

45 Casebook 6 (1876-1879): p. 1226. The letter he wrote was found in Casebook 2 (1869-1870): p. 10.
Graph 5 shows the total number of patients living in countries other than Belgium, registered in all eighteen casebooks (numbers 1-17). The number of patients living in France nearly always exceeded the number of people from the Netherlands, except for Casebooks Five and Six. These two books cover the period June 1873 to August 1879. The number of ‘French’ and of ‘Dutch’ patients fluctuated, but this was most marked with those from France. The enormous peak of sixty-eight patients from France in Casebook Sixteen (1896-1898), to a large extent, is caused by people coming from the Department of the Pas de Calais.

The places of residence of patients from France and from the Netherlands demonstrate that they were coming principally from specific regions in these countries. Patients residing in France lived predominantly in the Pas de Calais; patients from the Netherlands, for the most part, came from the province of Zeeland. Both regions directly bordered Belgium, but the frontier of Zeeland was a little closer to Ghent than that of Pas de Calais. Terneuzen, the town from where most Zeeland patients came, was about 42 kilometres away from Ghent; the distance between Roubaix, the place of residence of most ‘French’ patients, and Ghent was about 55 kilometres (Figure 2).

Occasionally, ‘foreign’ patients came from other parts of France and the Netherlands. The myopic Mr. Guichard lived near Bordeaux, consulting Van den Berghe on only one occasion. He took the opportunity to obtain medical
In Search of a Cure

advice for the disorder he had suffered from for sixteen years. Unfortunately, why he was in Ghent is not known. Occasionally, a patient from Paris consulted Van den Berghe and, once in a while, Dutch patients lived in other provinces such as Limburg and Zuid-Holland.

It is hard to believe that Dutch patients, unlike French patients, rarely consulted Van den Berghe in writing. Yet, it does seem that Dutch patients were more inclined to visit the practice in Ghent than to send a letter. References to received or missing letters and quotations were almost solely in the files of patients from France. In Casebook Eight, however, none of the files of the fifteen patients from abroad contain remarks concerning correspondence. No copies were made, neither were there any remarks regarding the ‘style of the patient’. As Van den Berghe was extremely busy, lack of time might have had a great impact on his case notes’ taking and precision. However, there are no notes concerning correspondence in Casebook Fifteen (1894-1896) and, during these years, the practice was much quieter in terms of new patients. Yet, Casebook Sixteen, with its 68 patients from France, suddenly contains many quotations.

Questions to be considered include, for example, the following: did the ‘foreign’ patients differ from the Belgian ones in terms of age, gender and consultation behaviour, why would people decide to make the effort of consulting a physician practising so far away, and would Van den Berghe’s homeopathic background have influenced that decision? An analysis has been made of the social composition of the Zeeland clientele, their consultation behaviour and the complaints for which they consulted Van den Berghe. Furthermore, a highly interesting attempt to explore possible ways of mutual influence between these patients has disentangled the family relations of various Zeeland visitors. Several patients had family living in Ghent, or they originated from Belgium. Consequently, some of these patients probably had become acquainted with Van den Berghe through Ghent relatives. The Dutch Madame DeDeckere-DeKorte, from Hoofdplaat (Zeeland), must have been advised by her daughter Marie to consult Van den Berghe. Marie had been born in Hoofdplaat but lived in Ghent from 1877. Marie paid her first visit to Van den Berghe in July 1886. When her mother came to stay with her, suffering from burning sensations in her hands and coughing accompanied by expectoration, she was brought along during her daughter’s final consultation.

Patients from Everywhere

with Van den Berghe. One patient in the Ghent sample originally came from Houtenisse, also in Zeeland.

Ghent always had attracted people from Zeeland during the nineteenth century. Its regional function as a central market place had led to the development of a strong infrastructure, an extensive road and water system that reached beyond the Dutch border. In 1827, the Ghent-Terneuzen canal connected the two cities and from 1869 there was a direct rail connection. Although people from Zeeland could use various means of transportation, those living in small villages probably had to walk or take a carriage to get to the nearest connection and the subsequent journey by train, steam tram or boat could still take a long time. The connection between Terneuzen and Ghent took about three hours by train. People from the southern part of Zeeland, Zeeuws-Vlaanderen, were particularly oriented towards Flanders and Ghent. It was the most natural thing to travel to Ghent for all sorts of reasons. The Dutch government hardly invested in the area during the entire nineteenth century and most of the economic or infrastructure developments were financed by Belgian capital. Catholic education was not available in Zeeuws-Vlaanderen and many children living near the border were sent to Flemish schools. On the other hand, Belgians had also settled in Zeeuws-Vlaanderen as large landowners from the 1830s. Therefore, it is possible that some of the Dutch patients consulting Van den Berghe were of Belgian origin.

The supply of orthodox, licensed practitioners in Zeeland was rather limited in the 1890s. Although the number of physicians increased, they were present only in the cities. Most of Van den Berghe’s patients lived in areas where their availability was inadequate and people depended primarily on the services of the local midwife. Therefore, sufferers living in the border region of Zeeuw-Vlaanderen probably would have crossed the frontier to consult a physician. Moreover, it seems that competition from Belgian doctors complicated the possibilities of Dutch practitioners of starting a practice. Belgian physicians would charge lower fees for Dutch patients and, apparently, held office hours in Sas van Gent, in Zeeuws-Vlaanderen. Finally, one Dutch

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49 Casebook 11 (1885-1887): p. 401 A+B. Marie’s final consultation was on August 5th, 1886 and her mother also would never call again upon Van den Berghe’s services.


52 Knotter, De aantrekkingskracht van een homeopaat, 102-107. Interviews held by Knotter revealed this orientation of Zeeuws-Vlaanderen people on Ghent.

In Search of a Cure

contemporary stated that the mentality of people living in the south of Zeeland had many similarities with that of the Flemish. A large part of the Catholic population preferred a Catholic physician in Flanders. Ill people living in Zeeland, hence, had only limited healing options available, particularly those who wanted homoeopathic treatment. Homoeopathic, licensed practitioners do not seem to have been present in Zeeland until 1912. Unlicensed homoeopaths might have been, as evidenced by a trial against a man from Goes who had supplied people in his surroundings with homoeopathic medicines.\(^{54}\)

Would Van den Berghe's Zeeland patients have preferred his homoeopathic treatment or were they just charmed by the successful stories of their neighbours, family, friends or colleagues? The story of a Dutch boy inflicted with an ailment of the hip joint may demonstrate a lack of preference for homoeopathy. His parents brought him to Ghent to visit the hospital and he finally became Van den Berghe's patient as the result of an encounter with a complete stranger. Stories concerning the therapeutic past of other Dutch patients reveal that many of them had tried orthodox therapies and remedies. At least two Zeeland patients had used homoeopathy previously, either by consulting another homoeopath, or by self-medication.\(^{55}\)

The corroboration that Zeeland patients had relatives in Ghent and, thus, knew about Van den Berghe, could be true also for patients living in France. If language is taken as an indication for nationality it is probable that some of the patients living in France were Belgian or even originating from Ghent. Most patients from France resided in or near Roubaix and Flemish sounding names such as Vandecasteele, Bogaert, Dewindt and Decock are quite often present. As Zeeland inhabitants always had been drawn to Ghent, the North of France also had had its appeal for Belgian citizens. In times of economic decline or political unrest many people, not only men, but entire families, left everything behind to emigrate temporarily. Roubaix formed one of the main objectives and, therefore, would be known also as the 'Belgian colony'.\(^{56}\)

Between 1861 and 1865 Ghent was paralysed by 'la famine de cotton', the cotton famine. Emigration to the North of France boomed and was even organised partially by Ghent cotton barons. Two thousand people left the city, many of whom moved to Armentières which, like other French textile centres, suffered less from 'the famine' as it did not depend exclusively on the cotton

\(^{54}\) Knotter, De aantrekkingskracht van een homeopaat, 25-31.

\(^{55}\) Casebook 17 (1898-1901): p. 369: Madame Meertens (age 40) who lived in Terneuzen, had consulted previously a homoeopath in Brussels. As Ghent was nearer, this might have been her reason to switch physicians. Casebook 17 (1898-1901): p. 909: Jacobus Demeester. (age 37) from Terneuzen also told Van den Berghe he had made use of homoeopathic self-treatment.

Patients from Everywhere

industry. Armentières was pre-eminently a linen city; Roubaix’ textile industry consisted mostly of cotton fabrics. Occasionally, advertisements originating from France appealed for Ghent workers. In 1869, for example, a factory in Roubaix asked for weavers. Approximately fifty Ghent labourers left for Paris, in August of the same year, to load and unload coal. Their daily wage of four francs was considerably higher than the average wage of a worker staying in Ghent. Moreover, the social climate in Ghent, with its many strikes and work stoppages, occasionally forced labourers who were still willing to work to earn a living elsewhere. In 1871, for instance, over fifty strikes in Ghent forced 516 textile workers to flee to Northern France. Seasonal work in France was very popular amongst the Flemish population as it was usually agricultural work which did not require any particular skills. The Belgian agricultural crisis of the mid-nineteenth century led to a permanent migration of people who wanted to escape food shortages, over-population and the loss of cottage industry. The migrant workers predominantly were from East and West Flanders and until World War One c.40,000 people per year left for months to all departments north of Paris. The Flemish especially were popular workers because they did not complain about the tough working and living conditions, were satisfied with the abstemious meals and worked the hardest. They were paid by the piece, which made it important to work as much as possible in the shortest possible time. The higher level of wages in France was an important factor in deciding to migrate temporarily or permanently.

Whether or not the patients travelling from France were French nationals, their reasons for wanting to journey to Ghent still have to be explored. Some will just have been advised by others, such as relatives and acquaintances living in Ghent or fellow villagers, to attempt to consult Van den Berghe. The influence of villagers is fairly apparent in the casebooks, although it is not confirmed by solid written testimonies. The sixty-eight people from France consulting him for the first time between December 1896 and November 1898 (Casebook Sixteen) were living mostly in the same villages or towns. In some cases, such as that of Emile Blaise, dissatisfaction with other orthodox

healing methods led to the change of therapy and made people want to try an 'alternative'. Homoeopathy, therefore, was both a last resort and a conscious attempt for some to use a different healing method. Yet, if people wanted to try 'something else', they could have found it closer by. Unlike the province of Zeeland, the north of France did have its own homoeopathic practitioners, located principally in the cities, where it would have been easier to get to than to consult Van den Berghe.61

The 'foreign' clientele of Van den Berghe displays some variance with the Belgian clientele, residing in Ghent or elsewhere. Few 'French' children visited him, and, when they did, were accompanied often by an adult also in need of medical care. The male and female patients living in France and the Netherlands were, in general, not of different ages than the Belgian patients. Zeeland men and women were, respectively, on average 35 and 34 years old.62 However, 'French' female patients were, on average, at least six years older than their fellow countrymen.63 Amongst the 'Dutch' patients of Van den Berghe a slight male predominance prevailed where, of the adult Zeeland patients, 53 per cent was male; of the twenty-three children, fourteen were boys.64

Table 5. The Average Number of Consultations per 'Residence/Country', Based on Casebooks 1, 8 and 17 (1869; 1881-1882; 1898-1901)

<table>
<thead>
<tr>
<th>Average number of consultations of:</th>
<th>Male and female patients</th>
<th>Male patients</th>
<th>Female patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghent</td>
<td>8.0</td>
<td>8.2</td>
<td>7.9</td>
</tr>
<tr>
<td>Outside Ghent, but Belgium</td>
<td>8.2</td>
<td>9.5</td>
<td>6.9</td>
</tr>
<tr>
<td>Zeeland (the Netherlands)65</td>
<td>6.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>5.7</td>
<td>4.3</td>
<td>7.2</td>
</tr>
</tbody>
</table>

62 Knotter, De aantrekkingskracht van een homeopaat, 44-46.
63 This conclusion is based on an analysis of the ages of French citizens available in Casebooks 1, 8 and 17. Of 62 patients (21 per cent of the total number of 290 'French' patients) ages were noted; men were on average 30 and women were nearly 37 years old.
64 Knotter, De aantrekkingskracht van een homeopaat, 43.
65 Unfortunately Knotter did not study separately the number of consultations per gender. Casebooks 1, 8 and 17 reveal the data of only thirty-one patients (16 men and 15 women) who lived in Zeeland and their average number of consultations leaves behind a rather distorted picture: male patients 20 consultations, female patients 6 consultations. Knotter, De aantrekkingskracht van een homeopaat, 59-62.
Finally, the men and women living beyond the Belgian border consulted Van den Berghe less often than patients coming from Ghent and elsewhere in Belgium (Table 5). The Zeeland patients, on average, made use of Van den Berghe's skills six times and their number of consultations ranged from one to forty-four. Unfortunately, an analysis of possible differences in consultation behaviour between 'Dutch' men and women is not available. Patients residing in France, on average, consulted Van den Berghe on 5.7 occasions, but it is notable that female patients from France, on average, were more often in contact with him.66

2.4 Recapitulation

Van den Berghe must have been a busy man who worked long hours to meet the needs of his patients from Belgium, France and the Netherlands. His homoeopathic practice welcomed many new patients each year, even when he had established his name and started to develop a regular clientele. Although conclusive statistics are lacking on the average number of patients he treated every day, his large-hearted acceptance of new patients exceeded that of other early nineteenth-century homoeopathic physicians from Belgium and abroad.

This chapter on the overall clientele of Van den Berghe demonstrated the rather ordinary composition, such as age, of his patient population in comparison with that of other homoeopathic physicians. Notwithstanding, the Ghent practice seems unique in the numbers of women that were treated. Although, nowadays, it is common for homoeopaths to treat far more women than men, this was not the case in nineteenth-century homoeopathic practices. The female preponderance in Van den Berghe’s practice grew remarkably and the sex ratio of the entire clientele, the number of males per 100 females, changed from 77 in 1869 to 71 at the turn of the century. Van den Berghe’s patients not only lived in Belgium, but they also came from abroad. The majority, however, resided in Belgium and they lived mostly in the province and the city in which he practised.

A separate analysis of patients who did not live in Ghent but elsewhere in Belgium showed that the ‘so-called’ non-Ghent clientele grew and consisted also of more women than men. Yet, these women, on average, had fewer consultations than the men; opposite to the consultation pattern of the Ghent clientele. Non-Ghent women would never keep up with the consultation behaviour of their Ghent ‘sisters’, whereas non-Ghent men beat the male patients who lived in Ghent. Patients from further away, presumably, were more inclined to consultations in writing and, hypothetically, they visited, 66 This is based on the consultation data of 72 patients living in France (36 men and 36 women).
therefore, the practice in Ghent less often. Although the difference between written and personal consultations, at times, is difficult to detect, the consultation behaviour of patients living outside of Ghent has been undertaken. The number of consultations of Ghent patients, remarkably, was not as divergent from that of ‘outside’ patients as might have been expected. They only visited Van den Berghe slightly more often.

Two per cent of Van den Berghe’s complete clientele lived in countries other than Belgium. Whether these ‘foreigners’ had a non-Belgian nationality is unknown. Traditionally, many Belgians, temporarily or permanently, left their native country to earn a living elsewhere. Ghent inhabitants, especially in times of economic crisis, left their city to work in the textile cities of the North of France. Therefore, it is possible that a number of ‘foreign’ patients had Belgian nationality. The ‘foreign’ clientele deviated from Van den Berghe’s general clientele in the sense that only a few children from abroad were treated and that, especially among the Dutch patients, the men dominated. Moreover, patients from abroad, on average, asked for medical support less often than patients in Belgium, with the lowest average for the people living in France.

Now that the composition of Van den Berghe’s entire clientele has been reviewed the medical ‘adventures’ and experiences of the Ghent sufferers within his patient population will be discussed. The following chapters will be dedicated solely to Ghent, its citizens and sufferers and systematically work towards the personal accounts of those appealing for treatment by Van den Berghe. Yet perceiving, deciding, applying and complying with medical matters are human acts shaped and influenced by the environment in which the ailing person has roots. The structure of the following chapters serves to explore the development of lay knowledge and experiences regarding health, illness, healing and the body, starting with society at large and concluding with the personal stories of suffering, agony and, even, fear.

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67 Archival research regarding these ‘foreign’ patients has not been carried out.
Health, Illness and Healing in the Ghent Community

The undernourished population is living in miserable circumstances and is carrying around atrocious conditions. Spoiled lungs, ulcerated and inflamed eyes, deformities resulting from protracted and partial labour, gastric walls drunk to shreds, all are the order of the day. Tens of thousands fall victim to epidemics. Consumption is a national disease!

The average nineteenth-century Ghent city-dweller had an intricate life, literally and figuratively, struggling to survive. The state of public health left a lot to be desired as men, women and children inhabited an insalubrious environment in which life could not be taken for granted and where disease could overcome anyone. These circumstances shaped people’s expectations and experiences and affected the medical choices they made in case of illness. The search for the actions and motivations of the ill requires consequently considering illness, health and healing as social constructions. What people do (or desist from) is prompted by the meanings they attach to their suffering and the perceptions of the illness by themselves and others. Health-care seeking behaviour (therapeutic decisions) and lay medical knowledge relate, therefore, to social, cultural and economic factors and to the availability of certain treatments and practitioners. A (re)construction of a valid picture of people’s ideas, attitudes and activities regarding health-related issues involves the Ghent sufferers being approached from two perspectives. The broad perspective of the community or culture to which they belonged (society at large), including the options for healing available to them, and from the micro-perspective of their individual social circumstances and personal experiences with health, illness and healing.

This chapter concentrates on the general circumstances of Van den Berghe’s Ghent patients during the second half of the nineteenth century. The socio-economic conditions prevailing in the city are explored, as are the options available for healing ill citizens. The therapeutic pasts of his patients are discussed to assess which actual choices people had and made during earlier instances of illness. The individual circumstances of a sample of Van den Berghe’s patients, their ailments and their personal experiences as users of homoeopathy will be explored in later chapters.

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2 See the Introduction.
3.1 The 'Manchester of the Continent': Ghent in the Nineteenth Century

The inhabitants of Ghent participated in an urban and advanced industrial society. Many people earned a living by working long hours which, often, compromised health in one of the cotton or linen factories. The industrial character of the town held a strong appeal for those looking for work and the population grew steadily during the nineteenth century. In 1815 Ghent had 62,738 citizens, in 1850 106,704 and, at the end of the century, more than 160,000. This population growth in Ghent, however, was not as pronounced as in other Belgian cities as the textile industry offered only limited employment expansion after 1850.

Ghent’s Population

The population structure of Ghent manifested some characteristics which were strongly influenced by its specific social-economic situation. Fifteen per cent of the population belonged to the upper and higher middle classes, thirty-four per cent to the lower middle class and fifty-one per cent to the working class in the mid-nineteenth century. Furthermore, the city housed a preponderance (seventy-five per cent) of people between twenty and sixty in the first half of the nineteenth century. Only one fifth of the population was twenty or younger and less than one in ten citizens was above the age of sixty. A substantial proportion of these elderly were migrants, attesting that the native Ghent people died earlier because of the harsh living and working conditions and epidemics. The second half of the century showed a similar age pattern. Nearly two thirds of the population were between 15 and 65 years of age and the elderly (over sixty-five) constituted almost six-and-a-half per cent. The average age of Ghent citizens was twenty-five, the women being two years older on average than the men.

Ghent’s population was not only young, it exhibited also a specific gender composition: more women than men inhabited the city. This female surplus was strongly connected with the city’s industrial character and had been present in the first half of the nineteenth century. The textile industry appealed to large numbers of female workers and nowhere in Belgium was the

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share of women in the work-force as large as in Ghent. Mostly young unmarried women worked in factories as wedlock and additions to the family usually constrained the ability of women to work. Domestic service, besides the factories, also made it easier for women to find work in the city. Ghent domestic staff mainly consisted of women, and having servants was very common; the average bourgeois person had at least one servant or domestic at his service. Many women spent long hours working outdoors and, even if they were housewives, their customary task of primary caretakers of all household issues, the near-constant pregnancies and births must have had a great impact on their health.

The men, women and children who lived in Ghent often did not know how to read or write. Illiteracy was particularly common in the first half of the nineteenth century, but around 1860 still forty per cent of the women and fourteen per cent of the men could not write. Thereafter, literacy increased, partly as a result of a growing number of children who attended school. Literacy was related to people's economic and social backgrounds. Illiteracy was most common among factory workers, but an exception among intellectuals and manufacturers. Servants usually knew how to write, especially the males. Illiterate people, not surprisingly, lived mostly in the traditional labourers' districts. The ability to write was related to social environment and partially determined the choice of partner. Anyone born into a family of illiterates would probably remain illiterate for the rest of their life.

Ghent citizens married rather late until the last quarter of the nineteenth century. The surplus of women already meant a considerable number of single females and widows, and the average matrimonial age was high. The main barrier to marriage was the economic situation which impacted particularly on working class people. The improvement in living standards enabled more frequent and earlier marriage. The choice of a suitor, besides love, was still determined primarily by social status. Nobility usually married nobility and working class people, as a rule, found marriage candidates amongst their own ranks. The average length of a marriage was fifteen to twenty years. One in five marriages ended because of high mortality within five years. The existence

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9 This was a general tendency all over Belgium, in sharp contrast with France and England, where the age of marriage was below twenty-five. Cf. Eric Vanhaute, 'Leven, wonen en werken in onzekere tijden. Patronen van bevolking en arbeid in België in de 'lange negentiende eeuw', BMGN 118 (2003), 153-178, q.v. 166.
of a large group of marriageable ‘survivors’ was often pointed out as the cause of growing immorality as indicated by the numbers of pre-marital births and of abandoned or illegitimate children.10

Thirty to forty per cent of all brides in nineteenth-century Flanders were pregnant and five per cent of new-borns were illegitimate children.11 As the means to avoid pregnancy did not go beyond coitus interruptus and abstinence, it is likely that contraception hardly contributed to this rather low percentage of illegitimates. Occasionally, but only by people of the higher classes, condoms were used.12 Abortion probably kept down the number of children born outside and inside wedlock. Although definite numbers can no longer be retrieved, the numerous advertisements for abortifacients and midwife-abortionists, and the estimates of contemporaries, are strong indications that the practice of abortion was widespread.13 The custom of legitimising children through marriage increased during the century. Yet, the family density (including parents) diminished from 4.5-5 to 4-4.5. Initially, the difficulties of getting married forced children to leave the parental house at a later age or, even, to eternal celibacy. The improved economic situation enhanced the matrimonial market and, thus, led, ultimately, to smaller families.14 A tendency supported also by a changing housing situation and a decline in the number of children per married couple.

The average working-class family had to combat under-nourishment and even starvation, especially during the first half of the century. Cotton workers’ families had meagre diets. Bourgeois families on average spent one quarter of their incomes on food and drink. In 1861, the average male cotton worker earned fourteen francs a week, a female worker earned approximately nine-and-a-half francs a week and children below the age of twelve between four and eight francs for one week’s work. In 1880, a cotton worker would start earning eighteen francs and his female colleague eleven francs a week.15 After mid-century the shortage of food ended, crop failure disappeared and Belgium started to import wheat. People no longer had to face hunger but food quality fell. However, this lack of quality would eventually disappear and, at the end

10 Vanhaute, ‘Leven, wonen en werken’, 172.
11 Ibidem, 170-171.
15 Scholliers, Arm en rijk aan tafel, 24, 80; Marc Roose and Dick De Vuijst, De kranten van Gent, 1860-1914, deel 1: Gent barst uit haar vestingen (Ghent: Fascimile, 1996), 8.
of the century, the consumption of animal calories also became common among working class people.16

Ghent’s Development

Ghent shook off its provincial character during the first half of the nineteenth century and developed into a ‘modern’ city.17 Initially, Belgian independence from Dutch rule in 1831 had a deleterious effect on the economy but increasing mechanisation halted the decline. The economic development determined the townscape: almost all the first cotton factories were built in monasteries and the acute shortage of dwellings was obviated by the creation of quarter and cloister houses. At the same time, works significantly affecting the infrastructure were carried out. Streets were broadened, bridges were built and, more importantly, the railway network was constructed. In 1838 Ghent had become a crossroad of railways.18 Culturally the city blossomed as the (State) University of Ghent was established in 1816, followed by the Palace of Justice, the casino and the opera. Ghent, by the 1850s, had been transformed into a modern city but, at the same time, the ‘city wall’ revealed its first cracks. Although the town had improved economically and culturally, few people profited socially and medically.

The citizens of Ghent had been tested already during the 1830s. The cholera epidemic of 1832 was a tremendous ordeal and Ghent was the hardest stricken town in Belgium as one in sixty-nine inhabitants died of the disease. Population density and increasing industrialisation were the culprits.19 The working population, besides worrying about health, also had to deal with its unequal social position. The new constitution of independent Belgium changed little in terms of social relations. Workers’ activities became extremely regulated, prohibiting them from forming unions and every worker had to carry a booklet containing their working history. The same constitution recognised the statutory equality of all women, irrespective of class. Although this new law ended the legal differences between women, they still had the same subordinate legal position as minors. Moreover, involvement in politics

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18 Coppejans-Desmedt, ‘Gent in de eerste helft van de negentiende eeuw’, 598.
was reserved for a limited group of people. In 1847 only 46,630 Belgian men met the property criteria to vote.20

The predominant cotton industry made Ghent a ‘thoroughly proletarian city with a large group of wage-depending labourers and a small group of rich employers’.21 Many factories were constructed in the city centre until 1860 but with the abolition of the patent law, industrialists started to build outside the city walls. In the north and north-west, factories became surrounded by workers’ districts of large numbers of small houses, many of them built in the enclosed gardens and courts of existing houses (beluiken). In addition to the impressive population growth, the cultivated surface area of Ghent expanded from 280 ha in 1860 to 550 ha in 1900.22 The living conditions in the newly developed workers’ districts were deplorable and disease and misery bred easily. The beluiken were often characterised as the second city in the city with, in front, ‘fresh air, space and a dose of health, at the other side, everything that could poison and shorten life, an accumulation of houses and families, the darkness, the weakness and the contamination’.23 The contrast with the lifestyle of the industrialists and the upper classes, with their luxurious residences in their own fashionable districts, was enormous.

What must it have been like to live in the workers’ quarters? The sewer-system was terrible and running water was lacking. Ten to twenty houses had to share one water pump and two toilets. The houses had thin walls, no windows, and sleeping and cooking conditions were primitive. In 1900 about one fifth of the Ghent population still lived in these circumstances.24 The sheer lack of privacy in the small working-class dwellings made the contact with corporality and sexuality rather informal. Sleeping, bathing and making love all happened in no more than one or two rooms.25 The working-class districts were considered as pools of destruction and sources of contamination, disease, promiscuity and alcoholism. As people were forced to use wastewater for cooking, epidemics such as cholera emerged frequently and resulted inevitably in many deaths.

20 Penn Hilden, Women, Work and Politics, 24-26; Roose and De Vuijst, De kranten van Gent, deel 1, 9.
21 Scholliers, Wages, Manufacturers and Workers, 17.
22 Roose and De Vuijst, De kranten van Gent, deel 1, 2-3.
23 Ign. De Rycke, J. Van Renterghem and P. De Buck, De beluiken binnen de stad Gent. Verslag over het onderzoek, gedaan ten jare 1904 (St. Amandsberg; Snoeck-Cools, 1904), 15-16. For the original Dutch text, see Appendix 2.
The housing, terrible working conditions and, importantly, regular starvation made the working-class population vulnerable and both adults and children died prematurely. The higher social classes, mainly because of their better living conditions, had a longer life expectancy.\textsuperscript{26} The national expectancy of life was thirty-eight in the mid-nineteenth century, forty-five in 1890 and fifty-one in 1910. These averages, for Ghent, were thirty-two in 1846, thirty-six in 1890 and forty-six in 1910. At the end of the nineteenth century the conditions of life among the working class generally improved, but death still showed a ‘social gap’ which, in comparison with the national average, resulted in Ghent’s exceptionally high infant and child mortality. One in four children died in the first year of their lives because of the inadequate care of babies and bad feeding habits. A poor diet could be avoided easily by breast-feeding but this easy and cheap practice was hardly carried out by women, irrespective of their social class. Breast-feeding was propagated fiercely, though the quality of the nutritional value of breast-milk from working mothers was doubted at times. Child hygiene met with great interest from the 1890s. Private initiative, at first, arranged for day care, \textit{gratis} milk handouts, weekly infant consultations and stimulation of breast-feeding. Government subsidies supported these initiatives only later. Eventually, more women started to feed their babies personally and the child mortality rate declined gradually.\textsuperscript{27}

Unhealthy working conditions and poor quality food made Ghent’s poor workers most susceptible to infection and the first victims in times of typhoid (1847-1848) and cholera (1848-1849). The cholera epidemic of 1866 resulted in 2,769 victims in Ghent; the infected population consisted of over fifty per cent of workers.\textsuperscript{28} The number of deaths was the highest in the third district (919) which was known specifically as a working-class area. The proximity of much still water in the canals but, even more, the large number of unsanitary \textit{beluiken} resulted in this high death rate. The first district with its upper middle class inhabitants faced 205 deaths. Contemporaries considered the use of alcohol as one of the main dangers for infection and the spread of cholera. This assumption was corroborated with the large number of deaths during the Ghent fair in July.\textsuperscript{29} There were so many victims of the cholera attack of 1866 as the population was still recovering from the so-called ‘cotton famine’. The early


\textsuperscript{28} However, as the entire Ghent population also consisted of a little over fifty per cent of workers, this ‘victim percentage’ is not surprising.

\textsuperscript{29} Godelieve, Cholera, 207-214.
years of the 1860s were marked by a deep recession in the textile industry, caused by the American Civil War. The supply of raw cotton stagnated, prices rose and the social consequences were terrible. 5,876 were unemployed at the beginning of 1863, whilst those who held on to their jobs received lower wages.30

Ghent would be overcome by more, yet milder, epidemics of variola, typhus, influenza and cholera from the 1870s to the 1900s. The 1871 variola epidemic, complete with cases of typhus, created especially a considerable number of victims, with a mortality of 37.5 per cent, comparable to the number of deaths during the cholera epidemic of 1849. Influenza came to the city from 1889 to 1890 but on a smaller scale and with less victims than in other Belgian towns and provinces. The Medical Committee of the Province of East-Flanders even reported that, concerning this outbreak, the province enjoyed an exceptional sanitary state.31 Belgium was infected again by cholera between 1892 and 1894, but the number of deaths in Ghent was not so severe. Koch had discovered the tubercle bacillus and administrative intervention and regulations prevented the spread of the disease.32

Besides the fear of being swept away by one epidemic or another, Ghent workers also had to cope with the risks of industrial work. The textile mills were extremely dangerous and many workers had survived at least one accident.33 Children were exposed also to work-place hazards. The scourges of child labour became clear once again during early 1872. In January a ten-year old girl lost an arm, a month later a nine-years-old boy was almost killed as he was dragged along by a gear wheel.34 Occupational disease also endangered workers’ health. Insufficient air circulation led to tuberculosis amongst weavers who constantly inhaled cotton dust. ‘Water cancer’ affected the hands of spinsters who worked amidst thick steamy clouds whilst spinning wet flax fabrics.35

The ever-growing population became a source of concern to the local authorities. The higher echelons of Ghent society looked at the presence of the large number of ‘uncivilized’ labourers with Argus-eyes. They not only formed a political threat but also the poor districts endangered health being a focus of epidemics. The fear of contamination was a constant source of agony and

31 Rapports des Commissions Médicale Provinciale. Province de la Flandre Orientale (1890), 155-188, q.v. 170.
32 Godelieve, Cholera, 221; Casteleyn, Epidemieën in België, 258-259.
33 Penn Hilden, Women, Work and Politics, 64; Backs, ‘Mortality in Ghent’, 544.
35 Roose and De Vuijst, De kranten van Gent, deel 1, 9.
numerous *enquêtes* were carried out on the hygienic situation and living conditions in these areas. All aspects of the daily life of the impoverished working population were monitored, aimed at imparting social discipline. Hygiene became fiercely propagated by means of water and soap campaigns and the publication of hundreds of health-guides. This health education made hygiene a virtue, 'decency and purity were expressions of a sense of duty and solidarity, of order and morality.' Hygienic behaviour became a manifestation of social conventions and respect for health rules. Consequently, physical hardship became less a punishment by God and more a disciplinary measure against social deviancy.36

Socio-economic developments also worried church authorities as they already had difficulties in holding on to the people at the beginning of the nineteenth century. One third of the people did not participate in the Easter celebration in the 1830s; indeed, a majority of the population did not go to Sunday Mass. Merely twenty per cent of the population were regular churchgoers in the 1870s. Amongst the working population in particular secularisation became apparent. Initially, the continuities between Socialist principles and Catholicism were emphasised but, gradually, Socialists disassociated themselves from Christianity.37 Alternatives were invented to replace religious rites and feasts. Christmas, for example, was never abolished but, instead of commemorating the birth of Christ, the birth of the other Messiah, Socialism, was celebrated. Furthermore, the Ghent Socialist Freethinkers Union initiated the replacement of Catholic transition-rituals by their own Socialist customs. The so-called Free Baptism and Feast of Youth replaced baptism and the first Communion.38 Nevertheless, the power of the Church never weakened completely. In difficult times of epidemics or famine, people *en masse* sought refuge in the Church hoping to avert misfortune.39 Moreover, religious rituals remained wanted very much at particular moments in life, such as marriage and death.

The inequality amongst Ghent’s population led to the development of a strong labour movement that ‘resolutely and autonomously barked up the socialist road’.40 Social unrest had already risen in the 1830s when small-scale...
riots about wage-cuts, unemployment and bad living conditions were far from rare and culminated with the so-called ‘cotton revolt’ in 1839. Troops opened fire and workers were killed for the first time in Belgium. The first mass strikes in Belgium took place at the end of the 1850s and resulted in union-like organisations such as the Broederlijke Wevers (Brotherly Weavers) in Ghent. The female workers organised themselves also as the Zusters Genootschap der Weefsters (Sisters’ Society of Weavers). Such organisations pretended to be sickness funds to avoid the prohibition on formal assembly, whereas they were actually trades unions.

In 1865 Ghent workers founded the Socialist co-operative organisation Vooruit, an initiative that was imitated soon throughout Belgium. These Maisons de Peuple (People’s Houses) provided their members with all types of services, food, clothing, housing, medication etc. at reasonable prices. As the workers gained strength through formal organisation, the state government realised that new legislation had to be enacted. In 1866 the prohibition of strikes and trades unions was withdrawn but true reform of workers practices was not yet accomplished.

In 1886 the Belgian bourgeoisie was repulsed and shocked by a violent worker’s uprising. The aggressive and bloody strike started in the Spring and continued for months with two major consequences. Firstly, a detailed inquiry was undertaken into the nation’s working class. This 1886 investigation revealed that many thought that social unrest was the result of immorality and blamed working women. Yet, nobody dreamed of prohibiting cheap female labour. However, the 1889 law on female factory work, which also applied to women working in mines, stone quarries and harbours brought some changes including the regulating of working hours and days. Girls and women younger than twenty-one could not work for more than twelve hours and for six days in a row. All women, in addition, could now claim maternity leave of four weeks. Despite the improvements created for women, the impact of the labour legislation was limited. Women above the age of twenty-one were not protected, except when they were pregnant, neither were the women who were active in trade, domestic industry or agriculture. Moreover, the regulation of female labour stemmed barely from humane considerations of these workingwomen. Although the fact that women fell victim to all sorts of abuse such as low wages, long working days etc. was not denied, the laws rather

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42 Roose and De Vuijst, De kranten van Gent, deel 1, 11.
43 Penn Hilden, Women, Work and Politics, 32-34.
served to protect public morals and health by promoting women’s true
destination as wives and mothers.44

The thirty years that Van den Berghe worked and lived in Ghent brought
more improvements for its citizens. Housing improvement measures were
carried out and the water supply was enhanced in some notorious districts. At
the end of the century considerable hygienic regulations had been implemented
and many extremely unhealthy areas had disappeared. Nevertheless, Ghent
still occupied the first place amongst Belgium’s twelfth largest cities with
regard to poor hygiene.45 Yet, the situation of Ghent labourers had generally
improved by the mid-1880s. An enquête on the economic situation of workers
concluded that the average labourer no longer needed to appeal for poor relief,
provided that he did not have too many children or the responsibility of taking
care of disabled parents.46 Another symbol of improved circumstances may be
found in the shift in the expenditure on clothing of Ghent workers’ families and
in the way that people dressed. Expenditure on clothing doubled between 1853
and 1891, and contemporaries commented that labourers became interested in
clothing.47 It was emphasised also that the improved situation of Ghent
workers would not have been achieved had the Ghent citizens’ morality not
improved: ‘… ne va pas sans une amélioration dans la moralité de la population
Gantoise’.48 Furthermore, the city of Ghent eventually led the way in social
politics at the end of the century. The authorities took up the task of public
housing and, in 1898, the city council approved the start of an unemployment
fund.49

3.2 Sufferers’ Options for Healing: the Availability of Medical Care

A nineteenth-century person, in general, was not enthusiastic about putting
their fate into the hands of professional academic medicine. At first, an average
citizen would revert to home remedies and family advice on the outbreak of an

44 Penn Hüden, Women, Work and Politics, 162-170; Nele Bracke, ‘De BWP en de relatie tussen
geslacht en politiek. Een erkenning van de reglementering van de vrouwenarbeid (1885-
1914)’, in: De Weerdt (ed.), Begeerte heeft ons aangerakt, 113-128. With regard to discussions
on female labour in an earlier period see: Denise Keymolen, ‘Vrouwenarbeid in België
omstreeks 1860. Vigerende en alternatieve opvattingen m.b.t. vrouwelijke huis- en
45 Godelieve, Cholera, 236.
46 Maurice Heins, De la condition économique des ouvriers Gantois. Etude statistique (Ghent: Ad.
Hoste, 1887), 12.
47 Peter Scholliers, ‘Kledingaankopen en de zin van het leven, of economie en identiteit in
België vanaf het laatste kwart van de negentiende eeuw’, in: Yves Segers et al. (eds.), Op weg
naar een consumptie maatschappij. Over het verbruik van voeding, kleding en luxegoederen in België
48 Heins, De la condition économique, 59.
illness. Modern medicine and a sanitary life style were not accepted easily as they did not fit in with the experiences and mentality or financial possibilities of ordinary people. Nevertheless, the number of medical doctors per head of the population increased during the nineteenth century, as did the number of people applying for medical care from such professionals. In 1860, 276 medical doctors were registered in East Flanders (3.45 per 10,000 inhabitants). Forty years later the number had increased to 460 or 4.47 per 10,000 inhabitants.50 Besides the growth in the number of orthodox physicians, the medical profession started to organise itself. Medical associations arranged for the protection of doctors’ interests by agitating against payment arrears and defaults and the circumstances in which physicians practised.51 However, major medical innovations and improvements were still in the future and medical science, in many cases, was powerless to do anything but to comfort sufferers.

When people fell ill and wanted or needed medical support they could choose between healing methods available in roughly four different sectors in the medical domain: (1) family or home medicine, (2) professional, licensed medicine, (3) unlicensed medicine and (4) religious medicine.52 The first sector refers to non-professional medicine initiated and carried out by the individual, the family or the social network. The home is the place where illness is first defined and dealt with. The second sector contains all forms of licensed professional medical treatment available, both orthodox university medicine and unorthodox therapies. The unlicensed sector refers to all forms of healing performed by practitioners without a medical degree. Religious medicine can be understood as another form of unlicensed medicine performed by religious and not medical personnel. At the same time, it refers to attempts people themselves make to avert illness. Religion, therefore, as a means of self-treatment. Yet, the boundaries between these separate fields are not as fixed and static as might be thought. On the contrary, the dividing line between one form of medical treatment and another can be rather thin.

50 Velle, *De nieuwe biechtvaders*, 348.
52 Arthur Kleinman, *Patients and Healers in the Context of Culture. An Exploration of the Borderland between Anthropology, Medicine and Psychiatry* (Berkeley etc.: University of California Press, 1980), 49-70. My four-fold division has been inspired by this publication, although I have changed some of the terminology. Kleinman refers to the first field as the ‘popular sector’ and to the third field as the ‘folk sector’. ‘Religious medicine’ does not form part of Kleinman’s analysis.
The categorisation of all these forms of deviant medical treatment poses methodological difficulties. Alternative, unconventional, non-conventional, unorthodox, irregular or folk medicine, quackery, medical fringe, marginality and healing alternatives are just a part of the large pool of terms regarding healing methods that deviate from the regular, the mainstream and that refer to the 'other' (e.g. homoeopathy). This distinguishing vocabulary and semantics are very significant from the viewpoint of the medical professionals.\(^{53}\) However, this historical study is concerned primarily with sufferers, patients and their preferences and experiences. They will not have been interested, in general, in whether or not their therapeutic choice was a healing method with an official status; they merely wanted to be cured or, at least, relieved from their suffering. Therefore, the labelling of the various forms of healing, from the patients' perspective, appears rather irrelevant. However, patients who did consciously choose and apply homoeopathy may have been interested particularly in homoeopathy's unorthodox label.

Nowadays, it is very common to add the term 'alternative' in referring to all medical practitioners who do not have a university medical degree and, thus, are not officially licensed to practice medicine. However, this term is a twentieth-century invention and, consequently, rather anachronistic when writing on the nineteenth century. Here, the term 'licensed' or 'qualified practitioners' will be used in referring to those who obtained an academic medical degree and, therefore, were licensed to practice medicine. Their healing methods can be divided into orthodox and unorthodox therapies. Orthodox medicine referred to in the sense of 'allopathic' medical science taught at university and not in the sense of 'old-fashioned' or 'pre-modern'. After all, orthodox, university medicine modernised especially strongly during the final decades of the nineteenth century. There were licensed practitioners who carried out medical therapies other than those learned at university. Practitioners such as homoeopathic physicians applied unorthodox healing methods. Lay-homoeopaths, therefore, should be considered as both unorthodox and unlicensed healers. The terms 'orthodox' and 'unorthodox', thus, refer to the sort of healing method offered; whereas the typology of

In Search of a Cure

'licensed' or 'unlicensed' medicine is directed at the judicial position of its practitioners.

Family or Home Medicine

A large part of the population dealt with illness personally. The advice of family or friends was sought and recipes were exchanged. This manner of self-treatment was based on verbal communication and custom. However, medical knowledge could be gained also from the numerous health-advice or self-help guides, 'allopathic' and homoeopathic, that were available in Belgium in the nineteenth century.54 French-language advice literature, by far, was in the

54 Non-homoeopathic (allopathic) advice-guides:
G. J. Swéron, Handboek over de gezondheidsleer ten gebruike der landbouwers ten platten lande (Brussels: Fonteyn, 1853); C.L. Gysselincx, De schat der kinderen, of raadgevingen an den jeugdigen leeftijd wegens het bewaren der gezondheid, overgenomen uit de beste letterkundigen en geneesheren; en vermeerderd met gezondheids- en opvoedkundige aanteekeningen (Ghent: J. Poelman de Pape, 1860); G.J. Swéron, La santé pour tout le monde ou petit manuel d'hygiène (Brussels: E. Guyot, 1868); Jan R. Snieders, Mentor. Verspreide aantekeningen over volksgeneeskunde en gezondheidsleer ('s-Hertogenbosch: Bogaerts, 1870); A. Sovet, Manuel d'hygiène publique et privée (Brussels: Jamar, 1875); H. Boëns, La fièvre typhoïde en son traitement a l'usage des gens du monde (Brussels: Manceaux, 1877); C.A. Fredericq, Handboek van gezondheidsleer voor alle standen (Ghent: Arnoot-Braeckman, 3d ed., 1878); C.A. Fredericq, Grondregels der gezondheidsleer (Ghent: J. Vuijlsteke, 4th ed., 1882); A. Becquerel, Traité élémentaire d'hygiène privée et publique (Paris: Asselin, 7th ed., 1883); E. Burvenich, L'art de vivre. Grand traité d'hygiène populaire (Verviers: E. Gikon, 1885); E. Burvenich, De reinheid van het lichaam (Ghent: Hoste, 1893); M. Platen, De nieuwe geneeswijze: leerboek der natuurlijke levenswijze, der gezondheidsleer en artsenijloos behandeling: een schat voor huis en huisgezin, voor gezonden en zieken (Brussels: Bong, 23d ed., 1900); A. Desmarez, Guide de la santé. Notion d'hygiène et conseils pratiques de pharmacie et de médecine (Ghent: J. Vanderpoorten, 1901); Hubert Boëns, L'art de vivre: traité général d'hygiène à l'usage de tout le monde (Paris: Hachet, w.d.).

Homoeopathic advice-guides:
Dr. Bertholdi, Consul d'un médecin homéopathie, ou Moyens de se traiter soi-même homéopathiquement dans les affections ordinaires, et premiers secours à administrer dans les cas graves; importance d'une pharmacie homéopathique domestique (Paris: Bailliére, 1837); Alfred Steen, Guide homoeopathique, pour l'usage domestique (Brussels: Tircher, 1858); P. de Molinari, Guide de l'homéopathiste, indiquant les moyens de se traiter soi-même dans les maladies les plus communes, en attendant la visite du médecin (Brussels: Tircher, 1859); G.P.F. Weber, Manuel homoeopathique du goutteux ou instructions pour se préserver et se guérir de la goutte (Paris: Bailliére, 1862); R. Noack, Guide homéopathique domestique à l'usage des familles (Lyon: C. Jaiilet, 1865); G.H.G. Jahr, Du traitement homoeopathique du choléra avec l'indication des moyens de s'en préserver, pourvant servir de conseil aux familles en l'absence du médecin (Paris: Bailliére, 1868); Th. Bruckner, Médecine homoeopathique domestique (Leipsic: Schwabe, 1873); Th. J. Prost-Lacuzon, Formulair pathogénétique usuel ou guide homéopathique pour traiter soi-même les maladies (Paris: Bailliére; 5th ed., 1877); E. Schaedler, Petit guide homéopathique contenant les indications nécessaires pour l'emploi des principaux remèdes homéopathiques dans les maladies les plus ordinaires (Leipsic: Schwabe; 4th ed., 1879); F.J. Orth, Le trésor médicale des familles ou traitement facile, rapide et par l'homéopathie des maladies les plus ordinaires d'après les meilleurs ouvrages connus jusqu'à ce jour (Toulouse: Imprimerie et fonderie générale du Midi, 1885); A. Claude, Premières notions d'homéopathie à l'usage des familles (Paris: Bailliére; 3d ed., 1886); H. Merckens, De homoeopathische huisdokter, bevattende de nodigste aanwijzingen, om de meest
majority, and this applies even more strongly to the homoeopathic guides. Although the Ghent population was predominantly Dutch speaking, it is probable that those who were literate could also read French. However, more research is needed on the likelihood of people making use of these health advice guides in terms of cost and availability in libraries. Book lists published in homoeopathic periodicals quote prices varying from one to three hundred(!) francs. These, however, were aimed at the professional readers of the periodicals.

Self-treatment was often considered as a threat to public health because of the carelessness and ignorance of lay-people. The advice-literature, therefore, predominantly served as a means of educating ordinary people. Some guides just promoted a healthy, hygienic and morally sensible life-style, emphasising the activities that improved the physical or mental state. Other guides contained a summing-up of frequent diseases and their remedies, yet hardly expatiated on how to prevent disease. Moderation of all kinds was propagated to obtain health and to prolong life. This pedagogic aspect was not restricted to allopathic remedy books; homoeopathic advice literature gave thought to hygiene as well.

The culture of self-treatment reflected in health-advice guides illuminates ordinary people's ideas about health-related issues and their actions in times of threatening illness. Parents, for example, who did not want their children to be inoculated, based their refusal on the idea that smallpox cleansed their children and preserved them from all sorts of other diseases. Indeed, many doctors were concerned about these persisting prejudices and refuted them in the advice literature. G.-J. Swéron, doctor in medicine, surgery and obstetrics, spent a whole chapter discussing and contesting, what he called, the aberrations and folk prejudices. Medical almanacs and advertisements formed another source of information for people who wanted to help themselves. The

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55 Just as most Flemish nowadays are bilingual in contrast with people from the Walloon provinces who usually only have a command of French.

56 Example derived from: Swéron, La santé pour tout le monde, 161-164.

57 G.-J. Swéron, Handboek voor de gezondheidsleer ten gebruike der landbouwers ten platten lande (Brussels: Fonteyn, 1853), 74-91, chapter 22; A. Poskin, Préjugés populaires relatifs à la médecine et à l'hygiène (Brussels: Société Belge de Libraire, 1898).

58 Gezondheidsraadgevende almanakken uitgegeven door apothekers, drogisten enz. (Ghent and Brussels, 1880-1882; 1895-1897; 1899; 1902-1904; 1906; 1908-1910). Health-advice giving almanacs published by pharmacists, chemists etc.
In Search of a Cure

almanacs and other small leaflets were printed in both Dutch and French. The fourth page of Belgian newspapers, for example the daily Gazette van Gent, was filled usually with advertisements on health-related issues. They recommended, in Dutch, mainly patent drugs fit for personal use which were very suitable for self-treatment. These ready-made medicines promised to relieve all sorts of ailments. Vannier syrup would help chest ailments, coughing or colds. Victor Locq capsules and syrup were very suitable for fainting, colds and, again, chest ailments. Standaert's pills helped against asthma, stomach affliction or a cough; and for consumption Sommerbrodt capsules should be taken. The advertisements guaranteed an improvement by simple domestic use. Het Volksbelang, a Flemish-disposed liberal Saturday paper, contained 'medical adverts' from the first year of publication in 1867. The almanacs and advertisements regularly made use of testimonies of satisfied users and had the format of 'mini-counsellors' because they described extensively how and for what ailments the medication should be employed. The practice of self-treatment was widespread in Europe and overseas at the end of the nineteenth century and women often seem to have been both the keepers and the users of home remedies.59

Unfortunately, little is known about the chemical composition of many patent medicines available in nineteenth-century Belgium.60 One health-advising almanac, recommending the American doctor Velsor’s medicines, discussed in detail the composition of the product, based on the judgement contained in a medical journal. The three drug therapies Dr. Velsor offered - Tisane Velsor, America Velsor and Velsor’s tea - were completely organic and consisted of several specified plants.61 Advertisements and almanacs imputed


60 The history of patent drugs and the market of self-medication is still largely unexplored territory in Belgium. It would make a very interesting subject for research into patient history.

beautiful characteristics to the drugs. The health-improving promises made were communicated frequently according to classical humoralism, terminology familiar to most people. It assured them of the termination of suffering by sweating, vomiting or defecation.62 Yet, some people will have become more ill than they were initially, as many patent drugs were strong. A painful example of the adverse consequences of home remedies is that of parents administering opiate-based drugs to their children to keep them asleep while they went to work.63 Homeopathic medicines, on the other hand, were noted generally for their supposed mildness, which might explain why some people eventually switched to homeopathy, requesting treatment for the consequences of the allopathic home remedies they had taken.

In England homeopathy was advertised widely and the trade in medicine chests matched the popularity of homeopathic domestic guides that could be obtained from homeopathic publishing houses and chemists. A study of the development of homeopathy in the British Isles claims that women, traditionally the caretakers in the family, probably were the predominant purchasers of these products.64 However, this remains debatable as other research has revealed that men also were acquainted with ‘homeopathic house-doctors’.65 In Germany some of the non-medical homoeopathic

associations by and for lay people saw it as their duty to supply their members with all types of services such as the provision of medication, and they set up their own pharmacies. In Belgium, in contrast, homoeopathy was barely brought publicly to the attention of or supported by lay-people. Homoeopathic medication, medicine chests or health-guides were not even advertised in newspapers. A specific reference to homoeopathy was made only rarely. Gustave Van den Berghe did so with his advertisement in the Gazette van Ghent announcing the opening of his practice in 1869. Apothecary Dwelshauwer occasionally gave notice of also having available homoeopathic medication. He advised the use of non-homoeopathic Blot pills to counteract ‘syphilitic diseases’ in January 1871 and advertised homoeopathic coffee by Severin. Yet, although homoeopathic over-the-counter medicines were not sold via advertisements, there existed homoeopathic apothecaries in Ghent and bookshops where self-help guides could be purchased. If desired, there was the possibility to employ homoeopathy at home.

Self-treatment will have been based partially on economic considerations as the cost of medical consultations may have had a large impact on the average family budget. It is not surprising, therefore, that a rising standard of living enabled an increase in medical consumption, i.e. consulting a medical professional, as families could now afford to call in the doctor. Twenty-first-century research into the motivation for the use of homoeopathy has revealed, furthermore, that ill people consider self-medication of great importance and that homoeopathy is better for this purpose than orthodox medicine. Moreover, an allopathic contemporary of Van den Berghe claimed that the public interest in homoeopathy resulted from its convenience to be their own doctor.

**Professional, Licensed, Medicine**

There were plenty of options in Ghent within the sector of professional, licensed medicine; hospitals, midwives, private allopathic general practitioners or

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67 This statement is based on the systematic investigation of, besides the Gazette van Ghent, several newspapers: De Gentenaar (no medical advertisements), Den Vlaming (medical advertisements, but no homoeopathy), Het Volksbelang (medical advertisements, but no homoeopathy), L’Impartial de Gand (medical advertisements, but no homoeopathy), Het Volk (medical advertisements, but no homoeopathy).
68 Gazette van Ghent, 5 January 1871, not paged. Dwelshauwer, Spiegelstraat 19 (Mirror street).
69 Velle, De nieuwe biechtvaders, 98.
71 Van Praet, De receptie van de homoeopathie, 121.
specialists and homoeopaths. The province of East-Flanders, in terms of the numbers of allopathic and homoeopathic practitioners, occupied the second highest place in Belgium in the nineteenth century. The province of Brussels, with the capital, had the highest level of medicalisation.

Eleven different homoeopathic physicians, including Van den Berghe, and three homoeopathic pharmacists in total resided in Ghent between 1869 and 1900 (Table 1). The number of allopathic practitioners (physicians, dentists and oculists) in Ghent increased considerably, whereas the number of homoeopaths remained more or less the same. Nevertheless, sufferers who specifically wanted to try homoeopathy could choose between several homoeopathic physicians.

Table 1. The Presence of Licensed Allopathic and Homoeopathic Practitioners (Physicians, Dentists and Oculists) in Ghent and East-Flanders, 1869-1900

<table>
<thead>
<tr>
<th>Year</th>
<th>Allopaths in Ghent</th>
<th>Homoeopaths in Ghent</th>
<th>Homoeopaths East-Flanders (incl. Ghent homoeopaths)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1869</td>
<td>86</td>
<td>4</td>
<td>Circa 10</td>
</tr>
<tr>
<td>1881</td>
<td>95</td>
<td>4-5</td>
<td>Circa 10</td>
</tr>
<tr>
<td>1890</td>
<td>120</td>
<td>4</td>
<td>Circa 10</td>
</tr>
<tr>
<td>1900</td>
<td>135</td>
<td>5</td>
<td>Circa 8</td>
</tr>
</tbody>
</table>

Source: Vervaeke, De sociale studie van een beroepsgroep; Van Praet, De receptie van de homeopathie; Bruggeman, Sociale studie van een beroepsgroep.72

Van den Berghe’s allopathic colleagues practised medicine in their own private clinics (home practices) or were affiliated to municipal medical institutions such as hospitals. As no homoeopathic hospitals were established Van den Berghe’s Ghent homoeopathic colleagues practised homoeopathy privately. None of the Ghent homoeopaths had a group practice; they worked as sole practitioners. All types of allopathic institutions were available to the sick and many were distinguished by the type of illness or the gender of its sufferers who qualified for treatment and care. Most institutions were controlled by the municipal administration, even if financed partly by private donations; yet others were private organisations. People were suspicious of treatment in hospital as the

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72 Greta Vervaeke, Sociale studie van een beroepsgroep: de geneesheren te Gent (1830-1890). Status-, stratificatie- en mobiliteitsschets. Unpublished licentiate thesis (University of Ghent, 1977-1978), 86-89; Van Praet, De receptie van de homeopathie, 12; Katrien Bruggeman, Sociale studie van een beroepsgroep. De geneesheren te Gent 1890-1914: status, stratifikatie en mobiliteitsschets. Unpublished licentiate thesis University of Ghent (Ghent, 1980-1981), 147. Vervaeke used two different sources to determine the number of allopathic licensed practitioners in Ghent, the Wegwijzer der Stad Gent (WW) and the Bestuurlijk memoraal van Oost-Vlaanderen (BMO), that contained different numbers. The average of the published numbers has been noted in the table.
largely failing therapeutic possibilities and inadequate hygiene and care created an image of hospitals as being the 'front room of death' (antichambre de la mort). Nevertheless, hospitals often did serve as relief centres for the poor as they offered free treatment. The fear of hospitals eventually faded away at the end of the nineteenth century with the introduction of new scientific knowledge and methods of treatment.73

The largest hospital in Ghent was de Byloke, the Civil Hospital, which had its own maternity clinic from 1828. The hospital had paying and non-paying clientele. The poor were referred by the city (poor) doctors or the police, in the same way as prostitutes. Paying patients usually applied personally for treatment and were expected to pay one month in advance. Children younger than ten and the mentally disturbed were not admitted and had to obtain medical care elsewhere. Insane males were admitted to the public Hospice Guislain from 1851, named after Joseph Guislain (1797-1860), a Ghent psychiatrist who reformed drastically the care of the mentally ill. The St. Vincentius hospital was run by the Sisters of Love, an order of nuns, and was for incurable and chronic patients of both genders. The Van Caneghem Institute was built in the 1850s to serve the blind. The Brothers of Love cared for the patients. The Lousbergs Institute was set up especially for old and invalid Ghent cotton and textile workers on the initiative of Ferdinand Lousbergs (1799-1859), a textile baron. The sisterhood of the Child Jesus cared for sufferers of eye disorders in the 'eye sufferers institution'.74

Ghent's poor could fall back on public poor relief. The city administration subsidised public, private and religious institutions and organisations involved in poor relief. The Committee of the Burgerlijke Godshuizen

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Health, Illness and Healing in the Ghent Community

(Public Hospices), overseeing the existing charity institutions where the ill, insane, orphans and elderly found shelter, paid for an average of 1,760 to 2,650 people who were admitted each year between 1820 and 1925. This is the average number of people staying in one or the other institution; the number of people helped during a year, however, was much higher. Yet, these people depending on welfare formed a very small part of Ghent’s population. Only approximately two per cent of the citizens, predominantly women, qualified for poor relief within the Public Hospices.75 The remaining needy were forced to get medical support elsewhere. It has been suggested that the low percentage of people supported by the charity of the Burgerlijke Godshuizen in the course of the century is related to the rise of other ‘networks’ such as sickness funds and slate clubs, which maintained the support function. The suggestion that the fading importance of public relief was due to changing social politics, as workers were urged increasingly to take their faith in their own hands, is at least as convincing as the first assumption.76

Unlicensed Medicine

Unlicensed healers practised medicine on a large scale in Belgium to the great dissatisfaction of the medical profession. Physicians tried to regulate, monitor and restrain all medical practices outside the legal norms during the nineteenth century. The repression of ‘quackery’ was discussed at congresses. Medical committees, local and provincial, were appointed to control the ‘medical market’ for illegal practices. Many licensed physicians, in addition, felt the need to publish on the subject. Numerous publications attacked and judged the illegal practice of medicine. The offensive against unlicensed medicine also included a ‘re-education’ of ordinary people to end strong prejudices about the preservation of health and the treatment of illness. Yet, an official association against the illegal practice of medicine, such as the Dutch Association against Quackery (Vereniging tegen Kwakzalverij) never gained a foothold in Belgium.77

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75 Coolens, ‘Armenzorg in het negentiende-eeuwse Gent’, 72-76.
76 Ibidem, 82.
However, unlicensed healers were not extinguished. They apparently
provided for a need by ordinary people and legislation did not prevent them
from helping their fellow men. Each year the provincial medical committees
produced an official report on their activities. The conflicts with unlicensed
medical practitioners were discussed in the paragraph ‘poursuites –
condamnations’ (persecutions and condemnations). These reports, thus, give an
impression of the type of (illegal) healers people could appeal to when
treatment was needed. The supply varied from uneducated women who acted
as midwives, and apothecaries or druggists who served as physicians, to people
with a ‘special gift’, such as Drieske Nijpers.78

A contemporary of Gustave Van den Berghe, A. de Cock, a teacher at
Denderleeuw, provided an impression of Belgian unlicensed healers.79 Many
rural inhabitants mistrusted the medical doctor and, therefore, sought quack
remedies that could be found anywhere, for example, the wonder doctor of
Moorsel, near Alost in the province of East-Flanders. Those who thought they
had cancer could consult cancer healers in Sarlardinge (in the south of East-
Flanders), Waasmunster (in the east of East-Flanders) or in Tellin in the
province of Luxembourg. These healers all prescribed an ointment to cure the
disease. In the surroundings of Liège there were ‘rebouters’ who, by rubbing,
were able to cure dislocated limbs. There also existed ‘readers’ and exorcists.80

Treatment by unlicensed healers was available in Ghent and they were of
special concern to the medical authorities. The local medical committee of
Ghent was sorry to conclude in 1882 that the illegal practice of medicine was
still present. It was being performed not only by people completely ignorant of
medical science but also by pharmacists who often practised medicine and even
performed small surgical procedures.81 These unlicensed healers sold their
merchandise through advertisements that also announced when and where
they could be consulted. The presence of Madame Enault was an irritant to
Ghent’s medical authorities. She removed teeth from the impecunious free of
charge and became very popular by giving money to the poor. She relieved
hundreds of people from their painful teeth on a daily basis and sold them
potions against mouth-wounds and toothache. She was active on the
Vrijdagmarkt (Friday market) in the city centre, where people sang to her and

78 M. Broeckhove, De wonderdokter Drieske Nijpers uit Sint-Gillis-Waas (Ghent: Koninklijke
bond der Oostvlaamse volkskundigen, 1980).
80 Cf. Willem de Blécourt, Het Amazonenleger. Irreguliere genezeressen in Nederland 1850-1930
(Amsterdam: Amsterdam University Press, 1999). De Blécourt gives a profound survey of
unlicensed female medical practitioners in the Netherlands.
81 Rapports des Commissions Médicale Provinciale. Province de la Flandre Orientale (1882), 137-168,
q.v. 163.
assisted with her carriage. Especially the innkeepers of the Vrijdagmarkt sincerely regretted her leaving the city at the end of July 1876.82

Religious Medicine

Although one should never condemn the sick calling in the help of religion, dedicating prayers to saints, or going on pilgrimage, such should, however, take place without interfering with the course of the treatment and after, in all cases, the advice of a physician has been enlisted.83

Religious medicine should be understood as a ‘combination therapy’ consisting of self-treatment and unlicensed medicine. Self-treatment is shown when people personally turn to God, praying for improvement of their medical condition. As soon as other religious people are requested to assist the recuperation, then it becomes a matter of unlicensed medicine. After all, people of the Church were not allowed officially to practice medicine.

Secularisation had started in the eighteenth century and intensified in the nineteenth century. It dispensed with notions regarding the origins and causes of illness of their religious and, sometimes, magical connotations and, consequently, advanced medical consumption. Illness changed from God’s punishment for sin into a natural process which could be overcome by human intervention.84 Nevertheless, when people were confronted with disease and suffering, religion continued occasionally to play a significant role.85 They believed that illness could be overcome through saints or their relics, by praying and processions or by the healing powers of pilgrimages. Particular saints, who were connected to particular diseases, could cure disorders. ‘Pilgrim healers’ were paid to go to the place of pilgrimage that was connected supposedly with the ailment. Information in books such as De bedevaartplaatsen in Oost-Vlaanderen was given on which places of pilgrimage should be visited for which diseases.86 The call upon saints could be done also in the privacy of the home, without having to travel or appeal for the help of others.

Furthermore, it was not uncommon that people of the church were involved in medicine. Episcopal workers not only wrote self-help guides but

83 Swéron, Handboek over de gezondheidsleer, 81. For the original Dutch text see Appendix 2.
84 Velle, De nieuwe biechtvaders, 78-79.
86 G. Celis, De bedevaartplaatsen in Oost-Vlaanderen (Gent: Vander Schelden, 1914).
also cared for and treated the ill and the needy.\textsuperscript{87} This treatment often consisted of more than praying and, at times, they carried out dangerous medical procedures. The role of religious women, who often acted as hospital nurses, was criticised as well. The medical authorities, not surprisingly, considered these works of mercy as acts of competition. Medical help was offered and medication prepared in cloisters. Religious nurses treated wounds and administered medicines. The local priest was often preferred to the doctor for treatment. More so, representatives of the medical professions feared that religious perceptions could lead sometimes to religious mania. Miraculous healings and occurrences of stigmata were ‘scientifically’ disqualified as phenomena resulting from suggestion and hysteria.\textsuperscript{88}

The Ghent population collectively went through a religious revival when feeling threatened by, for example, epidemics. Ghent Catholic newspapers proudly printed articles about the efforts clerics made during cholera episodes and the re-entering of apostates. The fear of disease temporarily drove people back to church as exemplified by, for instance, the number of people who went to Holy Communion. However, this religious upsurge was hardly permanent as, with the disappearance of the threat, people turned their backs on the church. Besides, using the Church as a haven of refuge depended on the perceived seriousness of the disease. People were terrified of cholera, but instances of smallpox, flu and typhus never led to an increase in expressions of devotion.\textsuperscript{89}

3.3 \textit{‘I Have Tried Whatever Needed’: the Therapeutic Past of Van den Berghe’s Patients}

Some people, before arriving in Van den Berghe’s practice, had been suffering for some time. Yet, not all had endured their health problems without trying to recover by turning to someone or something other than Van den Berghe or homoeopathy. When Van den Berghe was consulted for the first time, the physician usually inquired from the patient if other healing methods, medication or healers had been tried and, if so, for what ailments. The casebooks give the answers of the patients; they spoke about earlier suffering and previous attempts to cure. The patient’s therapeutic past or medical history sheds light on the options for healing from the patient’s perspective and also

\textsuperscript{87} E.g. J. Lambilotte, \textit{Den vertrooster of godvruchtige lezingen voor zieken en andere bedrukte persoonen} (Ghent: Van Ryckegem-Lepère, 1848); J.M.L. van den Bosch, \textit{Handboek voor lijdenden of genezing zonder geneesheer} (Louvain: Fonteyn; 4th. ed, 1859); J. Hillegeer, \textit{De liefdadige ziekendiender} (Ghent: Vander Schelden, 1861).

\textsuperscript{88} Velle, ‘De geneeskunde en de R.K. Kerk’, 1-21, q.v. 10; Velle, \textit{De nieuwe biechtvaders}, 160-164.

\textsuperscript{89} Casteleyn, Epidemiëén in België in de 19e eeuw, 193, 199, 309.
Health, Illness and Healing in the Ghent Community

makes it possible to differentiate between various types of patients. Three categories of patients, who consulted a homoeopathic practitioner, can be distinguished: shopping patients, 'alternative' patients and homoeopathic patients. Shopping patients inter-change between orthodox and unorthodox medicine, alternative patients inter-change between different types of unorthodox medicine, and homoeopathic patients solely use one healing method and only inter-change between different homoeopathic physicians. This last category also can consist of people who stayed with one single physician, such as Van den Berghe.

The casebooks provide statements of patients regarding previous experiences with health care and healing. Visits to doctors and other healers, the use of certain medication and the ways in which it was applied, by private initiative or by doctor's prescription, are recorded. Thus, the therapeutic past of some of Van den Berghe's patients can be considered applying the categories outlined previously. In a little over 800 cases - based on all eighteen casebooks - people (Ghent inhabitants predominantly) narrated in detail their previous experiences with family medicine, professional licensed medicine, and unlicensed and religious medicine. In comparison with the entire Ghent clientele of over 15,000 this number is small (appr. 5 per cent). However, they can contribute still to the purpose of drawing a picture of the patients' therapeutic behaviour before turning to Van den Berghe. Firstly, because patients who consulted Van den Berghe only once, and this concerns many, were not that communicative usually. The longer people stayed with him, the more information they tended to share. Secondly, the busier Van den Berghe's practice became, the less data the patients' files contain. He then preferred to note the, in his opinion, more relevant information omitting data of 'secondary' importance such as previous experiences.

Family or Home Medicine Previously Practised by Van den Berghe's Patients

A majority of Van den Berghe's patients had struggled previously with illness and were acquainted with medical practitioners, professionals and others, before they made their first appearance in his surgery. Initially, they had often tried to counteract their suffering themselves; self-medication was generally widespread and the patients' statements confirm this. People were easily overcome by disease and life consisted usually of several periods of suffering. Thus, when people told Van den Berghe about their experiences with medical care they were not referring solely to actions regarding their current ailment, it

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often meant that they described various instances of illness they had been confronted with during their lives.

Patients reported on taking medication personally, without the mediation of a physician or healer. A differentiation between 'allopathic' and homoeopathic self-treatment can be made in a small number of cases. One male patient suffered severely from various vague aches. He had made intensive use of allopathy, being treated by a physician first of all and, later on, giving himself morphine injections. By the time he consulted Van den Berghen the diagnosis had become chronic morphine poisoning. Sometimes, people specified the drugs they had taken, for example, by mentioning the use of digitalis or sulphur. However, these medicines could be used both in an allopathic and homoeopathic manner.

Sufferers relating their purging habit clearly performed allopathic self-treatment as with those reporting the use of 'sel anglais' (smelling salts). The taking of purgatives appears to have been widespread amongst all of the population. The purgatives, in many instances, served to encourage stools; some people were completely unable to perform a motion without the help of drugs. The casebooks mostly reveal the taking (prend) or abuse of (abus) non-specified purgatives. It is not clear whether the patient or the doctor made the distinction between use and abuse but, considering the consistency of notes on this subject, it seems likely that the patient declared whether the use happened on a 'normal' or 'abusive' level. People often knew very well which laxatives or emetics they were using and this was registered in their file. The most common laxatives were quinine, rhubarb, aloe, sal volatile and cod-liver oil. Cod-liver oil was used regularly to overcome indigestion and constipation, but one woman used it also to bring on her menses. Another medication, often privately administered, was described as a 'vermifuge', a common one being calomel. As children primarily were afflicted with worms, this medication was mostly given to them. They also often took cod-liver oil, a habit persisting far into the twentieth century.

The private use of homoeopathic remedies occasionally comes to light. Some patients had experimented initially with homoeopathic medicines at home. Others mentioned specifically the homoeopathic dosage they had taken. A man suffering sycosis had already taken graph. 6 (dilution of one part to six) for four weeks before he turned to Van den Berghe. Another patient started taking cham. 30 (dilution of one part to thirty) four days prior to consulting the homoeopathic physician. It was noted, of only one patient, that he had used

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something other than the regular ‘allopathic’ home medication or homoeopathy by drinking herbal coffee (café des herbes) for pain in his sexual organs.  

Self-treatment, sometimes, could lead to an aggravation of the suffering. There was a perception that too strong a dose of drugs could contribute to the development of complaints. A patient with complete blindness in his left eye thought his ailment was the result of taking a strong dosage of quinine for intermittent fever combined with a fall on his head. Notwithstanding the potential consequences of self-medication, they did not restrain people from employing it. Self-medication was a daily pursuit, for many, to preserve or restore health without being confronted with high costs or medical actions incompatible with individual ideas and experiences. The use of family or home medicine was the ‘field’ of medical treatment most mentioned by Van den Berghe’s clientele. Although the actual number of people who used self-treatment will have been higher as not everybody will have told Van den Berghe and the files contain rather scarce information in busy times, the four hundred people (out of 800) confessing that they had made extensive use of all types of home remedies suggests that self-treatment was applied frequently.

Previous Consultation of Licensed Practitioners by Van den Berghe’s Patients

Patients had been calling regularly on other health professionals about their conditions before consulting Van den Berghe. These previous experiences with professional health care, in most cases, were with orthodox ‘allopathic’ medicine, but unorthodox therapies were mentioned as well. The precision with which the differentiation between, for example, a practitioner (praticien = healer) and an ‘allopathic’ physician is made in the casebooks, makes it likely that the patients themselves were well aware of what kind of therapy they had tried. ‘After an allopathic treatment by almost ten different physicians who gave her up completely she made an urgent appeal for my care’. If the treating physician or the precise form of treatment were not mentioned, the casebooks reveal, at least, that sufferers had experienced allopathy (l’allopathie) or allopathic treatment (traitement allopathique).

The experiences with licensed medicine spoken about to Van den Berghe may be sub-divided into four categories (1) a specifically named physicians’ or other licensed practitioners’ treatment, (2) treatment by leeching and bleeding, (3) treatment in hospital, and (4) treatment by using ‘allopathic’ procedures, instruments or medical devices. Consulting licensed medical practitioners, physicians, ophthalmologists, dentists etc., was fairly common. The casebooks offer a list of names of people who had been consulted previously by Van den Berghe’s clientele. Occasionally, the patients specified the type of practitioner (i.e. their method of healing) approached for medical aid but, more often, only their names were given. This first category refers only to treatment given by practitioners with known names and includes both allopaths and homoeopaths. Some of the allopathic practitioners mentioned by the patients remain unknown because they were not living or practising in Ghent.96 The experimental use of all types of home medicine has its equivalent in the way people made use of professional licensed medicine as patients turned to various ‘allopaths’ and homoeopaths. Yet, slightly more homoeopathic physicians (66) than ‘allopathic’ practitioners (50) were mentioned (Appendix 3). This implies, presumably, that some of Van den Berghe’s patients were continuing the homoeopathic treatment already in use before meeting him. However, as many people alternated one treatment with another, it is presumptuous to state that a clear preference was displayed for the custom of using homoeopathy. This becomes clearer if the accounts of other treatments by anonymous practitioners people had tried are taken into account. They refer mostly to orthodox cures, remedies and procedures.

Two names are of significance; Dr. Libbrech and Dr. Rayé. Some of Van den Berghe’s patients had consulted both professionals. Auguste Libbrecht (1833-1894), an ophthalmologist, had founded the Ophthalmic Institute of East-Flanders in 1867. This clinic for eye diseases was situated in the Kraanlei (first district) and offered treatment for people of both sexes.97 Many patients suffering eye disorders told Van den Berghe that previously they had consulted this oculist who sometimes made use of the pracitce of leeching.98 Ch. Rayé (1811-1882) was a homoeopathic physician who had been consulted by quite a number of Van den Berghe’s patients. He sometimes made use of rather unconventional methods, allopathically and homoeopathically, to heal his patients. A five-year-old girl consulted Rayé with a knee injury and was treated

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96 Appendix 3 gives an over-view of the practitioners and of their professional field.
97 SAG, Wegwijzer der stad Gent en de provincie Oost-Vlaanderen voor het jaar 1869-1902 (Ghent, 1872).
98 A fifty-five year old man was treated with leeches by Dr. Libbrecht: Casebook 6 (1876-1879): p. 895.
with cow's blood; he rubbed it into her knee.\textsuperscript{99} Rayé did not practice medicine in Ghent, living in Vilvoorde (province of Brabant) near Malines some sixty kilometres away. He might have recommended Van den Berghe to his Ghent patients as soon as Gustave had set up his practice in 1869. The number of patients coming from Rayé was considerable during the first years of Van den Berghe's settlement in Ghent. It stopped completely after 1880 when Rayé was around sixty-eight years old and, presumably, had retired.

People experienced homoeopathy alongside traditional medicine. Mr. Michiels (50, profession unknown), for example, had been suffering from fits of pain in his chest, armpit, and left arm and heart area. First, an allopath had treated him without any result whatsoever. Thereafter, he underwent fourteen-months of treatment from J. Mouremans (1803-1874), a homoeopathic physician in Brussels, and his condition slightly improved. Mr. Michiels visited Van den Berghe for the first time in April 1869. Apparently he wanted to continue homoeopathic treatment, but a physician nearby was more convenient. Other sufferers, however, seem to have made a choice in favour of homoeopathy as they only had experience of this particular healing method. Yet, in most cases, it remains unclear why people exchanged one homoeopathic physician for another, especially when this decision forced people to travel. A person from Oosterzele, for instance, used to be a patient with Germaine De Cooman (b. unknown, d. 1889), mayor and homoeopathic physician in that town. This sufferer told Van den Berghe that he had received not only homoeopathic powders from De Cooman, but also that other physicians had given him drugs and salves. Why he now turned to Van den Berghe is not explained.\textsuperscript{100}

The men and women in Van den Berghe's clientele had often endured the orthodox practice of leeching (sangsues) and bleeding (saigner). Even at the end of the century sufferers still underwent these medical procedures and they were very specific as to how often and on which body part this practice was carried out.\textsuperscript{101} It seems that, for some, bleeding or leeching was a yearly ritual not only in cases of ill health but, more so, as a means of preventing disease. The results of this treatment were observable very quickly. One sufferer had two leeches the day before consulting Van den Berghe, as well as three weeks previously, and had undergone a large bleeding four weeks earlier.\textsuperscript{102}

The treatment by bleeding was based on the humoral pathology introduced by Hippocrates and specified by Galen. It distinguished four different body fluids (humores): blood (sanguis), phlegm (phlegma), yellow bile (chole) and black bile (melaina chole). Disease occurred when the balance

\textsuperscript{100} Casebook 1 (1865-1869): p. 733 (Mr. Michiels); Casebook 3 (1871-1872): p. 632.
\textsuperscript{101} E.g. Casebook 3 (1870-1871): p. 691 and 697.
between these fluids had been disturbed. Thus, bleeding was meant to restore the balance by removing superfluous fluids. There existed different means to do so. Internal cleansing was achieved by a clyster or purging (a treatment people could also apply privately). Leeches were placed on the body or a vein was opened to remove the affected blood. The doctrine of temperaments was connected closely to humoral pathology. People could be divided into four different temperaments, corresponding with the body fluids: a sanguine, phlegmatic, choleric or melancholic temperament. These temperaments were of importance for performing a bloodletting.  

As a homoeopath, Van den Berghe detested the 'allopathic' practice of leeching and bleeding, just as he loathed the use of purgatives and emetics. This dislike was expressed clearly in the casebooks; sometimes he did not persevere with the patient's story and introduced his own opinion. A patient who was first bled twice a year and, later on, underwent leeching was exposed to a monstrous abuse, 'abus monstrueux'. Yet, nearly one hundred of his patients (out of the 800 cases) had experienced this rigorous treatment at least once in their lives. Seventy-six of them spoke about leeching without any diffidence. It is often thought that the practice of bloodletting was relegated to medicine's past in the course of the nineteenth century. However, the stories of Van den Berghe's patients prove that leeching and bleeding were procedures endured still and believed by sufferers in the last quarter of the century.

At one time or another some people had undergone treatment in hospital (treatment category three). Most of the time the casebooks mention only the hospitalisation (être été en hôpital, allé au hôpital) without specifying which hospital, which conditions and for how long. However, it is certain that those who had been admitted to a Belgian hospital will have been treated according to orthodox principles, as no homoeopathic hospitals existed. Mr. Michel Vandenberghhe (not a family member) had been admitted to Saint Jean's hospital with jaundice where David Jacobs treated him with mercury for fourteen days. One patient had been hospitalised in a mental institution. Eduardus Duchaussois (68) consulted Van den Berghe in November 1872, three months after he had been released from the Hospice Guislain after a stay of two years. He came to Van den Berghe only once and would die a year later. Some could be very tenacious in searching for a cure for their condition. Emilie

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105 Lidy Schoon has pointed out that physicians (obstetricians/gynecologists) also still believed in this method. Cf. Schoon, De gynaecologie.
VandePutte (27) had been in hospital four times and had consulted four different allographs before she turned to Van den Berghe. The allographic physicians told her explicitly that they were unable to help her.¹⁰⁸

Stories about particular treatments suggest strongly that many more people will have been in hospital than the casebooks reveal. The procedures performed on them were often only carried out in hospitals. Those who had had surgery (operation) or a puncture (punctionner) or who had been cauterised (cauterisation) probably will have visited the hospital as an in- or an out-patient. Pier Cnudde (26), for example, suffered from polyps on his nostrils and had two unsuccessful operations in the last five years. It is likely that these had been performed in a hospital but he never said so. Initially, Van den Berghe cured him but, a year later, Pier returned with a re-occurrence.¹⁰⁹ One patient consulted Van den Berghe for a second opinion on having an operation. This man, suffering severe anal pain, had already tried allographic medication and was now advised to have surgery. He asked whether Van den Berghe thought the operation was needed and the homoeopath replied that he was not sure such a procedure would benefit the patient. Van den Berghe said he had more confidence in an internal homoeopathic cure and the patient started treatment with him. After three more consultations the man’s condition had improved considerably and he was able to pass painless stools.¹¹⁰

The last category of stories about people’s medical past concerns accounts of certain procedures, instruments and medical devices implying that the patient had made use of professional ‘allopathic’ medical practitioners. For example, a woman who had delivered by forceps will have had a professional obstetrician at her bed. Those who had been treated with injections, plasters and vesicants will have consulted an orthodox ‘allopathic’ practitioner and patients who mentioned having teeth extracted in the past probably saw a dentist. Finally, orthodox professionals had most probably treated people who had learned to live with a catheter or had endured an amputation.

Orthodox health professionals also offered other remedies such as hydrotherapy or water cure. Van den Berghe’s patients occasionally mentioned having tried the water cure. It was available widely in nineteenth-century Ghent as many private baths offered hydrotherapeutic programmes. The Byloke Hospital also had its own bath ward where people were treated on doctor’s orders.¹¹¹ Auguste Verhaeghe-deNaeijer, a sixty-year-old banker, mentioned

¹⁰⁹ Ibidem: p. 564.
the use of hydrotherapy. He had been afflicted with an eruption on his hands that had disappeared after a water cure in Aix la Chapelle. When he suffered from haemorrhoids he had been treated with leeches and now he tried homoeopathy to recover from headaches.\textsuperscript{112} Two patients had followed specific hydrotherapeutic treatment prior to consulting Van den Berghe, namely Kneipp’s water-cure, a combination of hydropathy, natural healing and herbal medicine.\textsuperscript{113} Mr. Denobele Vercruijsse (36) had endured a runny ear since his youth. An allopathic physician, the ear, nose and throat specialist Eugène Eeman, had improved the ailment, but had not cured the patient. There was a definite recovery after using Kneipp’s water-cure. A female patient from Malines wrote to Van den Berghe that she had tried ‘le système Kneipp’.\textsuperscript{114}

Unlicensed and Religious Medicine Previously Tried by Van den Berghe’s Patients

Is anything known about the use of unlicensed healers by Van den Berghe’s patients? Unfortunately, patients did not mention explicitly unlicensed healers, although their statement about seeing someone else without specifying who or what does not preclude this type of healer. Moreover, the sufferer was hardly concerned with the legal status of the practitioner he had turned to or simply may have been unaware of the illegal practice of some of them. However, Van den Berghe’s patients, judging from the casebooks, had been treated occasionally by unlicensed practitioners.

Pharmacists were mentioned sometimes because they were consulted about certain ailments for which they gave advice and medication. A pharmacist prescribed medication to a young woman (18) to stop her nose bleedings. However, the powder she was given aggravated her condition and, thus, she turned to Van den Berghe.\textsuperscript{115} A distinction between a pharmacist of ‘allopathic’ or homoeopathic denomination occasionally is made. Initially, one patient had visited pharmacist Dwelshauwer, Van den Berghe’s relative, who had a homoeopathic pharmacy. Yet, he was not a complete adherent of homoeopathy and advised this patient to have his gonorrhoea treated with allopathic injections.\textsuperscript{116} It was not unusual to enlist a pharmacist for medical advice, but this was mentioned in the casebooks on only a few occasions. Yet, it is only natural that people turned to a pharmacist, allopathic or homoeopathic,

\textsuperscript{112} Casebook 5 (1873-1876): p. 264.
\textsuperscript{113} Michael Stolberg, ‘Alternative Medicine, Irregular Healers and the Medical Market in Nineteenth-Century Bavaria’, in: Jütte, Eklof and Nelson (eds.), Historical Aspects of Unconventional Medicine, 139-162, q.v. 150.
\textsuperscript{115} Casebook 13 (1889-1891): p. 545.
instead of to a physician. The latter not only charged his patient for the medication but also there was payment for the consultation itself.

Sometimes, Van den Berghe’s condemnation of unlicensed healers and licensed allopathic practitioners affected his case-taking. He was quite expressive in judging allopathy and sometimes called healers who had been consulted previously by his patients, charlatans. Van den Berghe occasionally blamed allopathy for the condition of his patients. He noted that 'l'allopathie a fait un abus coupable' (allopathy has made a condemnable abuse) when describing a male patient who could no longer pass stools without purgatives.117 A police officer who visited Van den Berghe with a chest ailment had suffered previously an eruption on his scalp for which he had consulted another practitioner. Van den Berghe’s judgement of this other type of healing was far from comforting and he called the practitioners ignorant quacks who did not care for the life of their fellow man.118 His objections were not always this explicit. In some cases, he made use of punctuation (question marks or exclamation marks) to clarify his surprise or, even, contempt.

The carrying out of abortions was illegal and doctors generally were not very eager to perform this procedure. Yet, there indeed existed an abortion practice in Belgium; women aborted themselves and secret remedies were always available. Knowledge about abortionists and abortifacients could be gained via newspaper advertisements, although always in guarded terms. Midwives often offered their services if someone wanted to ‘restore her monthly period’, as a result of which they got involved in the illegal practice of medicine. It is difficult to estimate the number of abortions carried out in Belgium but, the evidence from numerous advertisements for abortifacients and abortionists, suggests that it must have happened very often.119 The women in Van den Berghe’s practice, interestingly, did not speak about abortion and it seems as though only one woman had her pregnancy terminated deliberately. This twenty-nine year old patient said she had been ill since the day a practitioner had performed an abortion by inserting and rotating an instrument in her womb some ten years previously.120 Such an explicit description of abortion was not given in any other case. However, concluding that Van den Berghe’s female patients abstained from such a practice would not be correct as they could just have not given him this information. Moreover, Van den Berghe’s French notes do not differentiate between a miscarriage and an

119 Celis, 'Abortus in Belgïë', 201-240.
120 Casebook 6 (1876-1879): p. 241. ‘… il y a 10 ans étant enceinte un médecin! a provoqué l'avortement en introduisant dans la matrice un instrument qu’il a tournée dans tous les sens – depuis lors est restée malade’.
abortion as both the involuntary and the deliberate termination of pregnancy are described by the term 'avortement'.

Patients did tell Van den Berghe about turning to religion or religious people to overcome disease and suffering. A male patient, burdened with mental problems, received homoeopathic treatment from Father D'hondt, who prescribed 'acon. + cof.' 6th dilution, a homoeopathic remedy. Clearly, this representative of the church was not a licensed practitioner. Religious means of expression were also tried to overcome suffering. Sufferers had turned to saints and the like on two occasions. One patient, who had been suffering diarrhoea for eleven years, was cured after a journey to 'holy land', terre sainte. Odyle De Bruyckere (23) went on a pilgrimage to Lourdes. She had severe pain in her arm and hand and, on the third day of praying to the Holy Virgin, the pain in her arm (not her hand) disappeared. Although, occasionally, Ghent's population displayed a reviving religiosity, Van den Berghe's patients did not reveal a strong belief in the healing powers of religion.

The stories of the therapies and remedies patients had experienced in the past make it particularly clear that much was available and much was used. People, without any hesitation, shared these experiences with their homoeopathic physician. They had experimented extensively, inter-changing between licensed and unlicensed medical practitioners or various home remedies. If one medical attempt had not helped them to overcome their conditions, sufferers considered their 'shopping' as ordinary and justified. The analysis of the medical practitioners that had been consulted previously by Van den Berghe's clientele revealed that, occasionally, some patients had not been using anything else than homoeopathy; leaving aside the question of whether they did so in private or with the help of others (professionals or not). Patients who only used different types of unorthodox medicine may have been present in Van den Berghe's clientele but explicit stories have not been found. The 'shopping patient', on the other hand, was omni-present, narrating previous medical ordeals and successes.

3.4 Recapitulation

As a heavily industrialised city with its growing and packed population in need of housing and work, Ghent was not easy to live and survive in. The insalubrious living conditions, meagre diets, long working hours, prolonged pregnancies etc. affected resistance and made a predominant part of the

121 Casebook 13 (1889-1891): p. 24. Aconite (Acon.) or monk's hood is often administered when people are dealing with fever and colds. Furthermore, it is of use in cases of neuralgia and fits of fear. Coffea (cof.) is very suitable for nervous patients. Cf. Voorhoeve, *Handboek voor homoeopathie*, 67, 90.

population (the working classes) very susceptible and vulnerable to the slightest of affections. Life expectancy was low and many newborns never reached the age of one. The unhygienic conditions in the city, much stagnant water, no sewage system, beluiken shared by too many people, allowed disease to spread easily and, once in a while, Ghent was startled by life-threatening epidemics. Eventually, the government, fearing social unrest as well as contamination, educated the 'masses'. A hygienic and morally edifying lifestyle was promoted and, at the same time, public works and sanitary measures were started. By the end of the century the general living conditions in Ghent had improved, as well as the socio-economic circumstances of the average workman. Nevertheless, the threat of disease and disease itself never disappeared from Ghent society and neither did all types of medical personnel and treatments. Ghent's 'medical market' seemed a patchwork of healing options available to people wanting or needing medical assistance. Whatever sufferers required, to experiment at home, to consult a professional licensed practitioner or to obtain the advice of someone outside the official system, several courses were open to them.

Self-treatment was widespread and home remedies could be obtained via a personal network of family and friends, by reading remedy-books and health-advice guides. Then, the medicines were available via advertisements, apothecaries and druggists. Yet, homoeopathic medication, or medicine chests suitable for home use were never recommended in advertisements. It was only Van den Berghe who advertised his homeopathic practice. Sufferers interested in homoeopathic family medicine could predominantly buy only French-language health-advice guides. Van den Berghe's book was in Dutch, but not suitable for self-treatment. In addition to the option of family or home medicine, medical professionals offered their services to the sick. Licensed medicine, performed by qualified personnel, was available from all types of practitioners; physicians, midwives, ophthalmologists, dentists etc. These professionals owned private general practices, or they had joined one of the many municipal or private institutions for health care. If treatment according to Hahnemann's principles was definitely wanted an appeal could also be made to physicians with a homeopathic background. Finally, unlicensed and religious medicine could also be found in the city. Unqualified healers, including people of the Church, gave consultations, providing ointments, pills and medicines for a diversity of ailments. In times of epidemics people, temporarily, resorted to devotion and worship of saints to avert the health threat, just as they did, occasionally, during personal suffering.

The past therapeutic careers of Van den Berghe's patients reveal the diversity of medical practitioners and healing methods, treatments and remedies available in Ghent. These stories, more importantly, demonstrate, at
the same time, that his patients were prepared to use all these options. Patients reported to Van den Berghe that they had tried all types of medical services, instead of rigorously clinging to one specific medical method. Nevertheless, it seems that, besides the particular and traditionally large share of home medicine in combating disease, these experiences were gained principally in the field of professional, licensed medicine. This is of interest as friend and foe had heard stories about orthodox medicine being harsh and, still, largely inadequate. Many of Van den Berghe’s patients had ‘shopped around’ in the past, searching for whatever available cure to relieve their agony. Indeed, they might continue to do so, even whilst being in the caring hands of Van den Berghe.
Citizens Suffering: the Ghent Patients’ Profile

Tuesday 17th August 1869. Thirty-three year old Clementia Marisal turns to Van den Berghe for the first time. She is unmarried and still living with her parents in the Sluizeken in the third district. Her father earns a living as a manufacturer, she provides for her own income as a (non-specified) merchant. This chestnut-brown haired woman has been afflicted with asthma for ten years and she has visited several ‘allopaths’, who only left her in despair. It is on the recommendation of a friend that she now consults Van den Berghe, but she immediately tells him that she has no confidence in this new attempt. Miss Marisal suffers from impeded respiration and constant coughing accompanied by mucus. Initially, her extremely ill appearance makes Van den Berghe think that she has phthisis (pulmonary consumption or tuberculosis). However, auscultation and percussion reveal that her lungs are still intact. She tells him that her ailment is hardly bearable; she has difficulty in sleeping as the asthma fits force her to get out of bed to open the door and windows. Van den Berghe prescribes a ‘régime habituel’ (ordinary diet), lachesis¹ 30 (10 globules) and prohibits specifically the use of nitrate paper, a form of self-treatment for tightness of the chest that Miss Marisal is constantly burning in her room to ease her asthma fits. The second consultation takes place within five days and her condition has improved already. Miss Marisal’s condition worsens in mid-September after she has been struck with terror, witnessing a fire. However, sixteen consultations and six months later Miss Marisal is cured from her asthma and, when Van den Berghe publishes this case in July 1878, she has not had a relapse.²

Clementia is one of thousands of Ghent citizens who made use of homoeopathy in the second half of the nineteenth century. She is also one of many who felt the need to call upon the services of a professional to restore health. Yet, she was a merchant of independent means and, hence, financially able to choose any form of medical care. However, imagine a factory worker who, after a

¹ Coming from the poison-gland of the lachesis-snake, this medication is used in case of illnesses that resemble the course of sepsis (e.g. typhus, diphtheria, scarlet fever). It is prescribed also for throat ailments and for various complaints of menopausal women, especially when they are skinny and melancholic. See J. Voorhoeve, Homoeopathie in de praktijk. Medisch handboek (Zwolle: La Rivièr e & Voorhoeve BV; 13th ed., 1972), 107-108.
fourteen-hour day of hard work, returns home ill. He is living in a relentlessly
growing city where poverty, hunger and disease strike many; trying to make
ends meet for eight children and a wife. Would he do anything to improve his
condition or, instead, considering his personal situation, have no option but to
return to work the next morning, however ill?

This chapter is concerned with the background of Ghent people who
chose to consult Van den Berghe. A picture is drawn of these sufferers' personal
circumstances, where they lived and how they earned a living. The
aim is to determine whether social background may have influenced decisions
about consulting this homoeopathic physician. It has been argued that clients
of British homoeopaths were not distributed randomly among all social strata
and that the use of homoeopathy, instead of being based necessarily on medical
considerations, was often the product of social circumstances and influences.
Therefore, personal preferences or individual considerations are passed over in
this chapter to concentrate on the characteristics of the patients as a group.

The results are derived from and based on two samples of patients living
in Ghent. The first sample contains the Ghent patients registered in Casebook
One (1865-1869), Casebook Eight (1881-1882) and Casebook Seventeen (1898-
1901) excluding the Ghent patients recorded in the second sample. The first
sample is used to determine the development in Van den Berghé's practice in
the course of time in order to establish whether the composition of the Ghent
clientele underwent any changes. This sample consists of 1,385 patients. To
obtain a more continuous cross-sectional picture without time-specific elements,
a second sample has been taken selecting roughly each fiftieth Ghent
patient mentioned in all eighteen casebooks. The second sample has been taken
to get a more general profile of the Ghent clientele throughout the whole period
of Van den Berghe's practice and consists of 441 patients. Of these 441 patients
additional information on personal circumstances and the social background of
patients has been retrieved, by analysing the birth, marriage and death
certificates and the straatnamenregister (street name register). Both samples
added up to a total number of 1,826 Ghent patients which is approximately

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3 Cf. Anne Hilde van Baal, 'Being Ill in the City: Nineteenth-Century Patients in Ghent and
their Experience with Homoeopathy', MedGC 22 (2003), 147-175.
4 Phillip A. Nicholls, 'Class, Status and Gender: Toward a Sociology of the Homoeopathic
Patient in Nineteenth-Century Britain', in: Martin Dinges (ed.), Patients in the History of
Homoeopathy (Sheffield: EAHMH, 2002), 141-156, q.v. 141.
5 Chapter 6 treats the subject of the patients' personal experiences, the disorders that
required medical care and their behaviour towards Van den Berghe. There, the possible
relations between patients' consultation behaviour and their gender, profession and living
districts will be discussed.
6 For example, Van den Berghe's Dutch publication on homoeopathy may have drawn a
specific public to his practice in 1881-1882.
7 In the municipal archive of the city of Ghent.
fourteen per cent of the entire Ghent clientele. Thus, the two samples in combination produce a multi-purpose idea of the Ghent clientele at large and of the individual patient’s circumstances.

4.1 A Patients’ Portrait: Age, Gender and Marital Status of the Clientele

The general features of the entire clientele have been addressed previously and, here, a sample of Ghent patients will be analysed. The differences between the overall and the Ghent clientele will be outlined and a comparison with the composition of Ghent’s population will be made.

Age

Graph 1 gives an insight into the number and percentage of Ghent patients per age category, based on their ages at the time of their first consultation with Van den Berghe. It reveals that adult patients, i.e. men and women above age sixteen, were in the majority: 1,439 or 79 per cent. His clientele consisted of eighteen per cent of young sufferers: 320 patients were age sixteen or younger. The ages of sixty-seven patients, or four per cent, were not registered.

Graph 1. Van den Berghe’s New Ghent Patients per Age Category, 1869-1902 (based on the combined sample of 1,826 Ghent citizens)

The age category 0-16 primarily consists of children between 0 and 10 years old, 234 out of 320. A considerable number (166) of babies and toddlers (age five or younger) were taken to Van den Berghe for treatment. More than half of the visiting sufferers were between seventeen and fifty years old. The age-category

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8 About fifty-seven per cent of all patients (= 12,560 patients) resided in Ghent, therefore the samples represent appr. fourteen per cent (1,826) of all Ghent patients. Of 67 of these sampled patients the gender was unknown.
Table 1. Average Age of New Ghent Patients According to Gender (based on the sample of 1,385 patients: 1869; 1881-1882; 1898-1901)\(^9\)

<table>
<thead>
<tr>
<th>Casebook</th>
<th>All</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (1869)</td>
<td>33.6</td>
<td>31.6</td>
<td>35.6</td>
</tr>
<tr>
<td>8 (1881-1882)</td>
<td>30.3</td>
<td>28.4</td>
<td>32.1</td>
</tr>
<tr>
<td>17 (1898-1901)</td>
<td>34.6</td>
<td>34.5</td>
<td>34.7</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>32.8</strong></td>
<td><strong>31.5</strong></td>
<td><strong>34.2</strong></td>
</tr>
</tbody>
</table>

The average age of Ghent patients, adults and children, was 32.8, when consulting Van den Berghe for the first time. Female patients were, on average, more than two years older than the men (Table 1). This average age was subject to fluctuations between 1869 and 1902. Ghent patients were, on average, younger than non-Ghent patients, but Ghent women were slightly older than female patients who lived elsewhere (Table 2).

Table 2. Average Age of New Non-Ghent Patients According to Gender (1869; 1881-1882; 1898-1901)\(^10\)

<table>
<thead>
<tr>
<th>Casebook</th>
<th>All</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (1869)</td>
<td>35</td>
<td>37</td>
<td>33</td>
</tr>
<tr>
<td>8 (1881-1882)</td>
<td>34.5</td>
<td>36</td>
<td>33</td>
</tr>
<tr>
<td>17 (1898-1901)</td>
<td>34</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>34.5</strong></td>
<td><strong>35.6</strong></td>
<td><strong>33.3</strong></td>
</tr>
</tbody>
</table>

The new Ghent patients were, on average, older than the average Ghent population.\(^11\) This may have three reasons. Firstly, the older people became the higher the chance of falling ill and, thus, the need to consult a physician. Secondly, the decision to visit Van den Berghe might have been taken long after all other healing options had proved ineffective, as in the case of Clementia Marisal. Indeed, the interest in homoeopathy often has been explained by

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\(^9\) Cf. Chapter 2, p. 53. Based on the data (used in Chapter 2) about 2,552 patients from everywhere (Belgium and abroad) mentioned in Casebooks 1, 8 and 17.

\(^10\) Ibidem.

\(^11\) Cf. Chapter 3, 76.
Citizens Suffering

discontent with orthodox medicine. Yet, it still has to be ascertained whether there was an awareness of consulting a homoeopathic practitioner. Finally, the lower average age of the total Ghent population was primarily related to its enormous workforce. Perhaps, Van den Berghe’s Ghent clientele did not mirror the city’s population as, for instance, the clientele probably would display a higher average age if it consisted of a rather small number of labourers. Nevertheless, it is not surprising that the number of his patients above the age of sixty dropped considerably. It was not until the late nineteenth century that living standards and, thus, the average age of death increased. The life expectancy of the average Belgian at birth was only forty years in the middle of the century. The mortality rate (number of deaths per 1000 inhabitants) in Ghent dropped from 34 in 1866 to 20.8 in 1896 and, in Belgium, the number of people reaching old age increased. However, the ‘privilege of longevity’ was primarily reserved for women.

Gender

An investigation into the working and living conditions of Ghent’s cotton workers was undertaken in the mid-nineteenth century. One thousand men and one thousand women, amongst others, were questioned about their physical and mental condition. 782 men stated that they enjoyed perfect health and 893 women claimed to enjoy good health. The complaints of the men and women who were of ‘ailing’ or ‘average’ health did not differ considerably as both suffered pulmonary affections, headaches and gastralgia. Some women endured the consequences of childbirth whilst men claimed, twice as often as women, to have suffered serious illness. The two doctors who carried out the inquiry came to the interesting conclusion that the factory woman was healthier than the factory man. In contrast with the general perception about women’s delicate and weak constitution ‘the woman better endures the influences of factory conditions than the man’.

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12 The theme of dissatisfaction and the question of the process of choice will be discussed in Chapter 6.
13 This subject will be touched upon later in this chapter.
16 Mareska and Heyman, Enquête, 190.
The casebooks suggest that women were more inclined to consult Van den Berghe than men. However, this should not be interpreted as indicative of the general attitude of Ghent women with respect to illness. Female patients dominated amongst Van den Berghe’s Ghent clientele: 58 per cent women and 42 per cent men (Graph 2). The gender of ten people is unknown. If the children are excluded from this gender analysis, this female proportion rises to 60 per cent. The sex ratio of his new Ghent patients changed markedly over the years as in 1869 the sex ratio was 80, but at the end of the century it had dropped to 58. In 1881-1882, it had been approximately 68. As the gender pattern of the Ghent clientele deviated from that of the entire clientele, the preponderance of women increased over time.17

This general female domination is not easy to explain, but logical suggestions can be offered. Ghent, in any case, had more female than male inhabitants as, economically, this industrial conglomerate had much to offer in terms of factory work and domestic service. Moreover, the double task for some women of being a working mother with ‘two jobs, only one of them waged’18, undoubtedly, will have affected their physical and mental state of health. Yet, men often focussed professionally too much on one single field, which affected their health as well. Despite the positive findings of the mid-nineteenth-century inquiry into women’s health, other female textile workers enjoyed lesser health. Female workers in Bremen (Germany) in the textile industry at the turn of the nineteenth century had more frequent illness and

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17 Cf. Chapter 2, Table 2.
18 Penn Hilden, Women, Work and Politics, 58.
were affected longer than their male colleagues.\textsuperscript{19} Finally, homoeopathic treatment itself might have been attractive for women, because of its presumed mildness or as a cheap method for self-treatment.\textsuperscript{20}

\textit{Marital Status and Family}\textsuperscript{21}

Marie DeRycke was twenty-two years old when she got married and would have eleven children with her husband Livinus, a weaver. Yet, her marriage was not happy as she often felt threatened by her husband. Marie reported to the police in 1903 that her husband was ‘bold’ towards their children and herself. Livinus especially tried to incite his sons to fight. Nevertheless, she would stay with him until the day she died.\textsuperscript{22} The archives, in this case, reveal a little more about the quality of marital relations; data that are unique and, in other cases, hardly available. Normally, the municipal records only reveal if and when a person had got married. The casebooks also occasionally give away whether a woman was married or not as in Belgium it was (and still is, just as in France) common to use different terms of address for unmarried and married woman. Van den Berghe employed this difference; he referred to unmarried women as \textit{Mademoiselle} and married women as \textit{Madame}. If a woman had been widowed he wrote down the word \textit{Veuve} (widow). No such different titles existed for men; in their case the municipal archives had to reveal their marital status. Yet, occasionally the patients’ files disclosed that the man who consulted Van den Berghe was a widower or married.

If anything more is known about the marital status of Van den Berghe’s patients most of them seem to have been married at the time of their first consultation; some for the second or third time (Table 3). The majority of these married patients were women.\textsuperscript{23} The unmarried sufferers were mainly between

\begin{itemize}
  \item Of nearly forty per cent of the people in the combined sample, 695 out of 1,826, information has been found on their marital status and/or family situation.
  \item Based on the notation used for married/unmarried and widowed women.
\end{itemize}
seventeen and thirty years old at their first consultation with Van den Berghe. Some of them would remain unmarried for the rest of their lives, others would eventually get married.

Table 3. Marital Status of Van den Berghe’s Adult Ghent Patients, 1869-1902 (based on the sample of 1,826 Ghent patients)²⁴

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>All Patients</th>
<th>Male Patients</th>
<th>Female Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>419</td>
<td>130</td>
<td>289</td>
</tr>
<tr>
<td>Separated</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Unmarried</td>
<td>215</td>
<td>46</td>
<td>169</td>
</tr>
<tr>
<td>Widowed</td>
<td>57</td>
<td>12</td>
<td>45</td>
</tr>
<tr>
<td>Unknown</td>
<td>744</td>
<td>385</td>
<td>359</td>
</tr>
<tr>
<td>Total</td>
<td>1,438</td>
<td>574</td>
<td>864</td>
</tr>
</tbody>
</table>

Three are known to have lived separately from their spouses, but any legally divorced have not been found. Finally, fifty-seven patients were living in widowhood. Rosalie Schelstraete, born Uijtterhage (24), was the youngest widow. She turned to Van den Berghe on 28th October 1888; five months after her husband had died of phthisis. She consulted him only twice, coughing and spitting blood. The results of the treatment remain unclear, but within a year she would die.²⁵

The family situation differed as some patients had children without being married; others who were married never experienced parenthood. Four women confessed that they had had children without having had a husband. Maria VanDamme, for example, had given birth to a daughter in 1876 at age nineteen, Carolina Adrienna. Carolina, unlike many other children, would grow up to adulthood and, when she was sixteen, her mother married and, thus, ensured her legitimacy. The girl partly grew up in the VanderDoncktdoorgang, in the heart of Ghent’s red light district, where her mother ran an inn. The neighbourhood was rough and Maria fell foul, on several occasions, of the law. She had to appear in court on six occasions for offences such as serving alcohol after hours, nuisance at night and for

²⁴ Thus, the 320 children aged 0-16 have been excluded from this analysis. Of the remaining 1,506 patients another 68 were left out because their ages and/or gender were unknown. If both the age and gender of a person were unknown, he or she was excluded once and not twice. Gender unknown: 67, age unknown: 10, people of whom age and gender were unknown: 9. 67 + 10 = 77 - 9 = 68.

Citizens Suffering

wounding. Servant Romanie would have two illegitimate children, one of whom died a year after it was born. Pharaïlda, also a servant, lost her child within a week of giving birth. The fact for some married women, that they did not have children was argued to be the cause of suffering. Madame Colson suffered mental weakness caused by grief and anxiety over not having any children since her marriage six years previously.

However, many patients had or would have large families with offspring and, on average, they would produce 3.7 children. The family density depended on the composition of the family, i.e. whether the parents were married, unmarried, separated or widowed. At least twenty-five people were the only still living parent. The largest family represented in the sample taken from Van den Berghe’s Ghent clientele were the VandenVeegaete’s. The mother of this family, Amelia, had given birth to sixteen children. Yet, when she consulted him in 1884 she already had lost ten of them. Sometimes, parents took along all, or at least some, of their children for medical advice, which, arguably, made Van den Berghe develop into a family physician.

4.2 Sufferers and Their Environment: Living and Working in an Industrial Bulwark

Although data regarding the clientele of other Belgian homoeopaths are not available, it has been argued that those from the ‘higher echelons’ were the main supporters. The prices for homoeopathic products, the predominantly urban character of the therapy being primarily available in urban surroundings and the publication of popular works for the well-to-do, are strong indicators that Belgian homoeopathy was a matter for the higher social classes. The Belgian upper classes were not only supporting financially homoeopathic

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28 Casebook 17 (1898-1901): p. 592
30 Based on the second sample of 441 Ghent patients. Archival research revealed that 205, at one stage or another, would have children or, on the contrary, never would reproduce. Three widowed and sixteen married people never had children.
31 Casebook 10 (1884-1885): p. 179 A-F.
32 This development will come up for discussion in the next chapter on children and families as patients.
dispensaries, their high grade of medicalisation also made contact with homoeopathy easier. In addition, the higher classes were most susceptible to homoeopathy as their literacy enabled them to be acquainted with the controversy between allopaths and homoeopaths discussed in newspapers and magazines. A further argument is that the more affluent had a personal financial position which made them independent in their therapeutic choices. However, these arguments are based on ‘official sources’ such as books and homoeopathic periodicals published by members of the homoeopathic movement and not on primary data such as patients’ files. Consequently, the appeal of homoeopathy to the lower and middle classes has been disregarded.

*Patients’ Occupations*

The various occupations held by the Ghent patients, besides Van den Berghe’s willingness to treat poor patients for free, demonstrate that his clientele consisted of people from totally different social backgrounds and, consequently, reflects Ghent’s population and society at large. Members of the upper classes of society especially visited Van den Berghe at the beginning of his Ghent practice. Nobility, landowners, industrialists and those of private means all made use of this homoeopaths’ knowledge. Van den Bergh e noted the titles of the nobility and, accordingly, it can be stated that, over time, the interest in Van den Bergh e or in homoeopathy by those of high status diminished considerably. New patients of noble origin no longer appeared in his practice and by the end of the century there were practically no members of the nobility left amongst his clientele. The lower middle class, small shopkeepers and craftsmen, and the working class, on the contrary, increasingly started to consult Van den Berghe. Although noble people disappeared from his clientele, their interest in and use of homoeopathy may have continued outside his practice. Homoeopathy remained in use within the noble family De Kerchove d’Ousselghem long after contact with Van den Berghe had ceased. Three-year-old Maria De Kerchove was taken to Van den Berghe in August 1869. She would be his patient on only that occasion, but years later, when she lived at the princely court in Bruges, she still used homoeopathy.

Graph 3 gives an insight into the occupations of the patients at the time of their first consultation with Van den Berghe. If the patient was the head of the household, his profession was taken, if not, the profession of the husband or father was taken as a starting point. It becomes clear immediately that people of

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34 Letter from Baron De Kerchove d’Ousselghem, 17-12-2001. The grandmother of Maria, Virginia De Kerchove d’Ousselghem born De Clerque Wiscoq, is a direct ancestor of his Lordship. He wrote that his brother -in-law told him that: ‘[...] quand il allait visiter sa grand’mère à la Cour du Prince a Brugge, il avait vu chez elles une grande quantité de fioles de médicaments homéopathiques’.
small means (group 1), servants, wage labourers and factory workers, made up the largest part of the Ghent clientele.

Yet, one factory worker was not like another, i.e. some were very skilled workers who earned a reasonable living. The Van Wichelen family, for example, consisted of five people of whom four worked in the textile industry. The father of the family, Augustinus, earned a living as a weaver in the Louisiana factory. He, his wife and two of their three working daughters

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35 Of the 1,385 patients from the first sample (three different casebooks), 94 had an occupation mentioned in the file. More detailed information with regard to profession and addresses has been gathered on the 441 Ghent patients of the second sample (see page 112). Eighteen patients were registered as not having a profession, four patients were retired and of eight patients the occupation remains unknown. Seventy-six children and women, accompanied by their fathers or husbands, were not taken into account, as they, as head of the household, were already included in the sample. Of 429 (94 + 335) patients the occupation has been processed.

visited Van den Berghe between 1900 and 1902. Augustinus will have been a highly skilled worker as he received a royal decoration second class. More so, they never received gratis treatment confirming that the family was viable financially.

People who were active in trade and industry (group 2) formed the second largest occupational group. However, the financial means and, therefore, the personal circumstances within this second group differed extremely. Some were large merchants or manufacturers; others were self-employed or small craftsmen scraping a living. The personal circumstances of patients from manufacturing families were of a totally different order than those of barbers, brewers and grocers who are included also in the second occupational group. Manufacturers could belong to the upper strata of society, with money and status. The factory workers earning a living in textile companies are in group 1, group 2 comprises their masters. Some members of the wealthy families of textile barons made use of Van den Berghe’s treatment, especially during the early years of the practice. Nathalie and Leon Baertsoen were the wife and son of the textile manufacturer Pierre Joseph Baertsoen (1799-1881). Nathalie (age 50) suffered from chronic tuberculosis for which she consulted Van den Berghe on ten occasions between May and November 1870. Although specific notes on the results of the treatment were not made, she only died in 1893. Thus, it is likely that her condition improved or, at least, did not deteriorate. Her son Leon (b. 1845), the youngest of four children, consulted Van den Berghe for asthma that he had developed two years previously. After nine consultations in 1870-1871 he would not return. When his father died in 1881, Leon took over his position at the mill. The Baertsoen factory employed 250 people in 1862 and, unlike other companies, Beartsoen did not have to fire anyone to overcome the cotton crisis; they just introduced a shorter working day of seven hours. Leon managed 350 people in the Baertsoen-Buysse mill in 1890.

Another ‘manufacturing’ patient was Joseph de Hemptinne, director of the de Hemptinne Jos. mill and father of Josephine (age 18) who also consulted

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40 Scholliers, De Gentse textielarbeiders, File 6, 23, 28.
Citizens Suffering

Van den Berghe.41 He was a conservative Catholic who once had an audience with the Holy Father and, in consequence, was known also as ‘the pope of Ghent’. He founded the Crusaders of Saint-Peter in 1871, a society of militant conservative Catholics which sought a monopoly of the Church that was extremely opposed to socialism and liberalism.42 Josephine met Van den Berghe five times that year suffering from insomnia, which she explained by the grief over the death of her mother a year earlier.43 Josephine was described as being vivid and impressionable. She had consulted previously Dr. Libbrecht, an ‘allopathic’ ophthalmologist. The de Hemptinne mill employed 350 workers in 1872; in 1885, when its name was changed to NV Florida, this number had grown to 580.44

Maria Desmet-Ghekière was married to Adolphe Desmet (1824-1889), manager of the Desmet textile mill. She started consulting Van den Berghe in 1869 at the age of thirty-six and she remained in his care until 1872.45 They never had children and, since the time of her marriage some twenty years ago, she had had menstrual problems. However, she actually consulted Van den Berghe with regard to mental problems as she felt anxious, absent-minded and frightened and often had palpitations, migraine and constipation. She visited Van den Berghe seventeen times and her file reveals that her mental state eventually improved. The mill of Mr. Desmet offered employment to 310 people in the early 1870s. It kept up with the developments in the de Hemptinne factory in the 1880s by employing more people and becoming a limited liability corporation named Louisiana. Maria Desmet outlived her husband and died in March 1890 leaving, in her name, 250 franks to the poor.46

Agriculturalists (group 3), not surprisingly, considering the urban surroundings, and military or police personnel (group 4) were hardly present among the sample of Van den Berghe’s patients. Two people earned a living in agriculture. One of them, Nathalie Ghijselinck-Verzeelen (63), was, at her age, probably not very active. Five people were connected to the army or the police force. Mr. Parent was a forty-year-old third lieutenant suffering from liver

41 Joseph’s visit to Van den Berghe was mentioned only in one of Van den Berghe’s small notebooks, he was never registered officially at his own page in one of the formal casebooks. Cf. AVB, Notebook ‘Symptomes médicamenteux observés sur mes malades et observations clinique’, inv. no. 30, from 1871, 197 pages, 148-149.
46 Scholliers, De Gentse textielarbeiders, File 6, 25-27; Rapport sur l’administration et la situation des affaires de la ville de Gand, 1890 (Ghent, Ad. Hoste, 1891), 44.
atrophy. He had taken a variety of different drugs to counteract his liver condition, without any improvement, before becoming Van den Berghe's patient. The nineteen-year-old soldier V. consulted Van den Berghe with balanitis (swollen penis or inflammation of the glans), which caused erection problems and a little secretion. He acquired his sexual ailment five days prior to his visit to Van den Berghe. V. did not offer an explanation other than that he had not been with a woman.

Two patients, furthermore, worked for the Ghent police force and one patient was married to a policeman. Both unmarried police sergeants also endured sexually related disorders. Guilllaume S. (29) had crusts all over his face, an ailment he thought to be caused by his excessive propensity for masturbation. He told Van den Berghe that he never longed for women but, instead, masturbated twice a day. Ivo D. (31) had a venereal disease and suffered pain in the urethra and seminal tube. His genital disorder had started some six years earlier and treatment by other physicians had not helped; nor did he profit from Van den Berghe's healing methods. Forty-four patients in the Ghent sample belonged to the intelligentsia (group 5), as they were students, teachers, artists and twenty-six members of the clergy. Group 6 consists of thirty-seven patients, most of them were people of private means or proprietors.

Traditionally, homoeopathy had always its attraction for priests and other religious people, both as practitioners and as patients. A good number of homoeopaths, whether in Protestant or Catholic countries, originally had studied theology or were descendants of clerical families. Clergymen supported the battle for the establishment of homoeopathy and always had been amongst the clientele of homoeopaths. It is argued further that this clerical support was the result of a firm belief in the effectiveness of

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Citizens Suffering

homeopathic medicine, a conviction that is connected strongly with the appreciation of homoeopathy's mildness. Homoeopathy was very suitable for pastoral medical lay practice, just as it was suitable for self-treatment. Homoeopathic appreciation of the spiritual and the immaterial, the idea of illness being caused by the disruption or damaging of the life force, fitted perfectly with the world view of clergy.

The background and education of Belgian homoeopaths does not reveal such a religious connection, as none of the homoeopathic physicians practising in the last quarter of the nineteenth century seem to have studied anything other than medicine. Conversely, they often had a career as army doctors. This was not unusual as, in Russia, military doctors applied this healing method and, occasionally, soldiers and officers were treated homoeopathically. The same medical treatment was used, for example, in the Austrian and Italian Army and elsewhere.

People with a religious profession or calling were no exception within Van den Berghe's clientele, nor did they live only outside Ghent. At least 257 patients were vicars, sacristans, priests etcetera or had chosen a sequestered life as nuns (sœur), monks (frère) or beguines. Some were students attending a seminary. Nearly two-thirds were women and forty percent of them were beguines. Gent had several beguinages, such as the St. Elisabeth beguinage that had a small ward where old and needy beguines as well as other poor women were cared for. Many people from all layers of society were supported here during the 1832 cholera epidemic and, from the end of the 1840s, it also had a ward for the insane. The beguines were forced to leave in 1874 as the whole area became urbanised. Some of Van den Berghe's patients might have belonged to this order.

The type of residence of the other beguines was specified as 'grand' or 'petit' (large or small) beguinage. The small beguinage was situated in Ghent, the grand beguinage at the border with St. Amandsberg, less than 1.5 kilometres east. The petit beguinage was on Violettenlei that joined Stationstreet where Van den Berghe had his practice. Women who lived here had to walk only to the end of

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51 Stolberg, 'Homöopathie und Klerus', 136-142.
52 Van Praet, De receptie van de homeopathie, 103-109.
54 Looked for in all eighteen casebooks. A beguine is a lay-sister who lives in a beguinage (court of almshouses) together with kindred spirits.
the street; the walk from the grand beguinage took less than half an hour. The short distance for the petit beguines to Van den Berghe made it very easy to consult him. Women who lived in the same beguinage advised each other on all sorts of things, including medical issues. Therefore, it is not surprising that, occasionally, they consulted Van den Berghe together.56

This analysis of the social background of Van den Berghe’s patients reveals that his practice underwent a ‘popularisation’. Initially, those who visited him often belonged to the higher social rankings in society. Their interest in Van den Berghe’s homoeopathic treatment eventually declined and the clientele increasingly came to consist of sufferers from the lower middle and working classes. Moreover, the number of poor patients who were treated free of charge increased. The preference for homoeopathy, which was fashionable and expensive, among the British social elites has been explained as a statement regarding their exclusive social position and a symbol of social status as well as about their particular therapeutic decisions from the perspective of status group exclusiveness.57 However, these conclusions are based on what is known from the homoeopathic press (the upper class patients) from the hospitals (obligatory entry) and from homoeopathic guides. Van den Berghe’s casebooks, on the other hand, telling the stories of all sorts of patients, are more representative. Moreover, many homoeopaths claimed that homoeopathic medicines were cheaper than allopathic drugs. Nevertheless, Van den Berghe’s dispensary for gratis treatment became busier over time, thus, making homoeopathy available to the poor and diminishing the exclusiveness, which may have restricted sufferers from the high social classes.58

Patients’ Residential Districts

The districts where the patients lived, besides professions, might be helpful in reconstructing their social background. Ghent was divided into various districts all of which had their own peculiarities and specific characteristics. The abolition of the patent law (1861) marked the start of a new ‘make-up’ of the city. Factories were moved beyond the former city boundaries and the workers followed from sheer necessity. They left the old city centre to settle down in new districts in the north, east and west. The middle classes, in turn, demanded the renovation of the old heart of the town and started to build a

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56 E.g. Casebook 2 (1869-1870).
58 The option for receiving free treatment with Van den Berghe will be discussed in paragraph 4.3.
Figure 1. Map of the City of Ghent, Early Twentieth Century CBU, Collectie Kaartenzaal, map 1204. (The numbers with an H represent the auxiliary districts.)
new residential district in the south. The Ghent administration created new police districts in 1848 (the year of revolutions and upheavals throughout Europe) to improve control. Initially, this system started with five districts, but over time the continuing growth of the population and the development of new neighbourhoods led to an extension of the number of districts and auxiliary-districts (Figure 1).\textsuperscript{59}

Van den Berghe began his practice in 1869 on the Muinkkaai in the fifth district and, a year later, moved to the fourth district where he bought a house in the Statiestraat (Station street). Most patients lived in the same district as Van den Berghe did, 95 or 22 per cent of the sample of 441 Ghent patients (Graph 4). Some of them even lived in the same street. The auxiliary districts created over time have been counted as part of the original district to which they belonged.

![Graph 4. Districts where Van den Berghe’s Ghent Patients lived, 1869-1902 (based on the sample of 441 Ghent patients)](image)

The fourth district was the smallest in Ghent and adjoined the first (city centre) and third district (labourers’ area). The Zuid-quarter (fourth district), together with the third, had been notorious for its bad living conditions and its public and secret houses of ill repute in the middle of the nineteenth century. The second highest death rate was recorded in the fourth district during the cholera epidemic of 1848. However, it would undergo more alterations than any other area; in addition to the construction of the railway station in the 1830s numerous sanitary measures were undertaken which improved considerably the living conditions. Public works, according to the Zollikofer-DeVigne plan,

\textsuperscript{59}Devolder, \textit{Gij die door ‘t volk gekozen zijt}, 462-465.
Citizens Suffering

during the 1880s completely changed the face of the neighbourhood where Van den Berghe was living. The area was one huge construction site for nearly eight years and broad roads such as Vlaanderenstraat replaced the dirty working class streets. This district with its middle-class houses and spacious streets became the pride of the town. The relatively large number of patients from this particular district will have been prompted by the convenience of having a doctor nearby.

A number of patients lived in the first district, renowned for its beauty and status. Although, this was the area where the 'rich and famous' lived, several patients living here did not meet these criteria. Most of the new wealthy patients residing in the first district consulted Van den Berghe in the first years of his practice. However, the percentage of new well-off sufferers from this district had declined considerably by the end of the century. A number of people registered in the first district were working as servants, living in with their well-to-do employers. Furthermore, the first district had its beluiken and 'lesser' streets. Three people living in this district were treated free of charge, indicating that, although they lived among the upper classes, their personal situation could not stand the test of comparison.

The third and sixth (auxiliary) districts were reputed to be the old and new working-class areas. The third district in the north of the city originated from the beginning of the century when the textile industry was expanding. Ghent underwent a considerable territorial growth around 1860; the north-west attracted new factories and the area was filled with working-class houses. The old third district was expanded with two auxiliary areas: Dock and Muide. The living conditions in the new (sixth) workers’ district presumably were better, as the houses received more light and fresh air and the streets were widened. The sixth auxiliary district with the Rabot-area was developed in the 1860s under the guidance of several cotton barons, amongst whom De Hemptinne and Desmet, patients of Van den Berghe. The area had been always virgin swamp territory, but now gained its own channel, railway station, boulevards, streets and housing. These new quarters were almost solely the creation of private initiative. The sixth district demonstrated, therefore, better living-conditions, yet nothing was done to improve the circumstances of the people in the old labourers’ district. The third auxiliary district Dock nearly bordered the

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62 Scholliers, De Gentse textielarbeiders in de 19e en 20e eeuw, 118-138.
fourth, while patients coming from the district Muide had to travel nearly three kilometres to reach Van den Berghe.

The fifth district was situated in the south-east of the city and rather respectable but the notorious Batavia-quarter besmirched its reputation for a long time. The slum clearance in this quarter forms a striking example of the city implementing prestigious urbanisation projects. The expropriation of the Batavia-quarter by the urban administration was done without regard for the fate of the hundreds of people who lived there, the demolition starting in 1881. Where once three hundred beluiken were situated the new faculty of sciences of the University of Ghent was built. The fifth auxiliary district was an exception to the rule that workers mainly lived in these auxiliary areas. The Citadelpark was created, on the initiative of local administrators, with beautiful gardens and promenade walks where the Ghent bourgeoisie could saunter. This part of the city pervaded an explicitly higher middle class character and because of the exquisite villas became known as the 'Millions-quarter'.

The second auxiliary district bordered nearly all other districts, except for the fourth and seventh, and was situated in the south-west of the city. It was surrounded mainly by the Leie River. The second district was never known specifically as unsanitary, although it housed also people in beluiken. The distance to Van den Berghe's practice was a minimum of one kilometre. The civil hospital Het Byloke was situated in the second auxiliary district. The seventh district was situated between St. Amandsberg and the fourth district (of which it used to be a part) in the east of Ghent. The distance to Van den Berghe's practice was not great.

Thus, patients came from the farthest corners of the town and, moreover, every district housed patients that he treated gratis. Yet, the fourth district, where Van den Berghe had his practice, produced the most patients in the Ghent sample, and most of the poorest sufferers came from this area. This analysis of the districts in which a sample of Ghent patients lived strongly and, not surprisingly, suggests that the distance to a physician's practice influenced the decision to use that practice.

4.3 Too Poor to Pay: Patients Treated for Free

From the start of his settlement in Ghent, Gustave van den Berghe has had the good fortune of seeing the privileged classes of society flocking in his practice; in his dispensary he did not withhold his

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63 Nowadays, the central library is established here.
64 Roose and DeVuijst, *De kranten van Gent*, deel 3, 9-12; De Rycke, Van Renterghem and De Buck, *De beluiken binnen de stad Gent*, 55.
65 De Rycke, Van Renterghem and De Buck, *De beluiken binnen de stad Gent*. 

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Indeed, the poor regularly attended Van den Berghe's practice and then found kindness when they received treatment without ever having to pay. Approximately one in twelve patients did not pay. Most of these patients did have a job, however badly paid, though none of them had to deal with the consequences of unemployment. This is rather remarkable, as the economy stagnated between 1873 and 1895. Agriculture was in crisis and cottage industry disappeared, thereby creating an 'army' of unemployed.\textsuperscript{67} The free treatment needed and received resulted primarily from low incomes and family circumstances, such as the number of family-members, matrimonial problems, or people becoming widowed.

Melanie Martin-Finjaer (42), for example, a married woman, worked as a day-labourer and had one daughter Rachel (13) who was employed as a flax worker.\textsuperscript{68} The father, Isidorus, a peddler, had left his wife and child just one month before Madame Martin consulted Van den Berghe for the first time in 1891. After one year of separation Isidorus returned to his family but he could not earn an income as he had become lame. They lived in a \textit{beluik} in the Kerkstraat, in the vernacular called 'Nieuwe Koer' (New Court).\textsuperscript{69} When Felix Leijman called on Van den Berghes's assistance in January 1882 he was immediately registered as a \textit{‘pro deo’} patient.\textsuperscript{70} He was a bookbinder's assistant, had four children and was the sole provider as his wife did not work. Three more children were born between June 1882 and 1888 and all family-members consulted Van den Berghe. Three children died, but the other family members remained patients. The death of those children was not considered apparently to be a failure of Van den Berghe, but an inevitable disaster of nature. His free treatment, on the other hand, might have been the reason to stay as patients as the financial situation left them no choice.

Not all patients Van den Berghe treated for free belonged to the working class but the majority did (Graph 5). Madame Manesse received \textit{gratis}
In Search of a Cure

treatment, although she could be classified as lower middle class. She visited Van den Berghe, as a widow of a tailor, at the age of seventy-three in July 1899. She had six children, but no-one officially supported her. Perhaps, her widowhood made Van den Berghe show mercy, yet being widowed did not result automatically in free treatment. Madame Manesse consulted Van den Berghe on 111 occasions in less than three years.\textsuperscript{71}

![Graph 5. Percentage of Patients per Social Class and Patients Treated for Free, 1869-1902 (based on the sample of 441 Ghent patients)](image)

Van den Berghe's philanthropic mentality was not the only component of poor peoples' choices about consulting him. They had other therapeutic options, treatments that also were offered for free. If people did not have the financial means to seek medical care they could approach municipal institutions for public poor relief or forms of privately initiated charity. Ghent, from 1797, had two municipal organisations responsible for poor relief, the Bureel van Weldadigheid (Bureau of Well-doing) and the Commissie van de Burgerlijke Godshuizen (Committee of the Public God-houses). The Bureel appointed physicians ('poor-doctors'), surgeons and midwives and it arranged for price agreements with apothecaries. The Bureel had inspectors or armenmeesters

\textsuperscript{71} Casebook 17 (1898-1901): p. 257.

\textsuperscript{72} This graph displays the patients' occupations divided into social class. The division into higher and lower middle class negates the differences that may have existed within occupational groups and brings together people with (more or less) the same social and financial position. Bankers, merchants, intelligentsia, barristers, judges etc. represent the higher middle class that refers to people of independent means. People belonging to the lower middle class did not depend on waged work, as they earned a living as craftsmen and small shopkeepers, but their income will have been substantially lower.
Citizens Suffering

('poor-masters') who reviewed the situation of those applying for support, who monitored the poor and others who needed aid, and who verified whether the ill were visited regularly by a doctor. These armenmeesters were responsible for ascertaining if the claim for poor-relief was justified and, therefore, reported on behaviour, attitude and income of the applicant. The Commissie co-ordinated the administration of the existing charitable institutions that took care of the sick and insane and of orphans and the elderly. Other charitable initiatives also received a subsidy from the city. Several ecclesiastical societies assisted poor citizens, charity workhouses (ateliers de charité) for the temporarily unemployed and private organisations doing good works with the help of the municipal administration and private donations.73

The possibilities of protection from poverty, moreover, had increased by the end of the century. The 1850s witnessed the rise of the first trade unions. The cotton spinners organised themselves in the Broederlijke Maatschappij van Wevers (Brotherly Association of Weavers) and the Maatschappij der Noodlijdende Broeders (Association of Needy Brothers). Members were supported financially in case of illness, accident or unemployment.74 Thereafter, a variety of mutual aid societies (sick funds) followed, providing social security when members were overtaken by misfortune (illness or disability) and even death (funeral, pension for the widow). Membership was voluntary. A few societies were recognised officially and, thus, eligible for government subsidy. As the perception of poverty altered, from an individual's fault to a social problem, the authorities' contributions increased towards the turn of the century.

The Belgian Parliament enacted in 1894 a law on mutual benefit funds which, amongst others, exempted them from taxes and created a system of subsidies. The funds, such as political parties, were organised on denominational lines. More workers, who also were enjoying an improvement in their standard of living, were able to afford health insurance, but the majority could not. Health insurance was not made compulsory for people in employment; it was not until the Second World War that a general health-assurance scheme for workers was established.75 Notwithstanding, if

74 Van Conkelberge, Het Bureel van Weldadigheid (1821-1925), 38.
In Search of a Cure

protection for the worker and his family from sheer poverty and misery in times of illness was required a trade union providing health insurance could be found. In Ghent, for example, the Free Union of Sickness funds (Vrije Bond der Ziekenbeurzen) gave cover for 5 centimes per week. The members were entitled to free medication, physicians’ consultations, surgery and medicinal baths. Various physicians, specialists and apothecaries were affiliated to the Free Union. However, none of them practised homoeopathy.76

The Labour Exchange (Arbeidsbeurs) helped with finding jobs or workers.77 However, it evolved from poor relief and its charitable image hindered good relations with industry. Positions offered were mostly for ‘odd-jobbers’ and those in need of a proper job knew that the Labour Exchange could not offer what did not exist in times of unemployment. There was no job security for nineteenth-century Ghent workers; a new job one morning could be gone the next. Thus, the Labour Exchange could be a near-perfect institution. The Ghent Exchange began in 1891 and was used primarily in finding employment for household servants, metalwork, clothing, building and woodcraft. As the working class were integrated gradually into the democratic order and its progressive organisation, the Labour Exchange transformed into monitoring unemployment insurance.78

Why did some destitute appeal to Van den Berghs for medical treatment instead of turning to one of the many charitable institutions available in Ghent? Some plausible suggestions, rather than clear-cut explanations, can be made. First of all, to be accepted for poor relief a rather humiliating procedure had to be endured. First, an application form had to be obtained from the Bureel van Weldadigheid. Then, the form had to be filled in by the police commissioner of the police station in the district where the applicant was registered. The commissioner had to judge the eligibility for help. Next, the poor-master had to sign the form and approve or reject the request. The final decision lay in the hands of the Bureel itself. The Bureel was open on Tuesdays for the sick applicants. They waited for hours in an unheated hall and were expected to explain their circumstances in front of the other poor.79

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76 Anonymous, Samenwerkende maatschappij Vrije Bond der Ziekenbeurzen van Gent & voorgeborchten (Ghent, 1899).

77 The precursor of the present job centre.


79 Van Conkelberge, Het Bureel van Weldadigheid, 82.
Secondly, some of Van den Berghe’s ‘gratis’ patients may not have complied with the criteria for public poor-relief. Rachel (19) and Marguerite Van Fleteren (12) lived in the ‘best’ area of Ghent (the first district), but their father (a businessman and shopkeeper) had left his wife and eight children in the winter of 1896. Rachel and her mother were active as day labourers in 1898. One brother worked as a guard in the library of the Palace of Justice. Both girls visited Van den Berghe in 1898 and were treated free of charge. Why would they have gone there? None of the other siblings consulted Van den Berghe, nor did their mother. The request for poor relief could easily have been dismissed given their father’s profession and, thus, income, and the employment of several family-members. The Bureel may have ignored the fact that the married couple had separated and that the deserted family possibly did not receive any financial support. Therefore, it is possible that Van den Berghe’s willingness to treat gratis formed part of their decision to consult him.

Finally, although the various institutions provided for medical care, therapeutic choices were not available as all treatment and medicines provided were of an ‘allopathic’ nature. Therefore, some of Van den Berghe’s gratis treated patients may have made a conscious choice in favour of homoeopathy. However, in only one ‘pro deo’ case in the Ghent sample is it known that, prior to consulting Van den Berghe, the patient had visited another homoeopath.

Those treated for free by Van den Berghe mostly earned a living as day-labourers and factory workers, presumably in the city’s main industry: textiles. It was specified, in some cases, whether people worked as weavers or in a specific textile area such as cotton or flax. The women registered as seamstresses or ironers are counted also amongst this type of labourers. Strikingly, the new patients with this predominantly working-class background treated gratis did not live in the particular labourers’ districts. Most of them resided in the fourth district, indicating that Van den Berghe’s proximity might have contributed to their choice. Yet, the circumstances of those belonging to the lowest strata, where conditions of living and working inevitably made them more susceptible to ill health and forced them to rely on charity, often determined the wish to consult this homoeopath and/or to make use of homoeopathic medicine which usually was readily accessible.

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80 In Ghent several categories of poor people were registered: the elderly who could not provide for themselves because of their age, families who had insufficient income and suffered the burden of children and families of which the bread-winner was ill and therefore unable to provide for livelihood. Cf. Van Conkelberge, Het Bureel van Weldadigheid, 80-81.
4.4 Recapitulation

All types and circumstances of Ghent inhabitants were familiar with the existence of Van den Berghe's homoeopathic practice. The interest in this homoeopathic practitioner was not solely a matter of the well-to-do and the route to the practice on Statiestraat was open to everyone. Ghent patients, in general, were of all ages, of both genders and from all social strata, just as the overall clientele. The majority of his patients were adult men and women over the age of sixteen, eighteen per cent of all patients were younger. Moreover, those between seventeen and fifty years of age were present overwhelmingly in Van den Berghe's Ghent clientele. The average age of the Ghent patients differed from that of the city's population as the clientele, on average, was older. Perhaps, there had been other health-improving attempts already made prior to consulting Van den Berghe, or the fact that old age often is accompanied by more instances of ill health for which medical care is needed. The Ghent clientele gradually changed in several respects over time, demonstrating that the choice to use homoeopathy, besides personal preferences and medical considerations, was determined partly by social components.

The composition of Van den Berghe's patients altered in terms of gender and social class. Women dominated the clientele as well as people with lower status from the middle and, especially, working classes. He treated more women than men from the very outset of his Ghent homoeopathic practice, but the extent of this female predominance increased. The sex ratio (number of men per one hundred women) dropped from 80 to 58. Thus, Van den Berghe's practice became more and more a female one.

The social background of the clientele, besides the growing number of women in the clientele, also shifted gradually. Although professional and daily life circumstances were varied, the interest in Van den Berghe and/or homoeopathy from the upper classes declined considerably and more from the middle and lower classes applied for treatment over time. Thus, the practice underwent a clear popularisation. The number of people treated free of charge also increased. However, the growing number of working-class patients was not reflected in the districts in which they lived. Although some of them resided in the specific workers' areas, most of his patients lived in the same district where he had his practice. Therefore, Van den Berghe's proximity must have influenced the wish to consult him.

The unfortunate situation of the poor, probably, not only created a larger propensity for ill health, but also a dependency on cheap or free medical services offered by charity. Van den Berghe offered such an opportunity for free treatment alongside the official charities supported by city administrations. He announced publicly his readiness to treat people for free and, thus, created a
strong source of appeal for homoeopathy. In many cases, patients' decisions to consult Van den Berghe were determined by the *gratis* treatment Van den Berghe offered rather than by clear medical considerations, such as a preference for homoeopathy. Although no direct testimonies of this kind have been discovered, the behaviour of Van den Berghe's wealthy patients suggests that rich homoeopathy users and supporters may have employed homoeopathy initially as a status symbol expressing and accentuating their exclusive social ranking. The decline in upper class clientele coincided with growing numbers of working class patients and patients treated free of charge. The expansion of the availability and accessibility of Hahnemann's doctrine by means of free dispensaries (and in other countries: hospitals) diminished the elitist outlook of its users and therefore could have tempered the enthusiasm of the upper classes. Another option may well have been that these wealthy patients turned to 'allopathy' as orthodox medical science had made considerable advances by then. However, the near disappearance of wealthy and noble patients from Van den Berghe's clientele does not exclude the possibility that they continued privately to use homoeopathic medication, nor that they consulted another homoeopathic practitioner.

Each individual will have had their own personal reasons or justification for consulting Van den Berghe and using homoeopathy. It is not completely clear on what the decision was based: Van den Berghe as a fine physician, Van den Berghe as a representative of a specific healing method called homoeopathy, or Van den Berghe as a provider of free medical care. It has been established for now that choice and decision were processes influenced by economic considerations and social circumstances. The decision to consult a homoeopathic doctor was more than a medical decision, it was 'exercised within, and patterned by, the constraints of social structure.'

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82 This is in accordance with the findings of Nicholls.
83 The search for these personal motivations will be continued in the next chapters.
84 Nicholls, 'Class, Status and Gender', in: Dinges (ed.), *Patients*, 154.
Illness as a Family Affair

Gustave Van den Berghe's patients have been pictured as a component of a larger entity, as part of his clientele and as members of Ghent's society and they have been considered from a distant 'outsiders'-perspective to provide some general conclusions about their socio-economic background. Social circumstances and economic considerations underlay choices or decisions to consult Van den Berghe or to use homoeopathy, but gender and proximity to the practice also had an influence. The consequences of illness within families and the actions they took to regain health by means of homoeopathy or, at least, by consulting a homoeopathic practitioner are to be analysed. It does so by considering the suffering of young patients, living in Ghent or not, within Van den Berghe's clientele and the number of Ghent families represented by, at least, four family members.

5.1  Children and Youngsters as Patients

Relatively little is known of children as users of homoeopathy. The London Homoeopathic Hospital in the late nineteenth and early twentieth centuries treated 'a sizeable number of children, from the youngest to the age of 14 ...', though details of their ailments and treatment are not available.1 The idea existed, in the nineteenth century, that homoeopathy was suitable especially for children and as a form of domestic medicine. Homoeopathic practitioners and pharmacists provided sufferers with kits that contained medication and instructions for their administration.2 Women, as mothers responsible for taking care of their children, also might well have preferred the mild homoeopathy to the heroic treatments offered by orthodox medicine.3

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1 Bernard Leary, Maria Lorentzon and Anna Bosanquet, 'It Won't Do Any Harm: Practice and People at the London Homoeopathic Hospital, 1889-1923', in: Robert Jütte, Günther B. Risse and John Woodward (eds.), Culture, Knowledge and Healing. Historical Perspectives of Homeopathic Medicine in Europe and North America (Sheffield: EAHMH, 1998), 251-273, q.v. 257.

2 Robert Jütte, 'The Paradox of Professionalisation: Homeopathy and Hydropathy as Unorthodoxy in Germany in the 19th and Early 20th Century', in: Jütte, Risse and Woodward (eds.), Culture, Knowledge and Healing, 65-88, q.v. 75.

3 However, although women may always have had a primary role in taking care of sick family members, this is not to say that they were also primarily responsible for making the decisions with regard to the choice of a physician or particular therapy. More so, these decision-making processes within families also differ in time and place.
Hahnemann’s attitude towards and his treatment of children has been studied. Hahnemann published a German translation of Rousseau’s ‘Sur l’éducation des enfants’ in 1796. The original had been altered slightly by Hahnemann, but his ideas did not differ significantly from those of Rousseau. He had an idealised view of the nature of children, needing to be fed by their own mothers, they should not be spoiled and they needed lots of fresh air. However, this idealism hardly seems to have been reflected in his practice. Hahnemann’s pre-occupation with the preventive treatment of scarlet fever was inspired barely by his wish to save children but was based on economic motivations. His publication on inoculation was aimed mainly at the selling of medication.

The letters from parents, relatives and one doctor about the condition of sixteen children, between a few weeks and seventeen-years old, demonstrate that most came from comfortable backgrounds and that their parents were literate and could afford expensive therapy. Therefore, the homoeopathic treatment of children was a luxury. Moreover, adults only turned to a practitioner for their children when the illness was considered absolutely dangerous. Hahnemann, in addition to written consultations, occasionally met them in his practice. Homoeopathy did not have specific child remedies, but his treatment of young children had two peculiarities. Children who had not been weaned had to receive the medication by breast-feeding. Therefore, the mothers had to take the medication to pass it on to their babies. Secondly, Hahnemann recommended treating small children by them smelling the medicines. Both forms of treatment did not make an appeal to the responsibility of the child but, instead, made the adults accountable for the course of the treatment.

The first homoeopathic children’s hospital in the German-speaking regions was opened in Vienna in 1879. The hospital provided free treatment and had forty beds. Children suffering from contagious conditions were offered ambulatory care to prevent the spread of infection. Most of the children treated in this hospital were girls from poor families. One third of the patients

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6 Ibidem, 128.

were younger than five years old and this age category also faced the largest number of deaths (70 per cent). The children's hospital, following the policy of other Vienna hospitals, probably did not admit or treat infants. Nearly half of all new patients admitted were diagnosed with conditions such as scrofula and rickets. Scrofula was not considered as one single disease, but was used to refer to many conditions including swollen glands, eye disorders and skin ailments. Gastro-enteritis, tuberculosis, bronchitis and pulmonary conditions were a considerable part of the afflictions and the principal deaths were from tuberculosis, scarlet fever, measles and diphtheria. Much of the children's suffering was related closely to their miserable living conditions and, in many cases, successful treatment was mainly the result of proper nutrition and hygiene in the hospital. The treatment varied from the taking of medication to gargling and inhalation.

Worried parents and their sick children frequently visited Van den Berghe. He treated from Ghent and elsewhere in more than thirty years, 3,464 children (or 15.7 per cent) aged sixteen or younger. The treatment of these patients would have been complicated if a mediator was needed to explain the suffering. Young children are (and were) not able to communicate their feelings and suffering in the way that adults are capable of expressing them. Those who accompanied them, therefore, put the young children's agony into words. The parent(s) were usually the companions; occasionally other relatives or acquaintances accompanied the children. This means that, especially with babies and toddlers, Van den Berghe, besides his own observations, was dependent on the description of symptoms by others than the actual patient. Therefore, the notes made by Van den Berghe often reflect parental worries towards their young children, rather than the experience of the child.

The files of the children, in comparison with those of the adult patients, are short and scarcely go beyond the topic of the complaints. The subjective experience of illness is barely touched upon, and mainly only when the patient was above the age of ten. These youngsters were more capable of understanding their condition and more emphasis was placed on their feelings and everyday lives. Occasionally, they revealed the capacity to connect their ailments with specific daily events. Oscar Stassens (12), suffering from nervous attacks, claimed that he had developed the ailment due to fits of fear. He worked underground in a cave, which he found very frightening, and was regularly beaten on the head, probably by his co-workers. Nevertheless, many youngsters were accompanied also by one or more adult(s). This might

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8 Infants were babies younger than one. Lucae, 'Das "Lebenswarthische homöopatische Kinderspital"', 89-92.
9 Lucae, 'Das "Lebenswarthische homöopatische Kinderspital"', 92-99.
have led to concealing information about the origin of ailments. Van den Berghe, for example, wondered if Maurice Steyaert (14) was ill because of masturbation. The circumstances were never clarified and this might be explained by the presence of Maurice’s mother at the consultations.11

Parental distress about their children’s health is not surprising. Belgium had a high infant and child mortality rate in the nineteenth century. An average of eighteen per cent of the children died before the age of one until the end of the century, twenty-nine per cent before the age of five, and thirty-three per cent before the age of ten.12 Most children died of enteritis, diarrhoea, chronic bronchitis, pneumonia, pleurisy, measles, small pocks, scarlet fever, whooping cough and diphtheria. Parents of daughters were anxious about their daughter’s health even more. There was the reality, in Belgium, of an ‘excess female mortality’ (EFM) in the nineteenth century.13 However, Belgium was no exception as other West-European countries had the same demographic pattern. The chances of dying for Belgian girls between five and twenty years old was, on average, sixteen per cent higher than for the boys in 1890. The excess female mortality had dropped considerably by 1910 to three per cent; this decline was more substantial in the Walloon provinces than in Flanders. The textile areas still retained an excess mortality of girls.14 The same illnesses lay in wait for both boys and girls, but girls were at greater risk of dying.15

The Belgian excess female mortality suggests that girls were disadvantaged both by society and by parents and not only in the labouring classes.\(^{16}\) Belgian society was still very 'masculine', male dominated and patriarchal, and men had a higher social standing than women. Men's roles were displayed outside the home, women remained as caring housewives, especially after marriage. This 'division of labour' was reflected also in daily events, such as having dinner together. Children and girls in particular were the last ones to receive food, especially in times of shortage.\(^{17}\) Thus, the way in which parents behaved was an expression of and contributed to daughters being disadvantaged. The working conditions of young girls also affected their health; the textile industry made use mainly of cheap female labour and girls had to work long hours in unsanitary circumstances. Furthermore, the traditional task of taking care of the household forced girls to stay indoors most of the time. The small, damp and inadequately ventilated houses in working-class neighbourhoods formed an ideal base for the spread of disease. Finally, if girls were the last ones to be fed, it is not improbable that parents neglected the medical needs of their daughters. Indeed, it has been suggested that excess female mortality was caused by a lack of medical care for young girls.\(^{18}\)

However, the medical neglect of daughters by their parents is not reflected in the child clientele of Van den Berghe's practice: there were slightly more girls than boys and this female over-representation was present in all periods.\(^{19}\) Yet, the difference is fractional: 54 per cent girls and 46 per cent boys. The ages of ten children are unknown, but his notation 'enfant' (child) suggests very young people. The rural practice in Zwevegem attracted only forty-nine children; all others consulted Van den Berghe in Ghent.

Most children were between 0 and 10 years old, but babies and toddlers (0-5) predominated (Table 1). Parents, apparently, were aware of the unstable viability of the very young. Nevertheless, this awareness does not seem to have led to regular consultation behaviour. Nearly a third of the children were taken to Van den Berghe on only one occasion and, then, they just disappeared from the practice. The condition will have improved for some of them to such an extent that returning was unnecessary, but some parents lost their child shortly after the initial consultation.

\(^{16}\) Cf. Devos, 'Te jong om te sterven', 68-72.


\(^{18}\) Devos, 'Te jong om te sterven', 72.

\(^{19}\) Research results again are based on the information gathered from Casebooks One, Eight and Seventeen, including patients from the Zwevegem period. These casebooks reveal medical information on 444 children from Ghent and elsewhere, nearly thirteen per cent of their total number (3,464).
Illness as a Family Affair

Table 1. Number of New Child Patients, from Ghent and Elsewhere, per Age Category
(1865-1869, 1881-1882, 1898-1901)

<table>
<thead>
<tr>
<th>Age category</th>
<th>Number of children</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 years old</td>
<td>208</td>
<td>48</td>
</tr>
<tr>
<td>6-10 years old</td>
<td>91</td>
<td>21</td>
</tr>
<tr>
<td>11-16 years old</td>
<td>135</td>
<td>31</td>
</tr>
<tr>
<td>Total</td>
<td>434</td>
<td>100</td>
</tr>
</tbody>
</table>

The Ghent Leyman family had to experience the death of three children.20 Their daughter, Clotilde (age 8), saw Van den Berghe only once in May 1882. She was brought to him, suffering from severe headaches in the back of her head, but died five weeks later. Two sons, Achille (2) and Oscar (6), remained in his care for a little longer. Achille became a patient in August 1882, after his older sister had already died, with an unspecified ailment. He returned in 1883 with another, more serious, condition: coughing and throat ache. Van den Berghe was unable to induce improvement and the boy died within a month of his last consultation in September 1883. Nevertheless, the parents had not lost their faith and, in January 1884, another child, Oscar, was brought to the practice. His condition improved after one consultation and there were two more in 1885. However, in 1886, Oscar could not be saved. He died on 12th April 1886 from colic and diarrhoea, six days after his last meeting with Van den Berghe. The official causes of death are unknown but, it was noted in the casebook, that several children had died from meningitis tuberculosis. Although Felix and Marie Leyman had lost three children, they did not hesitate to take more of their offspring to this homeopath. Van den Berghe treated four more children between 1884 and 1902 and, eventually, Ferdinand van den Berghe took over the treatment. The Leyman’s ‘loyalty’ towards Van den Berghe may have been maintained as they never had to pay for their consultations. Indeed, perhaps, they simply did not have any better alternative, whether it was homoeopathy or not. However, the continuing use of homoeopathy after Van den Berghe’s death strongly suggests that the therapy also had an appeal in itself, albeit that Ferdinand also offered them gratis treatment.

Although the eventual cause of death of the first three children was noted clearly by Van den Berghe the initial conditions remain rather vague. The same is true for other child patients but, in various cases, the main

symptoms can be deduced.\textsuperscript{21} He made an indisputable diagnosis in some cases; in others a summary of complaints that can be divided into main and sub-symptoms. Occasionally, Van den Berghe did not make any notes on the ailments.

Children were not brought to Van den Berghe solely when they suffered a life threatening illness. They endured all sorts of ailments and, whether or not the condition was lethal from a medical point of view, the interpretation of the care takers determined the decision to approach the professional. The parents decided for themselves whether their child’s condition was precarious and needed examination. Death left its mark on the average nineteenth-century family for it was no exception that parents had carried at least one child to the grave. They had often witnessed personally the death of a loved-one and did not want to experience such an ordeal again. This emotional burden could have an enormous impact on their physical and mental state. Some women consulted Van den Berghe because their grief over the loss of a child had affected their health. Paulina Mortier-VanEechen (44) had lost four out of her six children and suffered from grief to the extent that constantly she had nervous attacks.\textsuperscript{22} Maria Stasin (32), the wife of a furniture maker, consulted Van den Berghe in August 1878. She was affected emotionally because she had given birth to a still-born baby girl eight weeks previously. Moreover, she had lost another daughter to enteritis the previous year.\textsuperscript{23}

Table 2. Number of Patients Younger than 11, from Ghent and Elsewhere, Suffering from Children’s Diseases (1865-1869; 1881-1882; 1898-1901)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Number of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhoea</td>
<td>39</td>
</tr>
<tr>
<td>Measles</td>
<td>8</td>
</tr>
<tr>
<td>Scarlet fever</td>
<td>1</td>
</tr>
<tr>
<td>Whooping cough</td>
<td>13</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>61 (20.4%)</strong></td>
</tr>
</tbody>
</table>

Many of the children were afflicted with a cough, diarrhoea, back and joint ailments or eye disorders. One out of five children between 0 and 10 years old

\textsuperscript{21} Appendix 4 gives an overview of all complaints with which the children were brought to Van den Berghe. The appendix is based on what can be considered as the main reason of suffering.

\textsuperscript{22} Casebook 3 (1870-1871): p. 769.

\textsuperscript{23} Casebook 6 (1876-1879): p. 1425. Maria did not specify the sex of the stillborn child, but the death certificate reveals it was a girl. DSG, Burgerlijke Stand Gent, Acts of Birth, Death and Marriages, death certificate 1717/1878: ‘[...] de welke ons hebben vertoond een kind zonder leven van het vrouwelijk geslacht’.
suffered from typical children’s diseases (Table 2).\(^{24}\) None of them, remarkably, were diagnosed with gastro-enteritis, pleurisy or diphtheria. However, this does not mean that no one suffered from these diseases. Some of the patients with abdominal complaints and/or diarrhoea might have had gastro-enteritis. One patient was convalescing from smallpox and was left with a cough.\(^{25}\) At least thirty-nine young children were noted to have diarrhoea. They were often facing weight-loss, nausea and a lack of appetite. Four-year-old René developed diarrhoea out of misery. His parents wanted him to go to school and, indeed, forced him to go (*forcée d’aller en classe*), but he detested it so much that he was constantly crying and eventually contracted diarrhoea.\(^{26}\)

It is not surprising that parents took their children to a doctor with only a cough or diarrhoea, given the possibility of very contagious and dangerous whooping cough and the possible mortal implications of liquid stools. If one child fell ill with a particular disease, the others could become infected easily. Perhaps this was the case with the Mortier sisters. The first, Cordula, was diagnosed with whooping cough on 29th May 1881. Three days later her sister visited Van den Berghe with a severe cough. Their parents may well have been worried about contamination because, quite often, siblings suffered from the same illnesses.\(^{27}\) The Herbauw sisters were diagnosed with whooping cough and the Van Koebosch children had ringworm.\(^{28}\) The consequences of whooping cough could be enormous. The five-year old George Pycke, from Renaix in East Flanders, was paralysed since age one and his inability to move was the result of whooping cough. George was brought to Van den Berghe on four occasions in five months but his condition did not improve.\(^{29}\)

Skin ailments, including eczema, were a part of daily life. Many children suffered skin rashes and itch, or endured ringworm. The patients suffering from eye disorders were inflicted mainly with the very contagious eye infection, ophthalmia. Although it was not a typical children’s disease (adults could also contract it) it was of great concern to the medical authorities. The interest in clinical observations of school children increased during the second half of the nineteenth century. Various medical disciplines dedicated themselves to the improvement of school hygiene and the development of school medicine. Oculists, for instance, battled against the spread of ophthalmia and short sightedness in school children. Others concentrated on the recurrence of the

\(^{24}\) The following is based on 374 children whose ailments were clearly noted.


\(^{26}\) Casebook 14 (1891-1894): p. 556.


\(^{29}\) Casebook 17 (1898-1901): p. 897.
curvature of the spinal column. This disorder was found in the children visiting Van den Berghe as at least five children had a spinal deviation.

There were children suffering from backache and pains in arms, legs and knees leading to a predominantly chronic condition such as coxarthrocace, an affection of the hip joint. These children usually faced difficulties walking as one of the legs was longer than the other and suffered pain in thighs and knees. Van den Berghe published his findings on this ailment in 1878 when he described eight cases, seven of which concerned children between twenty months and fourteen years old. Some of them had visited previously allopaths, but they had been unable to improve their situation. One father had a very bad ‘allopathic’ diagnosis for his three-year old son who refused to walk. An eleven-year old Dutch boy had been treated by several Dutch doctors in vain. His parents decided to go to the Byloke hospital in Ghent hoping to find surgical relief for their child but they were told that new treatment was useless and that their son would never be able to use his hip. The family met one of Van den Berghe’s clients, on their way back to the Dutch province of Zeeland, who told them about the successes of homeopathy. They were advised to consult a homoeopathic practitioner and went to Van den Berghe who cured the child within three months.

Van den Berghe published these cases to exemplify the ignorance of allopathy. He stated that both the allopathic inability to cure affections of the hip joint and the successes of homeopathy in this area proved the superiority of Hahnemann’s therapy. Van den Berghe, in the article in l’Homoeopathie Militante, boasted about his successful cases, but the casebooks reveal that he did not always achieve a satisfactory result. He had treated in 1866 a girl in Zwevegem with coxarthrocace. The eleven-year old Sidonie had been afflicted with the disorder for four weeks. She was taken to Van den Berghe on six occasions from her home village and, when no results were obtained, the treatment was suspended.

The files of the children in particular demonstrate the attitudes and perceptions of their care-takers. They lay bare how children were observed and
Illness as a Family Affair
treated by their parents and reveal adult ideas and fears with regard to suffering. Care-takers monitored their offspring closely and they were often able to give detailed descriptions of what happened, or had happened, to their sons and daughters. Children who were emaciated considerably or who had no appetite were considered to be ill and were taken to the doctor. Children suffering from epilepsy usually faced a diminished consciousness during fits and hardly could recall what had happened during these episodes. Their parents were able to fill in the blanks. Moreover, some parents showed a certain level of medical knowledge and were not afraid to share this with the homoeopathic physician. They were well aware, for instance, of the risk of contagion of some diseases. The parents of an eight-year old girl with ophthalmia suspected her of having caught the ailment from the children next door. The explanations given for the malaise of a child could be related also to events in an adult's life. A nine-year old girl, who had not been taken to Van den Berghe by her parents, was said to have fallen ill because of the misconduct of her mother. This girl, Irma, suffered from great grief as her mother 'behaved scandalously' and had left her husband and children to live 'a debauched life in the neighbourhood'. The mother of a three-month old baby-boy, who had been ill since his birth, explained that she had an accident three months prior to the delivery and suspected this to be the cause of her son's suffering.

The treatment Van den Berghe offered to his child patients consisted usually of medication for the child and an instruction for the parents about diet and self-medication. It is not surprising that he felt the need to give these instructions as, for example, children were often given wine and coffee, even at a very young age. Van den Berghe wrote about a one-year old girl, suffering from diarrhoea: 'Régime impossible, mangeant de tout: bière, café, viandes!' (Impossible diet, eats everything: beer, coffee and meat!). Moreover, many parents acted as doctors by, for example, giving their children vermifuges. It usually saved the children from worms but, at the same time, led to the development of all sorts of other ailments. Children received also strong purgatives and laxatives from their parents on a regular basis. Occasionally, Van den Berghe made use of medical devices; a girl with a spinal deviation was advised to wear a corset.

The casebooks are rather silent on the taking of medication. It seems that most medication had to be taken by the child;

36 Casebook 7 (1879-1881): p. 669. 'on attribue cette affection a la contagion, on pretende que des enfants voisines lui ont donne la maladie.'
37 Casebook 16 (1896-1898): p. 19. 'a probablement gagni sa maladie de chagrin. Sa mere a une conduite scandaleuse x a quitté son mari x ses enfants pour vivre en libertinage dans le voisinage.'
40 Ibidem: p. 510.
occasionally nursing mothers had to provide the medicines to their babies via breast-feeding. This was the case with a two-month old boy suspected to be afflicted with syphilis, and with a baby girl of the same age who suffered from diarrhoea, colic and vomiting.41

Worries about their children's health did not prevent parents from experimenting on themselves or ignoring the doctor's orders. Adults occasionally continued giving orthodox medication to children despite the clear instructions of Van den Berghe. Thus, he was not considered as the sole authority and parents switched continuously between healing methods and practitioners to obtain a good result for their children. Other therapies and healers had been tried and consulted prior to consulting Van den Berghe and, in one case, the earlier experience had been with homoeopathy. A five-year old boy, suffering from meningitis and congestion with convulsions, had been taken first to Van den Berghe's Ghent colleague Eugène De Keghel.42 Other parents had visited a pharmacist; one girl was relieved from a rash on her scalp after a pharmacist had been asked for advice. Whether the medication was of 'allopathic' or homoeopathic nature remains unknown.43

The results of Van den Berghe's treatment in 287 out of the 444 cases are not registered and, thus, remain unknown.44 The majority of these unknown results refer to Casebook Eight, the period during which his practice was at its busiest. Only twenty-one young patients were noted as cured; fourteen in Casebook One, three in Casebook Eight and four in Casebook Seventeen. Occasionally, Van den Berghe became acquainted with the results of his treatment by means of a letter.45 The mother of Octavie DeConinck (16) informed Van den Berghe about the effects of his treatment. The girl suffered from far-advanced anaemia when she came to him on 16th April 1895. Two weeks later her mother told him that Octavie had died within hours of the consultation. The notes do not indicate whether or not the mother blamed Van den Berghe for her daughter's death.46 Thirty-four children visited Van den Berghe without any result being achieved. The majority of the known results refer to patients being relieved. Whether the positive effects of treatment were

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43 Casebook 17 (1898-1901): p. 918.
44 I could have searched the municipal archives to determine how many of these children stayed alive, but I considered that task unnecessary for this thesis. More so, the stories about families in Van den Berghe's clientele indeed do show that losing a child or children was far from unusual.
45 Of two patients it is known that Van den Berghe received a letter from the care-takers to thank him for curing the child. Both letters concerned patients living in Ghent. Casebook 1 (1865-1869): p. 841; Casebook 17 (1898-1901): p. 816.
due to Van den Berghe’s medical skills is impossible to establish as many children may have recovered without intervention.

5.2 It Runs in the Family: Van den Berghe as a Family Physician

Nowadays, it is usual for members of one family to be treated by the same general practitioner. When the children grow up and leave home and town they might choose a new physician, but many stay with the familiar one. The specialisation of general practitioner, i.e. family doctor, was not well developed in the nineteenth century. Personal care was often preferred to that of a physician and there was more trust in home remedies than in a doctor’s prescription. However, Van den Berghe’s patients’ files show that if one patient called upon his services another one from the same household could easily follow, thereby turning this homoeopath into a ‘family physician’.

Van den Berghe had always treated entire families and relatives during his years of practice. He was popular amongst the nobility in the early days and members of aristocratic families apparently inspired each other to visit him. These noble families disappeared later on and were replaced gradually by families from the lower social classes who were treated for free. Van den Berghe was consulted by 108 families of four or more members from one household between 1869 and 1902 from Ghent and elsewhere (Table 3).\(^7\) Fifty of the families, nearly 50 per cent, received free treatment. Unfortunately, nothing is known about membership of trade unions (mutual aid societies) or other institutions providing for health insurance.

Table 3. Total Number of Paying and Non-Paying Families (four or more people from one household) within Van den Berghe’s Clientele, 1869-1902

<table>
<thead>
<tr>
<th>Number of families</th>
<th>Average number of people per family</th>
<th>Average number of years of treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Families that had to pay</td>
<td>58</td>
<td>4.9</td>
</tr>
<tr>
<td>Families that were treated for free</td>
<td>50</td>
<td>5.1</td>
</tr>
</tbody>
</table>

The average number of people from one household hardly differed between the \textit{gratis} treated and \textit{non-gratis} treated families; the average being around five. Again, there was no significant difference in the number of years these families stayed with Van den Berghe. The largest family was among the non-paying patients; the Venneman family, treated between 1872 and 1901, was represented

\(^7\) These numbers are not based on a sample, but refer to the total number of families (four or more people) within Van den Berghe’s clientele, residing in Ghent or elsewhere.
by both parents and nine children.\textsuperscript{48} The Casteels family was treated for the longest period of time, but always had to pay for the treatment they received. This family generated five patients in forty-six years (1885-1931) and, thus, also laid its fate in the hands of Ferdinand van den Berghe after his father had died. All five patients, both parents and the three still living children had started the treatment with Gustave Van den Berghe. Three of them, mother Philoména and her adult children Maria and Augustus returned with his son Ferdinand.\textsuperscript{49} Some other families continued the treatment after Gustave’s death as well. Occasionally, family members had started treatment with Gustave, than disappeared as patients, to return in Ferdinand’s practice many years later.\textsuperscript{50}

A study of a number of these families should constitute a biography of ‘homoeopathic’ families. Families differed from each other about the level of devotion to Van den Berghe and members of one family did not always share, or continue to share, a trust in Van den Berghe and/or in homoeopathy. The ‘biographies’ provide an insight into the difficulties families had to face in daily life and how they responded to illness or the threat of death. Why was medical support sought from Van den Berghe? Was it 	extit{gratis} medical treatment, Van den Berghe’s personality, homoeopathic therapy, or some combination of these factors?

The decision regarding which family to explore further and which not, has been made mainly at random. The selected families reflect the families present in Van den Berghe’s clientele, in terms of social background and a spread through time (Appendix 5). The most solid information refers primarily to the first member of the family who consulted Van den Berghe.\textsuperscript{51}

\textsuperscript{49} Casebook 10 (1884-1885): p. 846.
\textsuperscript{50} E.g. Casebook 4 (1871-1873): p. 1696 (4 patients from one family treated between 1873 and 1903); Casebook 6 (1876-1879): p. 887 (5 patients from one family treated for free between 1877 and 1909). One Ghent family, for example, joined Gustave Van den Berghe’s clientele in 1884 and stayed with him until 1894. In the next twenty-two years no member of this family applied for treatment, only to return again after the First World War. See: Casebook 7 (1879-1881): p. 388.
\textsuperscript{51} The files of entire families available in the casebooks should be considered with care. Van den Berghe did not provide for sufficient free space in the files, in case others would follow the first patient. Patients from one family, therefore, are sharing the same file and if the official first page was full, Van den Berghe continued the notes on the leftover space in other people’s files. Consequently, the amount and content of the notes are rather scant. The first family-member usually has an orderly file, others are mostly squeezed in with short remarks on the medication given and hardly any or no remarks on the ailments.
Illness as a Family Affair

**Family 1: Baetslé (1869-1902), Paying Patients**

Franciscus Josephus Baetslé was born on 10th July 1826 in Ghent and, in 1854, he married Nathalie Nabijd, also born in Ghent on 31st January 1829 when he was working as a typographer and she as a tailor. Both could write. They did not abstain from sexual relations before marriage as their daughter Emilie had been born in November 1853. The couple would have another seven children in sixteen years, some dying at a very young age. Franciscus and Nathalie lived in a house in Palingstraat (Bel Street) from 1873; their children eventually would leave the parental house. Franciscus, who received a decoration in the 1890s, outlived his wife; she dying in 1895 and he in 1909. The Baetslé family would provide nine new patients for Van den Berghe between 1869 and 1900.

Franciscus, registered as ‘François’ in the casebook, was one of Van den Berghe’s early patients. The first consultation was on 21st November 1869 when he explained to Van den Berghe that he had been suffering for the last eight years though, currently, he had respiratory problems. He was constantly coughing and producing a gelatinous substance and, if not phlegm, an impeded respiration. Some general chronic complaints were present also: his stools were far from normal, often diarrhoea; his stomach, back and arm bothered him most of the time; he often had acid belches and occasionally a rash. Furthermore, he was often cold and damp weather impaired his condition. Van den Berghe added to the anamnesis that Franciscus was a ‘black man’ (hommé noire), making use of the characterisations within humoral pathology, and that his face was pale. Franciscus became a regular patient, unlike most of his family members. He consulted Van den Berghe 449 times between 1869 and 1902, nearly fourteen consultations per year. Some of these consultations were house calls.

When Nathalie was not feeling well in the spring of 1885, she was advised by her husband also to pay a visit to Van den Berghe. She did not become as ardent a user of homoeopathy as her husband as, possibly, she was hardly ever ill. She received treatment on sixteen occasions in five scattered years and her final consultation was in 1893. She died two years later, on July 8th.

Their son Desiderius, registered as Desiré, became a fairly regular patient until 1890, consulting Van den Berghe on sixty-four occasions in sixteen years; though he did not receive treatment between 1874 and 1876. He was three-years old when his father took him to Van den Berghe in the winter of 1871 but

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52 Casebook 2 (1869-1870): p. 167. The Baetslé family members: François (=Franciscus) 167A; Desiré (=Desiderius) 167B; Enfant (=Mathilda) 167C; Caroline (=Carolina Braeckman) 167D; Eugenie (=Eugenia) 167E; Madame (=Nathalia Baetslé-Nabijd) 167F; Oscar Braeckman 167G; Enfant Terbéé-Baetslé (=Josephine Terbée) 167H; Fils Braeckman (=Oscar) 167I. Cf. Appendix 5.
nothing was noted about the ailment. A week later, it becomes clear that he had worms. He had eczema on his scalp in 1872. The casebook reveals that Desiderius was treated for various ailments. He developed shingles at age five, which was successfully treated. Two years later he had a nervous tic in his face which also disappeared, but would return in 1880. Other ailments were a swelling in his ears and the loss of hair (1883) and ear-ache (1887). Desiderius would not consult Van den Berghe after the age of twenty.

In 1872 the second Baetslé child needed Van den Berghe’s services. Six month old Mathilde joined her father on 14th January with unknown complaints; Van den Berghe had not made notes in the casebook. He saw her three times in that year. Another consultation took place ten years later and after that Mathilde would not return as a patient. However, Josephina Terbée, daughter of Mathilde and Jean Baptiste Terbée, was brought to Van den Berghe with an anal problem and vaginal secretion in 1897. She received six treatments for this ailment. All her consultations were simultaneous to those of her grandfather Franciscus. Therefore, he probably took her to the practice. Two years later, although she now lived in Brussels with her parents, Van den Berghe examined her again. Mathilde could well have found a homoeopath in Brussels to take care of her daughter but, instead, decided to bring her to Ghent. It is not known if Mathilde gave birth to more children but, certainly, none were given into Van den Berghe’s care.

On 3rd November 1880 Van den Berghe entered a new name into the file of the Baetslé’s: Caroline Braeckman. She was Franciscus’ grandchild, a child of his daughter Emilie. Emilie, who had never consulted Van den Berghe, had married Simon Marie Braeckman (b. 1852), a fitter, in 1876. After her marriage she left her parental home and moved to the Bijlokevest in the second district. Caroline was their first-born in March 1877. In 1899 her younger brother Oscar (b. 1885) also needed medical attention and in 1900 another sibling, Diomède (b. 1891) also became a patient. Caroline, Oscar and Diomède were treated on only a few occasions by Van den Berghe. Caroline was treated in 1880, 1886, 1889 and 1892 and met Van den Berghe nine times; both boys were treated in one single year. Oscar underwent two treatments in 1889 and Diomède thirteen treatments in 1900. Two other Braeckman children, Eugenie (b. 1879) and Maurice (b. 1881) were never taken to Van den Berghe; not even when Eugenie suffered a life threatening disease from which she would die in 1894.

Eugénie Baetslé, at age twenty, came to see Van den Berghe in 1881 and, on a second occasion, in 1882; nothing is known about her complaints. Eugénie

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53 Simon Braeckman (b. 15-09-1852, d. 18-06-1937) once made use of Van den Berghe’s skills. On 26th January 1879 he was treated for pain on his breastbone (sternum). He attributed his ailment to having caught a cold. Casebook 6 (1876-1879): p. 1768. DSG, Archive Bevolkings-register Ghent, 1887-present: Filing Cards.
was never registered in the *straatnamenregister* as having any profession, whereas all the other children in this family, at one time or another, started to earn their own living. Perhaps she was of a general feeble constitution and, therefore, unable to work. She died in 1883, three days before her twenty-third birthday.

The homoeopathic experience of the Baetslé family started with the head of the household. Franciscus was the first to turn to Van den Berghe and, then, introduced his offspring to this physician. He must have been pleased with the treatment but the reasons for his satisfaction remain hidden. However, if Van den Berghe had not obtained positive results, probably the father would not have exposed his children to homoeopathy. Yet, the decision of Mathilde to bring her child from Brussels, when the capital was the ‘Walhalla’ of homoeopathy, suggests that she also was pleased with Van den Berghe. At the same time, the trust in homoeopathy was not unthinking. Another Eugenie, daughter of Emilie and Simon Braeckman, died in 1894 at age fifteen and Van den Berghe was never consulted about her ailment. Moreover, it is remarkable that the girls in the family passed on their experiences to their children, whereas the boy, Desiré, did not continue with homoeopathy within his own household.

No testimonies of consulting other practitioners were given in all these years and only sporadically the casebooks contain remarks about self-treatment. Franciscus occasionally made use of *sal volatile* (smelling salt) and if his asthmatic fits were unbearable he smoked special cigarettes made of nitrate paper. Nothing is known of the therapeutic past, of the previous experiences with other medical treatments and remedies. The casebook containing this particular file starts in 1869. Van den Berghe had not yet made a habit of making notes on finances or fees, though he had certainly started the registration of his ‘Pro Deo’ patients. Although it is not known what the sufferers in the Baetslé family had to pay for their treatment, it is certain that they were not treated free of charge.

**Family 2: Coene (1876-1898), Paying Patients**

On a Sunday in August 1876 Veronica Coene decided to make an attempt to restore her health. Although she had given birth to a son two months earlier, she had not yet regained her strength. Her main problem concerned worms, but she also had breathing difficulties, a cough and no appetite. The left side of her upper belly ached and she thought it resembled some sort of beast running up and down her body. When Gustave saw her on a second occasion, he diagnosed a prolapsed uterus.

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In Search of a Cure

The condition of her womb was not the result, as with other women, of a succession of pregnancies. Veronica was the mother of three, one girl and two boys. The youngest child was Gustavus, the child she had just delivered. He was born on June 16th, but would die on 24th August of diarrhoea. Her daughter, Maria, had been born in 1870 and, two years later, the family was expanded with a son, Julianus. Their father was Josephus Coene, whom Veronica Van Wijnghen had married in 1868 at the age of twenty-one. Veronica became a loyal patient. Her first condition lasted a year. After thirty-four consultations, the worms were gone and the bestial-like sensations in her upper-belly had disappeared. Maria (age 7) developed asthma in 1877 and she was taken to Van den Berghe once in October. Veronica returned in December and complained about belches and water on her stomach. Van den Berghe suspected that she was pregnant. Seven months later, on 18th June 1878, she gave birth to her daughter Leonia. Virginia, during her pregnancy, developed toothache which would stay with her for many years.

The other two children would be introduced to Van den Berghe in 1878. Maria returned with constipation, a varying appetite and, later on, renewed asthma fits. Jules (7) was inflicted with colic and Leonia (5 months) needed treatment for diarrhoea. The toddler was cured but, in 1880, her luck changed. As Leonia’s condition made her vomit and cough constantly, her parents felt the need for medical supervision. Van den Berghe saw her once on 9th March and she died in June. Her father also consulted Van den Berghe that year but his complaints are unknown.

The consultations during the 1880s were almost experienced solely by Veronica and were all connected with the tooth-ache she had developed during her last pregnancy. She returned repeatedly but, from 1886, she would be free of it for more than a decade. Van den Berghe had treated Maria in the summer of 1885 for a knee condition which had been easily relieved. No one in the family consulted Van den Berghe between 1887 and 1890 but, in February 1891, Maria returned to the practice.

Van den Berghe treated all the Coene’s, except for Julianus, during the 1890s. As little space remained in their file, the notes on the conditions and suffering are scanty. Nothing is known of the complaints of the father, but he had fifteen consultations in 1891. Maria endured coughing in 1894, other health problems were not specified. Veronica was house-bound by severe headaches at the beginning of the decade and, therefore, Van den Berghe paid her a house call. Veronica’s dental ailment recurred in 1897, leaving her with swollen cheeks. The Coene family, i.e. Veronica, consulted Van den Berghe for the very last time in 1898.

Veronica Coene-Van Wijnghen, Josephus Coene and their children Maria, Julianus and Leonia all experienced Van den Berghe’s routine and the
functioning of homoeopathic medicine. Van den Berghe treated these five family-members on 115 occasions. The homoeopathic experience of Jules and Leonia was neither conscious nor permanent as Leonia died at a very young age and Jules was brought to the practice on only one occasion. Initially, Maria will have behaved according to her parents' rules. They, and especially her mother, were the ones who decided to bring her into contact with homoeopathy when she was seven years old. However, Maria's contact with Van den Berghe was most frequent in the 1890s when 33 out of the 44 consultations took place. Maria turned twenty-one in 1891 and, having reached the age of discretion, she could make her own adult choices and decisions. Josephus Coene, the father, will have been advised by his wife to go to Van den Berghe. He did so only in the years 1880 and 1891. As with the Baetslé family the women again seemed the most loyal to Van den Berghe. Maria became a quite devoted patient, but her mother, Virginia, took the initiative to consult this homoeopathic physician and did so for twenty-two years. It is difficult to assess the main reasons. They did not live in the neighbourhood, but some 1500 metres away. There was no financial gain as the family had to pay for the treatment. The likelihood is that the positive results obtained from homoeopathy and the kindness of the treating physician made them stay with Van den Berghe.

**Family 3: De Keijzer (1882-1898), Non-Paying Patients**

Four members, three children and one adult, represented the De Keijzer family. Julia (b. 1879), the first to be treated by Van den Berghe, was the daughter of Franciscus De Keijzer (1834-1897) and Maria Joanna Botman (1837-1909). Julia was the last of nine children; four of her siblings had already died. The five remaining children and their parents lived in 1882 at Groot Meerhem 133 in the old third labourers' district. Only the female members of this family made use of Van den Berghe's homoeopathy. The three brothers, Alfons, Joseph and Petrus never had medical treatment from Van den Berghe. The consultations were given free of charge.

Julia, her sister Maria (b. 1867) and their mother visited Van den Berghe with regard to one single ailment and for only a few treatments in 1882 and 1883. Julia had measles and was treated five times in little over a month in 1882. Maria (aged 16) consulted Van den Berghe twice in January 1883 with scabies that she had for the last year and that had resisted anti-scabies baths she had been taking. None of the other family members were contaminated. Madame De Keijzer received treatment twice in October 1887; her suffering was not explained. The De Keijzer women walked two kilometres to Van den

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55 Casebook 8 (1881-1882): p. 932. The De Keijzer family members: Julie (=Julia) 932A; Marie (=Maria) 932B; Madame (=Madame DeKeijzer-Botman) 932C; Enfant (=child of Marie) 932D. Cf. Appendix 5.
Berghe's practice on nine occasions, assuming that their *gratis* treatment meant that they were not able to pay for the tram.

The last De Keijzer was brought to Van den Berghe in 1898 and, according to the notes, it was a child of Maria. As she had moved to Brussels the child, who certainly had its father's name, was probably born there. It was four months old, having been born prematurely at seven months, and was suffering extremely from diarrhoea, colic and, previously, convulsions. Why Maria brought this child to Van den Berghe is unclear. There was no apparent dedication to Van den Berghe nor faith in homoeopathy as her earlier children had never been taken to him although their illnesses proved to be lethal. It would not be surprising if Maria was just visiting her mother (her father had died the year before) when her child fell ill and she did not know what to do, other than to go to Van den Berghe who offered *gratis* treatment.

The De Keijzer family were no ardent, convinced or dedicated users of homoeopathy or supporters of Van den Berghe. The men in the family never called upon Van den Berghe's services and the women who did, only did so on a very few occasions. Usually non-paying patients stayed with Van den Berghe for a longer period of time than paying patients. Although the De Keijzer's seemed inspired mostly by the free medical support from Van den Berghe and, thus, their experience with homoeopathy, they did not stay in his clientele for long.

**Family 4: De Keukelaire (1887-1897), Non-Paying Patients**

Van den Berghe rendered his services to a member of this family for the first time in 1887. The patient was Theodorus Marinus De Keukelaire (1858-1923), husband of Maria Petronilla Botman (1853-1944) and father of four. They had been married in 1879, were both illiterate and, hence, unable to sign their marriage certificate. Maria had given her husband one son and four daughters since, but the son (their first born) had died four months after his birth in 1880. The girls were stronger and would all reach old age. Theodorus worked as a packer in a factory in 1887 and his wife contributed to the family income as a cotton spinner. They lived in Mortierstraat, in the fourth district. Maria gave birth to their last child in 1888. She, unlike many other married women, worked outdoors and both parents kept on doing so for as long as their health permitted. They will not have had much surplus income and, therefore, Van den Berghe treated all members free of charge. The family moved frequently during the 1890s. They occupied six different addresses, in four districts,

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56 Casebook 11 (1885-1887): p. 639. The De Keukelaire family members in the way they were registered in the casebook: Théodore (=Theodorus) 639A; Sophie (=Sophia) 639B; Marie (=Maria) 639C; Nathalie (=Nathalia) 639D; Adolphe (=Adolphus) 639E; Louise (=Louisa) 639F. Cf. Appendix 5.
Illness as a Family Affair

between October 1890 and 1895. The De Keukelaire family, except for the early death of their first-born child, was saved from mourning over direct family members for decades. Theodorus was the second to die in 1923 at the age of sixty-five. Maria had to bury two more children as she did not finally pass away until 1944 at the age of ninety.

Theodorus, Théodore according to his file, was twenty-nine when he consulted Van den Berghe in January 1887. He had been ill for six weeks initially with the coughing up of blood. This had faded considerably but he still suffered from a dry cough and an impeded respiration. He also had chest pains. Van den Berghe was to see Theodorus thirty-five more times until January 1888. Besides the concluding remark that Theodorus was feeling very well (26th January 1888) the case notes are sparse. The second ailment that needed medical attention was influenza in December 1891. Three visits were sufficient to cure him and he now stayed healthy for some years. He left his factory work at the beginning of 1895 and started as a dockworker. The last time Theodorus needed treatment was at the end of 1896 when a cough and expectoration bothered him once again. He told Van den Berghe that he blamed himself for his suffering because he had had a cold drink while he was perspiring. Theodorus consulted Van den Berghe forty-two times in total.

The first child, Sophia, was taken to Van den Berghe in November 1888. The five-year-old girl was constantly coughing. She was treated on thirteen continuous occasions in 1888 and 1889 and was cured. Maria was introduced to Van den Berghe in 1889 with nettle rash. After two treatments with arsenic she recovered but, in 1890, the ailment returned. Maria was given the same medication and a long-lasting improvement was now obtained. Van den Berghe was needed to help this child once more in the Spring of 1894. Maria had developed an affection of the hip joint (coxarthrocace) and suffered from considerable pain in her right knee and thigh. Apparently, she and her parents were not pleased with the results and, when Maria returned in December, she had been treated and cured by another physician. Meanwhile, the next ailment had occurred. She developed convulsions because she had been dismayed at the time of her menses. She had had her period once only and currently was four months late. Van den Berghe restarted the treatment with calcium carbonicum and she remained free from fits until March the next year and she had regained her menses. Maria had her last consultation with Van den Berghe on 20th March 1895. She consulted Van den Berghe all together fourteen times between 1889 and 1895.

Two other children fell ill in 1892 and were brought to Van den Berghe. Nathalia (age 9) needed five sessions with Van den Berghe to be relieved from diarrhoea and colic. Adolphe (age 4) was coughing, expectorating bloody mucus and had a fever. His ailment also disappeared quickly. Both children
returned in 1896. Nathalia with hoarseness and nearly constant headaches; Adolphe had caught a cold. Nathalia saw Van den Berghe all together ten times; Adolphe was taken to the practice on six occasions. Three, still living, relatives never attended Van den Berghe’s practice: the mother Maria and her daughters Sophia and Amelia. Van den Berghe mentioned the name of eight-months-old Louisa in the casebook in August 1897, but nothing is known about this baby-girl.\(^57\)

Five members (or actually six, including the unknown baby) of the De Keukelaire family consulted Van den Berghe seventy-three times in a ten-year period. Father Theodore counts for half of this number, making the loyalty to Van den Berghe a predominantly male affair. None of the ailments were of a chronic or life-threatening nature, but were acute instances of a diminished state of health. Not even Maria’s inefficient hip joint was a persistent disorder. Returning with various ailments suggests that they or, at least the father, had faith in Van den Berghe. On the other hand, treatment free of charge could have enlarged the faith in or, at least, the willingness to use homoeopathy à la Van den Berghe. His treatments were beneficial to almost all. Another medical opinion was obtained for the hip joint affection of daughter Maria but, as soon as this problem had been solved, a successful appeal to Van den Berghe’s care was made again. As the De Keukelaire’s were easily relieved from their complaints, it is rather strange that Van den Berghe saw none of them after 1896. They had not left the town, nor did they suddenly have to pay for Van den Berghe’s help.

Family 5: Wilmot (1881-1882; 1888-1898)\(^58\)

The history of the Wilmot family is the tale of two different households with ten relatives becoming patients. It began in 1794 with the birth of Gregorius Joannus Wilmot. In the late 1810s Gregorius married Joanna Francisca Duijschaver (b. 1792) with whom he had many children.\(^59\) Three sons and three daughters were alive in 1846. Two of these sons came within Van den Berghe’s purview. Joannes (b. 1818) was the father of Joannus Franciscus Wilmot (b. 1845), whose household would start with Van den Berghe’s medicine in 1888. His uncle Petrus (b. 1829 and brother of Joannes) and family had consulted Van den Berghe six years earlier.

\(^57\) There is nothing present in the archives that provides any information.

\(^58\) Petrus Wilmot and family: Casebook 8 (1881-1882); p. 478; Joannus Franciscus Wilmot and family: Casebook 12 (1887-1889); p. 135; cf. Appendix 5.

\(^59\) The exact date of the marriage is unknown. DSG, Straatnamenregister 1838-1846: Kelderstraat behuik 9, district 4.
Illness as a Family Affair

Wilmot's I (1881-1882), Non-Paying Patients

Petrus Wilmot (1829-1908) was a calico-printer by profession when he married Maria Theresia Verhulst (1832-1908) in 1857. They already had one daughter, Hortensia (b. 1855), who became legitimised by the marriage and received her father's name. Petrus and Maria, prior to their marriage, had been living separately in Veerstraat (district 4) but now started a joint household. Their matrimonial life gave them eight more children, six girls and two boys. This branch of the Wilmot family consulted Van den Berghe for a period of seven months from 30th December 1881 to 8th August 1882. Five members of this household, one related by marriage, became patients.

Eugenia (age 13) was the first who needed care; she was treated for the longest period and had the most consultations with Van den Berghe. She visited him on 30th December 1881 and, although she was three weeks from becoming thirteen, she said that she had already reached that age. It is not known if she was accompanied during this visit. Notwithstanding, she did not need any help in explaining what was wrong with her, an insufferable eczema. Eugenia visited Van den Berghe for the last time in March 1882. The results of her treatment are unknown. Her father, Petrus Wilmot, appeared in the practice the next month. Perhaps, he felt confident about the results obtained for his daughter; on the other hand, he may not have had any other choice to be treated gratis.

Petrus' (age 52) first consultation took place in April 1882 and he only returned once more in June. Van den Berghe saw two more Wilmots in August. Virginia (age 5) was coughing and her mother, Maria Theresia, whose suffering was not specified. Virginia came twice, Madame Wilmot apparently thought once was enough.

The last Wilmot-member was not yet a relative at the time of her first consultation. Twenty-one-year old Maria De Raedt, the future wife of Carolus, consulted Van den Berghe once on a Sunday in October 1882. She was working in a factory and, as industrial workers only had Sundays off, she may have wanted to visit him on this particular day to avoid the loss of income.

The family contained six more children, but they were not mentioned in the file. Moreover, the period of treatment and the number of consultations of all relatives is not impressive. No patients' positive comments on their state of health have been found. Van den Berghe could have considered it not worth mentioning or too time-consuming to make extensive notes. On the other hand, the short period of time that the Wilmots used Van den Berghe's homoeopathy suggests that they were not very impressed by the therapy or the healer. Even his willingness to treat this poor family for free did not make them continue treatment. The motives for terminating the relationship with Van den Berghe
are not known though they did not leave Ghent. The other branch of the family, descending from Petrus’ brother Joannus, was more tenacious.

Wilmot’s II (1888-1900), Non-Paying Patients

Joannus Franciscus Wilmot, nephew of Petrus, had been married in February 1874 to Virginia Eduarda Diegenant (b. 1849) who lived in Gentbrugge where the ceremony took place. Virginia moved to Ghent in March of the same year and the couple settled in a house in Kelderstraat (district 4), both earning a living as flax workers. It took some time before their first child was born but, meanwhile, other relatives lived with them. Virginia would give birth to six children between 1879 and 1890; four of them, however, died at an early age. Joannus changed profession during the 1890s and worked as a wine puller (wijntrekker). This Wilmot family was more consistent in consulting Van den Berghe than the other relatives. They were treated between 1888 and 1900 and all family members became patients.

The first patient was four-year-old Léon (1883-1959) who was brought to Van den Berghe with contusions on his head and face on 13th January 1888. He had fallen into a hole two weeks earlier and bled considerably. The contusions had improved but Léon was left very discouraged and frightened. In addition, he had anal worms and, in the evenings, he was red-hot. A week later, Van den Berghe noted that he had a very ill appearance. After twelve consultations Léon was recovered and he would never visit Van den Berghe again.

Léon’s mother, Virginia, followed at the end of March. She was treated four times in the Spring of 1888, but the notes only refer to the medication she was prescribed. Ten years later, on 9th March 1897, she visited Van den Berghe about her extremities being cold all the time. Virginia Wilmot-Diegenant consulted Van den Berghe nine times in total.

Two more members of the household joined Van den Berghe’s clientele in 1889. Josephus was treated for the first time on 20th February 1889. He suffered a very serious condition; he was throwing up, coughing, had a fever and no appetite. Van den Berghe was unable to relieve him; his last consultation took place on 11th June and he died on 27th June. Eleven days before Joannus Franciscus lost his son, he consulted Van den Berghe for the first time. Sparkles in front of his eyes made everything appear to be misty and limited his view. His sight was restored and, for the next three years, he did not need treatment. Joannus returned irregularly between 1893 and 1899 with a bad cough, new sight problems or involuntary loss of sperm. Although renowned ophthalmologists practiced in Ghent, Joannus never mentioned consulting them.60 Van den Berghe treated Joannus on thirty-six occasions.

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60 Cf. Chapter 3 and Appendix 3.
The last child of the Wilmot household treated homoeopathically by Van den Berghe was five-year old Mathilda who had a tongue ulcer in the summer of 1895. The ulcer continued to grow at first but she was cured within three weeks. Mathilde, like her father, was treated irregularly by Van den Berghe. She had swollen feet in 1897 and, in 1898, she suffered from a cough and dropsy. Nothing is recorded about her ailments at the turn of the century. Her last consultation took place in March 1900 and, by then, she had consulted Van den Berghe twenty-eight times.

The Wilmot II family made use of Van den Berghe’s homoeopathy for at least twelve years. Both parents and three children, two boys and a girl, joined Van den Berghe’s clientele during this period. Gender-specific loyalty was not present though little is known about the medical histories of the Wilmots, the experiences they had with other therapies, healers and self-treatment, before they signed up with Van den Berghe. He had had his practice for nineteen years when the Wilmots appeared. No use was made of Van den Bergh e for the first three children who died prematurely. It is possible that they were users of homoeopathy already, but with another practitioner. They could have been patients of, for example, Van Peene, Van den Berghe’s colleague who suddenly denounced homoeopathy in the mid-1880s.61 Notwithstanding, from the day the first child was brought to Van den Berghe, the Wilmots became loyal patients and consulted him on a regular basis. They did not lose trust when a child was lost in 1889 but, in contrast, with their relatives, continued making use of homoeopathy for another decade. Yet, the fact that this family was always treated for free may well have contributed to their perseverance in consulting Van den Berghe.

Family 6: Van Driessche (1901-1902), Paying Patients62

The head of the Van Driessche household was Alphonsus Philippus Van Driessche (1853-1919). His wife, Joanna Christina Tency (1859-1933), whom he married in 1876, was the daughter of his mother’s second husband. They had grown up together from 1868 when their parents married. Joanna was a bride of seventeen. Alphons and Joanna started their own household in December 1876 and moved to the Belgrad o Street (district 4) where they only lived for six months. Alphons worked as a cloth painter and Joanna was his housekeeper. They would have nine children between 1877 and 1895. The Van Driessche family was acquainted with the Wilmot family. Between 1877 and 1885 they lived at Veerstraat 94 where the families of Joannus Wilmot’s sister Maria (b. 1846) and brother Livinus (b. 1853) also had their residence. The Van

61 Van Praet, De receptie van de homoeopathie, 179.
Driessches moved frequently, but they always stayed in the fourth district. When the consultations with Van den Berghe began in 1901, six children were still living at home. The Van Driessche couple never left Ghent; he dying there in 1919 and she in 1933.

Palmyra Van Driessche (17), a student, started treatment with Van den Berghe on 21st February 1901. She consulted him with hiccough-like spastic belches that she had had for a couple of weeks. She experienced them again, especially the day before she had to take an exam. She received treatment for nearly twelve months during which time she saw Van den Berghe on twenty-one occasions.

Maria (19) soon joined her younger sister and consulted Van den Berghe about a dental ailment. She could have consulted a dentist, licensed or not, but did not mention anything to Van den Berghe. Madame Van Driessche-Tency (42) visited Van den Berghe in May of the same year with an unknown ailment. Later, she had back problems, which might have prevented from helping her husband in their paint shop. Irena (6), apparently, was treated twice, but only the prescribed medication was noted. Margareta (15) received treatment for stomach-ache in 1902 and Joannus (21), known as Jan, needed help for his difficult stools. The Van Driessche’s consulted Van den Berghe thirty-five times, with Palmyra consulting him most of all. The very last consultation, by Jan, took place on May 7th and, had not Van den Berghe died shortly after, some of them might have stayed with him. They did not return to the practice of Ferdinand Van den Berghe.

Van den Berghe kept inadequately the file of the Van Driessche family. The complaints were not noted in some cases, just referring to the prescribed medication. Palmyra, the first family-member who visited Van den Berghe, is the only one who has a slightly more detailed file. All members of the household, except for the father, experienced homoeopathy. They might have become regular users of Van den Berghe’s homoeopathy had he not died. The succession by Ferdinand took some months and, perhaps, they found another homoeopathic physician before he re-opened the practice. Several other physicians offered homoeopathic treatment in the city, such as Van den Berghe’s other son, Samuel, who opened his own practice in 1896. Their compulsory short-term membership of his clientele, at least, will have thwarted the possibility of the Van Driessche family becoming regular patients of Van den Berghe and, perhaps, even supporters of homoeopathy.

5.3 Recapitulation

Many young children were not yet able to speak for themselves and to explain to Van den Berghe what they experienced or felt. Instead, adults who accompanied them at a consultation, acted as intermediaries explaining their
suffering. Study of the medical records of children only reveals occasionally their personal subjective perception of disease or pain. It is often the agony and sorrow of worried parents’/caretakers’ that is brought to light in the casebooks.

The children taken to Van den Berghe were labouring under all types of ailments that, in principle, were far from being fatal. Yet, the high child mortality worried parents who were easily alarmed by a coughing child. Girls may have had an even greater chance of dying before reaching adulthood, mainly because of the traditionally less favourable attitude towards the female gender. Yet, within Van den Berghe’s practice, at least as much attention was requested for sick girls as it was for sick boys. Besides, both boys and girls suffered mostly from the same complaints, a cough, diarrhoea, eye disorders and all sorts of skin ailments, and twenty per cent of the children younger than eleven had to deal with the consequences of typical children’s diseases.

It was the accompanying party of a child who explained, on many occasions, what had happened. Some children were said to suffer from purely medical circumstances, such as being contaminated, some were victims of an accident or unhappiness and yet others were thought to have fallen ill because of the behaviour of adults such as the misconduct of a parent. Just as these explanations were not gender specific, neither was the treatment of boys and girls. They were usually prescribed medication and their parents were instructed on the diet that was needed. The children were told, most of the time, to take the medication orally, toddlers sometimes received it via breastfeeding and, occasionally, young patients were simply asked to take a sniff at a bottle containing liquid medication. More than a quarter of the children consulted Van den Berghe only once. Loyalty towards him or his treatment was not a priority for them or their parents. The remaining children did not persevere persistently with Van den Berghe. It seems, therefore, far more likely that parents were willing to try anything to counteract the potential threat imposed on the lives of their small loved-ones.

The stories about the ‘homoeopathic’ families also give insight into the caring attitude of parents for their children as, on some occasions, the ‘family treatment’ had started with the consultation of a child. Moreover, these biographies reveal the extent to which illness, birth and death within one single family had to be dealt with. The biographies show that, where large families are concerned, fewer remarks are present in the files about ideas, therapeutic experiences and medical knowledge. Even complaints are not properly noted in some instances. Yet, it is still possible to reconstruct slightly the dedication and loyalty towards Van den Berghe or towards homoeopathy and the relations within families.

The biographies being based on the information available in the casebooks and adjusted with data in the municipal archive.
Making use of Van den Berghe or, indeed, of homoeopathy was not restricted by gender or age. Sometimes, the head of the household, the father, was the first to consult Van den Berghe; sometimes, the mother was and, occasionally, a child was the first. The instances in which Van den Berghe’s medical skills were carried on to grandchildren are remarkable. Within the selected families it was only the daughters, not the sons, who introduced their children to Van den Berghe. However, the initiator in consulting Van den Berghe remains unknown. The decision-making process within a family, the discussions ‘around the kitchen table’ about what to do in the case of illness, is still very unclear. Moreover, family-members by marriage, who became patients as well, were people outside that particular initial household and eventually made their decisions within their own family surroundings. The same applies to grown-up children making choices and taking action for their own offspring.

What motivated entire families to put themselves in Van den Berghe’s care? Was it the specific treatment he brought into practice, was it his reputation and, therefore, his personality or was it the less ‘noble’ reason of financial benefit? Van den Berghe became the main physician for some families; he treated all members over a considerable number of years. Other families were less loyal, they made use of other remedies or practitioners or not all family members consulted Van den Berghe. Only the women became patients in the case of the De Keijzer family but, possibly, the men were continuously healthy. The consultation behaviour of the families shows that, although they sometimes stayed with him for quite some time, permanent loyalty towards Van den Berghe and/or a trust in homoeopathy is difficult to establish. Yet, their return after years of absence, the bringing along of children and grand-children of patients, the beneficial treatment of many disorders and the cures offered for free turned Gustave Van den Berghe into a family physician. However, the impression remains that for many, individuals and families, the appeal of Van den Berghe’s homoeopathic medicine was often based on the free treatment he offered. Nevertheless, such an assumption has to be treated with caution. It could be that, in the long-term, even families with small financial means found more success with homoeopathy than with any other remedy. It is far too rash to state that paying families made a more conscious choice in favour of homoeopathy than the non-paying families.

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64 I have read all patient files in the casebooks and can draw no other conclusion than that sons did not introduce their off-spring to Van den Berghe’s homoeopathy. At least no such story has been found. This is not to say that some might have chosen later on to try homoeopathy with another physician. The relation between gender and consultation perseverance will be closely studied in Chapter 6.
6

The Ailment, the Patient and the Doctor

Ghent 28 April 1899

Sir

No. 63, Book 17. I [do feel] a little better; the divagations have disappeared, but can't leave the room because of the tremendous headache and the weakness in the legs, I am also oppressed on the chest to such an extent that I can hardly breath all my respiratory organs wheeze, and food or drink can hardly pass from the part that goes from throat to stomach. My [...] is also raw, I think Sir that if I could expectorate a little, I would be relieved. I still don't have an appetite; I also did not go to the convenience since Monday. Behold Sir how I am feeling and thanking you in advance

My sincerest greetings

Bernard Pesant

N.B. My stomach throws up hardly and everything still corks up

Bernard Pesant (1860-1919), a butcher in Ghent, wrote this letter to Van den Bergh three months after he had started homoeopathic treatment. At his first consultation in January it became clear that he suffered both physical and mental problems, although the last category was not mentioned in his letter. Bernard Pesant was an emotionally labile person, afflicted with nervous crisis and fearing death. He had been, as he admitted to Van den Bergh, a frequent consumer of jenever and beer. Pesant attributed his ailments to his behaviour whilst being a soldier when he had neglected his diet and smoked a lot.

It was not unusual for Bernard Pesant to write to Van den Bergh. He had sent, on another occasion, an undated written cry for help. He had wrongly ingested too much medication and was constantly coughing and shaking and, therefore, unable to leave the house to see Van den Bergh in person.

Sir, By mistake I have at once taken an entire powder and now I do nothing other then vomiting and trembling. Please help me, yours truly Bernard Pesant Book 17 n. 63.2

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1 Casebook 17 (1898-1901): p. 63. Letter by Bernard Pesant to Gustave Van den Berghe. For the original Dutch text, see Appendix 2.

2 For the original Dutch text, see Appendix 2.
It is not inconceivable that Pesant's condition interfered with his professional obligations and his duty to provide for his second wife and their child, Maria. Life had not been easy on him. He had had four children with his first wife Maria Mestdagh (1869-1893) whom he had married in 1885. She had passed away in December 1893. Her death and the death of their last living child, Rachel, four months earlier, had taken place in the year that Pesant started to develop his complaints. Yet, these emotional events were not given as the causes of his unstable mental state; he attributed his suffering to events during an earlier phase of his life.  

Bernard Pesant stayed with Van den Berghe for a little over seven months and consulted him, personally or by mail, on thirty-five occasions; approximately five consultations per month. His case file suggests that his mental and physical condition had hardly improved, but Pesant decided not to use Van den Berghe any further. Then, his wife and daughter consulted him in January 1900. They only visited him twice, the mother suffering from backache and headaches and the child from a cough and eczema. The Pesants did not belong to Van den Berghe's clientele for a long time nor did they consult him on an extraordinary number of occasions.

Here, the Ghent patients' individual suffering and their personal stories about illness from the moment they entered Van den Berghe's practice are examined. An assessment is made about how long these people had been suffering and seeks to determine whether these patients were primarily inflicted with acute or long illnesses. The ailments people suffered from are considered and the possible correlation between personal circumstances and conditions, e.g. gender, social class and age versus illness, is provided. Moreover, questions regarding people's behaviour whilst under Van den Berghe's guidance and their 'loyalty' towards this homoeopath are asked by contemplating the consultation behaviour of patients, i.e. how often they consulted Van den Berghe and for how long they remained under treatment. Were most patients so-called 'shoppers' in the medical market or did most display persistence in undergoing Van den Berghe's homoeopathic treatment? The doctor-patient relationship is analysed by studying the attitudes of patients towards Van den Berghe and the patients' behaviour patterns. Thus, an impression will be given of the level of 'treatment participation' by patients and the balance of power between the sick person and the doctor.

3 With his second wife Livina Lammens (b.1867) he had two children of whom one died within three months after birth. DSG, Straatnamenregister 1881-1890: Dendermondsesteenweg 273, district 7 and Straatnamenregister 1891-1900: Dendermondsesteenweg 247, district 7.
6.1 Acute versus Long Illnesses: the Length of Suffering

Present-day research has shown that many people opt for homoeopathy out of dissatisfaction with orthodox medicine. The attempts to overcome their, often, long-term conditions with prevailing medical science failed and made them look for other options. Indeed, sufferers and homoeopathic practitioners nowadays often recognise chronic disease as the domain of classic homoeopathy par excellence. The treatment of chronic disease, according to homoeopathic medicine, profits profoundly from a detailed and careful anamnesis, in particular past affliction with skin ailments. This emanates from the homoeopathic idea that chronic suffering is caused by the suppression of three types of infectious diseases or miasms, sycosis, syphilis and psor (scabies). It is necessary to know if any of these three miasms have been part of the patient's medical history to treat people properly.

It was of great importance to Van den Bergh to follow Hahnemann's 'law' on proper case-taking and profound anamnesis and he arranged his office hours accordingly. Each first consultation was started with a general introduction during which he noted the patient’s name, age and address or place of residence. Then, he inquired after the medical history of the sufferer, past occurrences of skin ailments and venereal disease, and specifics about how long the patient had been afflicted with the present ailment. Finally, the patient was asked to describe what the suffering consisted of. These personal descriptions of symptoms and complaints were noted in the patient’s file, thus, reflecting primarily the sufferer’s own words.

Some people told Van den Bergh they had been ill for almost their entire lives; others had become indisposed just before turning to him. Although it is known that modern users of homoeopathy often do so because of chronic suffering, patients in the history of homoeopathy are hardly heard on this subject. Apart from the occasional extended case description, systematic

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research and data concerning chronic or acute suffering in consumers of homoeopathic medicine are not available. The term ‘chronic suffering’ relates to long-term afflictions, irrespective of whether the condition(s) are regarded as chronic, for example, epilepsy, asthma and various skin disorders. Thus, ‘chronic suffering’ refers to the length of the illness, whereas ‘chronic disease’ refers to specific conditions.

Those who chose Van den Bergh and/or homoeopathy were not driven merely by the lengthy nature of their suffering. Nearly sixty per cent of his sampled patients had been suffering for no more than one year, of them twenty per cent had fallen ill, at the most, one month before consulting him. Another twenty-two per cent had been ill for between twelve and forty-eight months. A little over ten per cent had been afflicted for five or more years. No significant differences were found between men and women; both genders had been suffering for much the same amount of time.

Hence, the ‘illness periods’ of the patients confirm that the ability to cope with health problems, or the mere acknowledgement of them, differed from person to person. The large group, for example, that visited Van den Bergh after suffering for one to three years implies that the limits of what they could endure had been reached. The health complaints, apparently, had lasted too long and doubts about any eventual recovery possibly made them turn to Van den Bergh as a last resort. These long-term sufferers, however, were often afflicted with seemingly acute, rather than chronic, diseases, such as a cough or a cold. Seventeen per cent of this group consulted him about abdominal and intestinal complaints. Back troubles and joint complaints were endured by five per cent. Van den Bergh noted, for another five per cent, that they were tuberculosis sufferers. This condition, at times, could lodge in people for a long time before ever becoming fatal. Some patients needed help for the consequences of a cerebral congestion or paralysis. Van den Bergh could often do nothing but offer understanding and mental assistance for them.

One long-term sufferer was Pier Cnuddé (26), an upholsterer, who became a patient in the winter of 1870. His suffering had begun five years previously when he was confronted regularly with a polyp on his nostrils. Two operations had not offered relief. Initially, Van den Bergh was able to make the polyp disappear but, in 1871, Pier was forced to re-start treatment as his nose condition had returned. Cnudde visited Van den Bergh with an ailment that had bothered him for some years. However, patients who claimed to be suffering unremittingly were not always suffering one single chronic disease.

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Some of Van den Berghe's patients had fallen ill long before but, now, were requesting medical care for complaints of a different nature. They might not have been feeling well or they were suffering from several ailments time and again. Francisca Droogers, a shopkeeper aged fifty-three, had been ill since her period ceased to appear eight years previously. Yet, the condition for which she consulted Van den Berghe in 1871 had nothing to do with this female disorder; she wanted treatment for a respiratory ailment. She was always coughing during the winter, which caused her headaches and back problems. Coachman Seraphien Broens (b. 1823) was the longest suffering patient in the sample. His health had been weak since he was born fifty-four years previously. However, he consulted Van den Berghe with complaints about his lack of appetite, an ailment that, at first sight, does not appear to be chronic. Jacques Evens (age 65) told Van den Berghe that he had been ill since the age of forty-six. It seems, though, that he was more bothered by his current failure in lovemaking. Evens had been used to having intercourse once a month with his first wife whilst, with his second wife, whom he had married the year before, he had not been able to do so as he had developed recently almost complete impotency.

Obviously, those suffering from one and the same condition for a very long time were also present among Van den Berghe's clientele. Jean Seghers had been struggling with constipation for thirty years. Widow Delathouwer could tell even more about the reasons for developing chronic complaints. She had suffered cholera in 1868, surviving this often lethal disease, but had been left with diarrhoea and pain in her womb. Thirty-one years later she became his patient, asking for a cure for these continuing problems. Moreover, disorders often reputed to be of chronic nature, for example, asthma, epilepsy, eczema and the like were treated by Van den Berghe on a regular basis.

### 6.2 Please Relieve the Agony: the Suffered Ailments

Even though, at times, the medical knowledge of ordinary nineteenth-century people was negligible, it did not restrain them from communicating perfectly what was wrong with them. Pain, discomfort, misery and worries were expressed easily and plainly. The sufferer used their own set of concepts and words, their own vocabulary, to describe health complaints. Occasionally, an appeal to the imagination is made when extensive examples were given to illustrate the sensations of suffering. Although the casebooks were the property

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In Search of a Cure

and working notes of the physician, the personal experiences and ideas of patients were integrated as well. The medical files are more than a reflection of the physicians' thoughts; they form, at times, a mirror of lay-notions about illness and suffering. The casebooks, yet, were not direct patient testimonies. The finite form, when noted, is predominantly in the third person singular: 'il me dit' (he tells me), 'elle attribue la maladie a...' (she attributes her illness to...). Nevertheless, their stories of physical and emotional distress are no less real.

Some came to Van den Berghe with a comprehensive list of complaints but, at the same time, were more often than not capable of distinguishing primary and secondary symptoms. In other cases, the person who was in need of medical attention singled out one particular ailment which required cure. These illnesses, conditions, symptoms or complaints with which Ghent people consulted Van den Berghe have, in accordance with the chapter on children and their conditions, been made into a reference list (Appendix 6).

Table 1. Disorders of the Respiratory Organs in Men and Women (based on the sample of 1,826 Ghent patients)

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td>14</td>
<td>7</td>
<td>21</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Cough and/or expectoration</td>
<td>136</td>
<td>145</td>
<td>281</td>
</tr>
<tr>
<td>Lung emphysema</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Pleurisy</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory complaints</td>
<td>25</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>Tuberculosis etc.</td>
<td>25</td>
<td>17</td>
<td>42</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>206</td>
<td>196</td>
<td>402</td>
</tr>
<tr>
<td><strong>(27%)</strong></td>
<td></td>
<td><strong>(18.5%)</strong></td>
<td><strong>(22%)</strong></td>
</tr>
</tbody>
</table>

All types of illnesses were present ranging from contagious and life threatening to non-infectious and/or easy to overcome. Even so, there was more risk, apparently, of catching one condition than another. A cough and/or expectoration (281), abdominal and intestinal complaints (221), headache (72), diarrhoea (66) and skin ailments (66) were lurking afflictions endured by thirty-

13 Cf. the Introduction.

14 Please note that the overview of the ailments of child patients in Chapter 5 was based on the files of children from both the Zwevegem and Ghent practice and living in Ghent or elsewhere. The current survey exclusively concerns patients from Ghent, both children (320) and adults (1,439), of 67 people the ages are unknown.

15 For a detailed account regarding the construction of the sample, please see Chapter 4.
nine per cent of Van den Berghe's sampled patients. Constant coughing, with or without bringing up phlegm or blood, equally bothered men and women who consulted this homoeopath. It is the single most present affliction in his patients yet, not the only one concerning the respiratory organs.

Table 1 reflects the disorders of the respiratory organs and shows that the men (27 per cent) in Van den Berghe's clientele were more often affected by respiratory ailments than the women (18.5 per cent). Asthma patients expressed much the same kind of suffering and the average asthma sufferer had the ailment for some time and would not be liberated from this condition. They, at best, would be less short of breath after Van den Berghe's treatment. A blond young man, eighteen years of age, had been suffering asthma for years and, in 1869, he sought a cure by consulting Van den Berge. The man was keen on travelling but staying at home in Ghent benefited his condition.

When he is in Ghent never has asthma attacks, neither any longer in the countryside, but in Vichy, in Coblenz and other German cities, just like at his mother's castle in Zotteghem, he is every night taken by an asthma attack.  

A female patient concluded that her asthma was the result of having caught cold some fourteen years previously. Another male patient had a rather intriguing story about the origins of his asthma. This thirty-six year old tailor told Van den Bergh that he had developed this respiratory condition six years previously, after he had seen a ghost in his bedroom.

People who had respiratory complaints faced symptoms such as impeded respiration, breathing difficulties or pain during inhalation. Bernard Standaert was one of the patients who complained about impeded respiration. He started treatment in September 1881, at age 49, and he stayed with the homoeopath for several years. Standaert consulted Van den Bergh very often; 227 times in five-and-a-half years, an average of forty-two times per year! At his first consultation, Standaert complained primarily about his impeded

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16 Casebook 1 (1865-1869): p. 908. 'qd [quand, AH] il est à Gand n’a jamais d’accès d’asthma, non plus sur des montagnes , ms [mais, AH] a Vichy, a Coblenz et autres villes d’Allemagne, aussi au château de sa mère a Zotteghem ttes [toutes, AH] les nuits il est pris d’un accès d’asthma'.


19 Bernardus Standaert (b. Tronchienne, 1832 - d. Ghent, 1888). Bernard earned a living as a weaver and, in August 1881, he was awarded a decoration second grade for his skills. He and his wife Elisabeth Minne (Ghent, 1832-1907) had three living children (three had died at a very young age) who were all registered as factory workers. Casebook 8 (1881-1882): p. 302; DSG, Straatnamenregister 1881-1890: Kasteellaan 423, district 7.
respiration which had been bothering him for four years; but he said also that recently he had developed a cough and brownish urine. His initial complaints never disappeared; on the contrary, new ailments were added. Bernard Standaert was not easily put off by Van den Berghe’s inability to relieve his suffering but, in April 1888, he eventually suspended the treatment. He died six months later on 26th October.

A few of those who consulted Van den Berghe because of coughing and expectorating will have been suffering from tuberculosis. Standaert, with his impeded respiration and cough, might have been a consumptive. One out of five deaths in Belgium around 1880 was caused by tuberculosis and, once afflicted with the disease, chances of survival were small. Coughing up blood or mucus was symptomatic of this often fatal disease. Tuberculosis, or consumption or phthisis, was a very serious illness prevailing amongst all social strata of the population. However, the working class especially fell victim. Seventy per cent of those who died from tuberculosis in Ghent between 1895 and 1898 were aged between twenty and fifty.20 Medical and political authorities hardly understood the nature and risk of contagion of tuberculosis, hence the settled notions that the disease was hereditary or caused by the promiscuous way of life of the working class. The infectious character of tuberculosis had been shown by Villemain in 1865 and, especially, Koch’s discovery of the tubercle bacillus in 1882, removed the presumption of the hereditary nature of the disease. The bad living and working conditions of people became recognised as the predominant source of infection.21

Girls and young women were more susceptible to tuberculosis than their male counterparts though the reasons are unclear. It has been suggested that this was because women spent more time in secluded non-ventilated spaces.22 Working women in German textile industries were extremely susceptible to lung tuberculosis and illnesses of the respiratory organs (often the forerunner of TB). This was explained by the dusty and high temperature working environment.23 Tuberculosis was hardly treatable and, therefore, substantial attention was given to means of prevention. The spread of consumption, according to medical professionals, should be stopped by improving socio-

economic circumstances, by promoting a hygienic life-style, by offering free X-ray examination and by separating consumptives in sanatoria.  

Forty-two people within the sampled clientele were specifically diagnosed by Van den Berghe to have suffered tuberculosis. No social class was immune from tuberculosis and, moreover, the consumptive patients were not living in the particular working class districts (Appendix 7). In three cases it is known that he was not able to help the patient; sooner or later they died from consumption. The merchant Joseph Bonne Maes (b. 1842) died of 'disease of the lungs' within four months of his last consultation with Van den Berghe. He left his wife and two small daughters, aged two and four. Eighteen-year old Gustave Geerlandt turned to Van den Berghe in the summer of 1897. He was overtaken by tuberculosis and suffered severe coughing, expectoration and pain in his left side. After an initial improvement, his condition deteriorated critically in December 1898, and Van den Berghe began prescribing Koch's bacillus and tubercles in homoeopathic dosage. It did not benefit Geerlandt as he died after sixty-nine consultations on 19th April 1899.

Van den Berghe did not deny nor conceal that medical homoeopathic science was mostly powerless in treating tuberculosis. He was honest towards his terminal patients, telling them that there was nothing he could do and that he would not take on their treatment. He then noted in the file 'ne l'accepte pas' ([I] do not accept), 'ne traiterai pas' ([I] will/shall not treat) or 'rien a faire n'accepte pas le traitement pour ne pas compromettre l'homoeopathie' (nothing left to be done, [I] do not accept treatment to avoid compromising homoeopathy).

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25 Phthisis is the Greek word, meaning 'wasting', hence the general term (pulmonary) consumption. In the patient files all three terms are used. The tubercle bacillus could also settle elsewhere in the body, instead of in the lungs, for example in the glands of the neck. This type, called scrofula, was the most common and less lethal. See: Joan Lane, A Social History of Medicine. Health, Healing and Disease, 1750-1950 (London and New York: Routledge, 2001), 141-143.


27 Casebook 16 (1896-1898): p. 263. The notation of this medication in the patient file was: Bacill. de Koch and Tub. De K. DSG, Straatnamenregister 1891-1900: St. Lievensstraat 167, district 7. Gustave Geerlandt was treated for free by Van den Bergh. Although he did not work, his family will not have been infinitely poor as his mother was an innkeeper and three of his (living-in) brothers worked as respectively housepainter, photographer and labourer.

Such remarks were found in his casebooks dating from before the Prussian, Robert Koch, discovered the tubercle bacillus in the early 1880s. After that time, Van den Berghe never refused a consumption sufferer ever again, even though the newly developed treatment was far from infallible and he would continue to lose patients.

The medical histories of relatives, more specifically the causes of death of deceased family members, were thought to be very relevant and, consequently, often formed part of the conversation between patient and physician. Knowledge about the incidence of tuberculosis in the family better enabled the physician to complete the anamneses in great detail and to decide on the proper treatment. Patients needed to share this information often solely to temper their anxiety. They were troubled by the fear of contamination after a relative had died of the disease. Tuberculosis deaths were to be found in the best of families and for many the loss of a loved-one to this dreadful disease had to be coped with. A male patient from Ghent had lost his parents, three brothers and one sister to phthisis. A female patient from nearby had also lost both her parents and three sisters.29

Besides disorders of the respiratory organs, abdominal and intestinal conditions were prevalent also among the Ghent clientele and, hence, population (Table 2).

Table 2. Gastro-Intestinal Suffering in Men and Women (based on the sample of 1,826 Ghent patients)

<table>
<thead>
<tr>
<th>Condition</th>
<th>Men</th>
<th>Women</th>
<th>Unknown</th>
<th>Total</th>
</tr>
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<tbody>
<tr>
<td>General abdominal and intestinal</td>
<td>67</td>
<td>154</td>
<td>221</td>
<td>221</td>
</tr>
<tr>
<td>complaints</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>34</td>
<td>30</td>
<td>2</td>
<td>66</td>
</tr>
<tr>
<td>Colic</td>
<td>4</td>
<td>10</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Anaemia</td>
<td>1</td>
<td>3</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Nausea</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Vomiting</td>
<td>4</td>
<td>13</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Worms</td>
<td>2</td>
<td>4</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Jaundice</td>
<td>3</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Other liver conditions</td>
<td>2</td>
<td>2</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>117</td>
<td>220</td>
<td>3</td>
<td>340</td>
</tr>
<tr>
<td></td>
<td>(15%)</td>
<td>(21%)</td>
<td>(19%)</td>
<td></td>
</tr>
</tbody>
</table>

Many city-dwellers expressed general complaints about affections in their upper and lower belly or stomach, or gave precise descriptions such as constipation and indigestion (or dyspepsia). These gastro-intestinal ailments

were common and a cause of death for many, especially children. If diarrhoea, colic, anaemia, nausea, vomiting, worms, jaundice and other liver conditions are added to the list of gastro-intestinal complaints, the total number of afflicted in the sample is reduced to 340 (19%). The men seemed susceptible to conditions of the respiratory organs. The women in Van den Bergh’s clientele, apparently, were more prone to abdominal suffering, twenty-one per cent compared with fifteen per cent for men.

More women than men in this homoeopath’s clientele were victim of abdominal and intestinal conditions. A study of the historical female body, on the basis of medical records and remains from ‘popular’ culture, provides several explanations for the vulnerability of women with regard to abdominal suffering. Some digestive ailments were simply more present in women, just as teen-age girls and fertile women were considerably more subject to peptic ulcers or fatal pelvic infections. Moreover, women complaining about abdominal aches, often probably suffered actually from infected abortions or the after-effects of childbirth.30 Housewife, Marie Coussens, needed medical care for abdominal pains, frequent diarrhoea and a swollen belly in December 1896. These complaints were bound to her feminine gender. The suffering had started after the birth of her first child eleven months earlier and was accompanied by strong vaginal discharge and an irregular menstrual cycle.31 Furthermore, it is quite possible also that women complaining about nausea and vomiting were not suffering from gastro-intestinal conditions but, instead, were pregnant. Nevertheless, although the abdominal suffering of women, in some cases, may be considered as suffering related to their gender (i.e. female disorders), they were usually afflicted with ‘just’ a gastro-intestinal illness.32

Ear, nose, throat and eye disorders were another large part of conditions that Van den Berghe treated. Men and women were almost equally afflicted with this type of ailment (6.4 against 6.7 per cent). Patients requesting medical advice and treatment for throat troubles complained about having a sore or constricted throat or being hoarse. Leonardus DeLeeuw’s hoarseness meant great inconvenience as he earned a living as a newsvendor. The ailment was caused by his job as he had to shout to draw attention but, at the same time, interfered with it. A forty-seven year old male singer also needed treatment for hoarseness as he was not able to perform.33 Madame Bosschaert (55) faced several health problems for eighteen months. Her throat had been cauterised

30 Cf. Shorter, Women’s Bodies, 231-236, q.v. 234-236.
32 Chapter 7 will discuss further the appearance of illness in women and then, above all, the so-called female disorders. The matter of venereal and other sexually related ailments suffered by Van den Bergh’s (mainly male) patients will also be raised.
before with iodine. She had been referred also to Aix la Chapelle to tackle the pain in her lower limbs with a water cure. Yet, none of this had improved her conditions. She consulted Van den Bergh with a wet and slimy throat and declining eyesight. Apparently, she did not have much confidence in his medical skills for, after two consultations within one week, she disappeared from the practice.34

Occasionally, sufferers from cardio-vascular ailments came to Van den Bergh, but he rarely diagnosed a serious heart condition (cardiac arrhythmia or hypertrophy). However, many were easily worried and complained about pain and pressure in the heart region or frequent palpitations. The possibility of blood vessels becoming constricted and, thereby, hindering movement was not recognised by patients, but may have been a cause of walking difficulties or of pain in the legs. Neurological conditions and affections of the nervous system were present in over nine per cent of Van den Bergh’s patients, with a slight predominance of these ailments in women (56 per cent).35 Headaches and migraine in particular formed female conditions, seventy-eight patients suffered from them, sixty-two being women.

Further comparison of ailments and gender of the patients does not reveal any significant results, except in the case of skin ailments and sex related complaints. Female patients endured seventy per cent of the skin ailments.36 Any explanation of the predominance of skin disorders in women is difficult, but that fourteen out of the nineteen children afflicted with such ailments were girls, suggests that the high percentage of skin ailments in women is caused partly by the susceptibility of girls. While skin ailments, apparently, were primarily a female matter, sexual and venereal ailments were overwhelmingly a man’s business. Van den Berghe, from this sample, treated fifty-four patients for genital disorders. Forty-one requested a cure for gonorrhoea, syphilis, chancre or herpes. Merely nine, one out of five, were women. However, that few women sought help for sexual ailments (or non-venereal conditions of their genitals) is less certain than it appears. Unless they told Van den Berghe that their ailment resulted from sexual activity female genital conditions were gathered under the heading of ‘female disorder’.37

35 The complaints brought together as neurological conditions and affections of the nervous system are: cerebral congestion, chorea, convulsions, dizzy spells, epilepsy, fainting fits, headache, hysterical convulsions, migraine, nervous disorder, nervousness, neuralgia, seizure, stroke and vertigo.
36 Complaints classified under the heading skin ailments are: itch, eruption, eczema, psoriasis, rash and ringworm. Small pocks are not included, yet in one case present. Ten-months-old Arthur DeBurie, son of a weaver, suffered that disease.
37 The suggested correlation between sex and venereal disease will be discussed and elucidated in Chapter 7.
The Ailment, the Patient and the Doctor

Men were more susceptible apparently to conditions of the respiratory organs and venereal disease; women were more prone to gastro-intestinal disease, skin ailments or headaches. Both sexes had an equal chance of getting ear, nose, throat and eye disorders. The examination of the complaints of patients, thus, gives some idea of the potential significance of sex and gender in developing or being more prone to certain conditions. Would social background constitute, at times, a determinant in the development of particular ailments?

What were the complaints with which patients consulted Van den Berghe in relation to their social class (Appendix 7)? Patients from the upper class mainly suffered from asthma, headache and skin ailments. Respiratory disorders especially seem to have been a problem of the higher classes; of the eight patients suffering asthma six belonged to the higher middle and upper classes. Members of the peerage, four women and one child, suffered the skin ailments found amongst the upper class. Those belonging to the working and lower middle class were often afflicted with abdominal and intestinal complaints or (expectorating) coughs. Diarrhoea, headaches and, again, skin ailments also had to be endured. However, this sample of Van den Berghe's patients does not provide evidence for strong conclusions on the risk of catching a particular disease because of social class and occupation. Yet, the number of working and lower middle class patients in Van den Berghe's practice, supposes in itself that people from less well-situated social backgrounds probably were affected sooner by illness than the upper classes.

Socio-economic circumstances, at times, formed a source of suffering as work could lead to all types of ailments. Industrial workers complained about the dusty environment causing breathing and similar difficulties. A thirty-nine year old female factory worker developed lung emphysema and she explained that her work in the dust (dans la poussière) made her cough. The amount of hours working in the printing business, for a thirty-five year old man, caused his complaints. After a good day's rest, X always went back to work with fresh courage on Monday, practising his trade in perfect health. However, his health deteriorated, if he had to work longer than six hours per day during the rest of the week. Labour could be a cause of illness and, sometimes, was recognised as such by patients. Conditions were more often explained, however, from an emotional or behavioural point of view.

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38 Social class is again based on the patients' professions, cf. Chapter 4, Graph 5, footnote 72. The number of 505 patients consists of the 441 people from sample (all casebooks) and 94 patients from sample one (casebooks 1, 8 and 17) of whom both condition and occupation were noted.


40 Ibidem: p. 704.

41 As will be attested in the last chapter.
This analysis of the connection between personal circumstances and, on the one hand, the susceptibility to disease and, on the other, going to consult a physician, concludes by considering age. Van den Berghe had noted both complaints and age of 1,428 adults in the sample (Appendix 8). A relatively higher sensitivity towards gastro-intestinal ailments came with advancing years, sixty per cent of the patients over the age of fifty suffered conditions of this kind. Older people were more often confronted also with weaker or painful joints and backs. The battle against a cough and/or expectoration was not reserved for people from a particular age category.

People older than fifty hardly consulted Van den Berghe for consumption, yet, it seems unlikely that there was no longer susceptibility to the disease above a certain age. It will have been the result of the fatality of this lung condition; most people did not survive the disease and died early. Fifty appears to form an age limit for other suffering as well. Typical women complaints were taken to the doctor less often, just as men suffering from venereal diseases appeared less frequently in Van den Berghe's practice. However, from this sample, it is largely impossible to make firm statements about the age at whichguard should be taken against which diseases. Nevertheless, young patients were more likely to catch one disease than another.

6.3 Patients' Consultation Behaviour: Frequency and Length of Time

Allopathic or homoeopathic self-treatment, consulting other allopathic and homoeopathic practitioners, experiences with unorthodox healers or methods; all of these options for healing were mentioned by patients who eventually consulted Van den Berghe. The therapeutic histories of the patients demonstrate that the sufferers were acting primarily as 'shoppers' changing between different orthodox and unorthodox healing methods, employed by themselves or by others. Still, it is possible that, after becoming acquainted with Van den Berghe and his homoeopathic treatment, there was an inclination to a more permanent and pronounced commitment to homoeopathy. Therefore, the consultation frequency and period of the sampled Ghent patients have been considered.

It is clear that the major part of Van den Berghe's Ghent clientele did not become permanently committed or, at least, not to him (Table 3). The 1,826

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42 As far as the ailments of children and youngsters are concerned please refer to Chapter 5.
43 Appendix 8 reproduces the data regarding patients above age sixteen, divided into age categories.
44 See also Chapter 7 on women's complaints.
45 See my earlier examination of children.
46 See Chapter 3, paragraph 3.
patients consulted the Ghent homoeopath on 17,811 occasions, including the written medical advice, an average of 10 consultations. The consultation frequency differed extremely. Some sought medical aid on only one occasion, whereas others continued to do so on many occasions. One lady consulted Van den Berghe 654 times over a period of fifteen years.47

Table 3. Frequency of Consultations to Van den Berghe, 1869-1902
(based on the sample of 1,826 Ghent patients)

<table>
<thead>
<tr>
<th>Number of consultations</th>
<th>Total number of patients</th>
<th>Total number of consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>487</td>
<td>487</td>
</tr>
<tr>
<td>2</td>
<td>303</td>
<td>606</td>
</tr>
<tr>
<td>3</td>
<td>202</td>
<td>606</td>
</tr>
<tr>
<td>4</td>
<td>116</td>
<td>464</td>
</tr>
<tr>
<td>5</td>
<td>118</td>
<td>590</td>
</tr>
<tr>
<td>6-10</td>
<td>242</td>
<td>1,864</td>
</tr>
<tr>
<td>11-20</td>
<td>164</td>
<td>2,411</td>
</tr>
<tr>
<td>21-30</td>
<td>79</td>
<td>1,959</td>
</tr>
<tr>
<td>31-50</td>
<td>56</td>
<td>2,143</td>
</tr>
<tr>
<td>51-100</td>
<td>38</td>
<td>2,750</td>
</tr>
<tr>
<td>101-200</td>
<td>14</td>
<td>1,946</td>
</tr>
<tr>
<td>201-600</td>
<td>6</td>
<td>1,331</td>
</tr>
<tr>
<td>&gt;600</td>
<td>1</td>
<td>654</td>
</tr>
<tr>
<td>Total</td>
<td>1,826</td>
<td>17,811</td>
</tr>
</tbody>
</table>

More than a quarter of the Ghent patients from the sample (487) consulted Van den Berghe only once. Although it could be argued that they were just trying to find the therapy or doctor that suited them, some of the ‘one consultation’ patients died soon after the date of their first visit.48 Van den Berghe had noted one female patient as living in Ghent, but she did not live there. Madame Dedeckere-deKorte from Hoofdplaat in the Dutch province of Zeeland, probably, was visiting her daughter Maria Theresia in Ghent, when she was afflicted with burning sensations in her hands. It is most likely that Maria, already a patient, advised her mother to go to Van den Berghe, and it is not surprising that she did not return subsequently. Nevertheless, some patients were cured after only one consultation.

The patients who continued their treatment returned usually within a week of their first consultation. These follow-up visits were not as lengthy as the first. Van den Berghe noted the current state of his patients as worse, same, or improved; their new complaints if present and the medication he had

48 Evidence from research in the municipal archive.
prescribed. The Ghent patients remained under treatment for seven months on average, sometimes for one and the same ailment; on occasion, people returned with totally new disorders. However, the data indicates that patients who continued treatment cannot be considered as definite 'stayers' (Table 4).

Table 4. Consultation Period of Van den Berghe's Ghent Patients, 1869-1902
(based on the sample of 1,826 Ghent patients)

<table>
<thead>
<tr>
<th>Consultation period</th>
<th>Total number of patients</th>
<th>Percentage of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day (= 1 consultation)</td>
<td>487</td>
<td>27%</td>
</tr>
<tr>
<td>2 days-4 weeks</td>
<td>558</td>
<td>31%</td>
</tr>
<tr>
<td>4-8 weeks</td>
<td>176</td>
<td>10%</td>
</tr>
<tr>
<td>8-12 weeks</td>
<td>108</td>
<td>6%</td>
</tr>
<tr>
<td>3-6 months</td>
<td>126</td>
<td>7%</td>
</tr>
<tr>
<td>6 months-one year</td>
<td>132</td>
<td>7%</td>
</tr>
<tr>
<td>1-2 years</td>
<td>89</td>
<td>5%</td>
</tr>
<tr>
<td>2-3 years</td>
<td>42</td>
<td>2%</td>
</tr>
<tr>
<td>3-5 years</td>
<td>45</td>
<td>2%</td>
</tr>
<tr>
<td>5-10 years</td>
<td>29</td>
<td>1%</td>
</tr>
<tr>
<td>10-30 years</td>
<td>33</td>
<td>2%</td>
</tr>
<tr>
<td>Almost 42 years</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,826</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

The consultation period is based on the dates of the first and last consultation and, therefore, refers to all ailments. The Ghent sample shows that fifty-eight per cent of the new patients disappeared from the practice within only four weeks while, within three months, more than seventy per cent would not return. The data do not justify a conclusion such as that long-term sufferers stayed longer than acute sufferers. Those who were treated for free, conversely, were more inclined to loyalty, staying under treatment longer or returning in case of other ailments. However, this 'commitment' may have been based on financial considerations, instead of on a conscious or lasting trust in homoeopathy and/or Van den Berghe.

The limited number of consultations and the length of time that patients surrendered themselves to Van den Berghe's caring hands demonstrate that

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49 An earlier inventory that included patients from outside Ghent and foreign countries showed that these patients, on average, stayed nearly five months with Van den Berghe. Cf. Anne Hikle van Baal, 'Homoeopathy in Nineteenth-Century Flanders: the Patients of the Ghent Homoeopath Gustave van den Berghe (1869-1902), in: Dinges (ed.), Patients, 237-258, q.v. 251.
only few of them became adherents. The therapeutic pasts of many patients revealed their search for a cure irrespective of the nature of the treatment. The manner in which attempts for improvement through homoeopathic treatment were made only corroborates the view that cases of a permanent choice in favour of homoeopathy were hardly found. People came to Van den Berghe, took his medication, consulted him on average nearly ten times and then disappeared again, perhaps trying their luck elsewhere. Yet, loyalty does not only speak from the time that people belonged to Van den Berghe’s clientele. Some will never have fallen ill again and, therefore, did not need any further medical attention. Commitment is expressed also by the way a patient behaves towards the doctor, by the characteristics of the patient-doctor relationship.

6.4 Patient-Doctor Interaction: Sufferers’ Attitudes in the Clinical Encounter

The setting of the consultation, the way in which the doctor addresses the patient, the level of medical knowledge on the part of the sufferer, the extent of co-operation and mutual understanding between the actors in the clinical encounter, and the issue of compliance are some of the components of the relationship between the patient and the doctor. The ways in which patient and doctor are able or unable to communicate with one another are strongly affected by both their individual ‘baggage’, i.e. prior experiences, expectations, assumptions and prejudices, and by the larger context of the actual setting of the consultation and socio-economic influences that determine the balance of power within the relationship.50 Thus, the mechanisms of the patient-doctor relationship apply as much to contemporary encounters, as they do to historical medical meetings. Yet, the balance of power has changed considerably over the centuries.

An examination of the structure and dynamics of patient-doctor relationships in eighteenth-century England concluded that the power was with the patient or, at least, with the relatively well-to-do patient.51 English society during the long eighteenth century (1700-1850) was characterised by its almost unlimited freedom and extensive consumerism. This liberal service economy led to economic growth and social change that shaped responses to the threat of disease. The medical market was an open world with complete freedom of practice and the availability of genuine healing alternatives to sufferers.

Liberalism shaped sufferers’ health-care seeking behaviour in that they did not surrender to professional medical authority. Sufferers’ medical affairs

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were a highly personal matter, energetically managed, negotiated and decided upon by themselves. Sick people were rather distrusting and suspicious of doctors as therapeutic efficacy remained dubious and overdosing seemed only to serve the doctor's wallet. Yet, people consulted more doctors and also increasingly engaged in consultations with various irregulars. The resort to 'medical alternatives' underlines the dominant power of eighteenth-century sufferers as they were the purchasers of the medicines. Moreover, making their own diagnosis, suggesting the necessary prescriptions, shopping around and continuing the habits of self-medication made the eighteenth-century sick the true agents of their own state of health.

This analysis is a valuable asset to our knowledge about patterns of behaviour in case of illness but, unfortunately, ends in the middle of the nineteenth century by which time, it is said, changes occurred in the relationship between patient and doctor. The medical profession gained a monopoly on the medical market with the setting up of the Medical Register in 1858, reducing the options for healing and, thus, affecting the patient's power. Furthermore, there was the emergence of fringe medicine, as opposed to quack medicine of the eighteenth-century and orthodox medicine, in early-Victorian England. All kinds of health movements, including homoeopathy, obtained a firm footing through their culture of self-determination, thereby promoting and granting the individual new control over their own health. This element of autonomy is thought to have changed the classic doctor-patient relationship because it detached individuals from medical professionals and turned them into their own physicians. Patients lost power, on the one hand, after the practice of medicine became restricted but, on the other, experienced, at the same time, an increase in choice and independence with the emergence of other health alternatives that made superfluous the interference of health professionals. Whether the official curbing of the freedom of medical practice reduced patient's power and ended the shopping behaviour of sufferers remains to be seen. The same applies to the assertion that users of nineteenth century 'fringe' medicine repudiated the medical profession. This may have been the case in Victorian England, but not in 'Leopoldian' Belgium.

52 Porter and Porter, Patient's Progress, 26-27.
54 Porter and Porter, Patient's Progress, 28.
An analysis of the relationship between doctors and their patients in the late nineteenth and twentieth centuries suggests that this relationship changed during the last quarter of the nineteenth century with the advance of medicine. Before this period orthodox physicians often approached their clientele with consideration. Medical science was held in low esteem and sick people preferred to treat themselves or to call in an irregular. However, patients increasingly accepted the doctor’s authority from the 1870s and became more compliant. This ‘sympathetic alliance’ would shatter eventually after World War Two. The progress in drug therapy, making many diseases curable and the development of new sciences providing a true diagnosis, profoundly altered the relationship between patient and doctor, ‘causing the doctor to be much more disease-oriented and less patient-oriented’.

The impact of the progress of medical science on the attitudes of sufferers towards their doctors is emphasised. The revolution in medical science immediately lent physicians respect and trust and gave them enormous power over their patients. ‘... the scientific medicine of the 1880s and after had the power to convince and to detach the patient from the ‘irregulars’ of yesteryear’. Moreover, the changing patient constituency of late nineteenth-century medical practices, i.e. women and children becoming patients, is entirely explained by the implicit confidence women had in their doctors as healers and not just because they were ill.

The progress of medical science and the changes wrought are undeniable. The development of medical devices, the discovery of the germ theory and the new science of pathology contributed to an enhanced understanding of the nature of disease. Doctors were better able to ascertain what a patient suffered from, but whether or not sufferers were diagnosed properly the efficacy of treatment was still limited. Moreover, instead of being interested in what was wrong with them, sufferers themselves rather wanted to know what the prognosis was and how the affliction could be treated. Diagnosing the disorder was of minor importance for English working-class patients, male or female, as long as the GP fulfilled their expectations by concluding the consultation with a bottle of medicine or a box of pills. In this sense, nineteenth-century sufferers hardly differed from those who lived in

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58 Shorter, *Doctors and Their Patients*, 23.
59 Ibidem, 127.
60 Ibidem, 111-112.
earlier centuries or in other countries. The female patients of the German physician, Johann Storch, displayed the same expectations around 1730. They were not interested in diagnostics but merely wanted a prescription to confirm their own findings about their suffering. The casebooks of this physician suggest that the prescribing had a symbolic meaning to women, to comfort and to support them, and provides a 'ritualistic confirmation'.

Sufferers also displayed a preference for easily accessible medicine in addition to wanting an adequate 'living up to their expectations' treatment. The practice of obtaining cheap patent medicines was explored instead of having to enter into a relationship with a doctor. The British public interest in patent medicines expanded enormously; sales increased from half a million pounds in the mid-nineteenth century to five million pounds in 1914. General practitioners responded by developing new strategies to attract patients in this tremendously competitive market. They realised the need to accommodate working-class patients by practising at a convenient location, having long and late surgery hours and offering care for a low fee. Thus, general practitioners adjusted their practice to the needs of their working-class clientele, which tipped the scales towards the patient in the doctor-patient relationship. This study of the evolution of British general practice refutes the claim that, at the end of the nineteenth century, medical science had made the patient largely obedient to the doctor. Another discrepancy is that the notion of a generally increasing trust of women in doctors' abilities and, hence, a growing female clientele is questioned by the notion that working class women were not keen on consulting general practitioners.

There is a more balanced analysis on the changing relation between the doctor and the patient in nineteenth-century Germany. It acknowledges that the contact between the lay-person and the physician significantly altered, from a client-dominated to a doctor-dominated relationship, but not in such an abrupt manner. Corroboration of the conclusion that physicians gained authority at the end of the nineteenth century is given with the example of changing attitudes towards hospitals and, consequently, growing hospitalisation. The hospital patient became dependent on the physician, whose world he now had entered; previously the patient was treated on their own territory, i.e. home). It was the doctor, whom the patient had not chosen, who largely decided on the therapeutics and the moment and length of the

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63 Digby, The Evolution of British General Practice, 228-232.
consultation. The distance between patient and doctor also enlarged because of the development of specific disease-categories and changing semantics. Patients and doctors no longer spoke the same language and lay-people could not grasp these changes in the medical discourse.

A valuable factor is the differentiation between expectations and behaviour of middle class and working class sufferers. Social background was an influential aspect in dealing with illness and a determinant in the doctor-patient relationship. Bourgeois patients had largely turned away from self-medication at the end of the nineteenth century. They had developed clear boundaries between ailments they could attend to and the ones that needed a doctor’s supervision. Contact with a doctor became obvious, whereas working class people still were involved mainly with traditional forms of self-medication, in which the woman played a decisive role. Yet, finally, health insurance enabled working class people to lay claim also to a doctor’s care.

Although the differences in interpretation and nuancing are abundant, most of the studies stress one general tendency about the doctor-patient relationship: viz. a changing balance of power between patient and doctor at the end of the nineteenth century, with the doctor gaining new authority and the patient becoming impressed by that authority. What do the Ghent patients of Van den Berghe demonstrate about the dynamics and foundation of their relationship with him? How did these patients value the contact with their homoeopathic physician? Were they willing to lay their fate in his hands, without any resistance or discussion, or did they believe that their choice to consult him gave them the right to dispute his therapeutic suggestions? The broader context of the consultation setting of Van den Berghe’s practice is given and the economics of the patient-doctor relation is studied. The extent of cooperation, commitment and compliance on the side of the sufferer will be assessed to determine whether the patient was in power or that the doctor was in charge.

The Consultation Setting: the Economics of the Patient-Doctor Relation

Gustave Van den Berghe was not a specialist physician. He was a general practitioner attending to greatly diverse ailments in children and adults, in men and women. General practice in Britain was often referred to as ‘cotton industry’, meaning and symbolising that professional and private activities

65 Lachmund and Stollberg, Patientenwelten, 171-176.
67 Ibidem, 192-200.
68 By economics I mean the implications for the patient-doctor relationship of the physical surroundings (the accommodation), the office hours arrangements (based on the background of the patients) and agreements on fees.
were carried out side-by-side.\textsuperscript{69} The doctor’s wife often took part energetically, managing the household alongside responsibilities to her husband’s practice. Besides the house calls Van den Berghe paid to patients who were too ill to leave the house, sufferers were expected usually to come to Van den Berghe’s medical offices which were established in his home. Angela Van den Berghe-Vanhoutte supported her husband by supervising all household matters. The Van den Berghes had two maids and one domestic in service, and Angela was responsible for the personnel cleaning the house, the consultation and the waiting room.

The accommodation for the practice of medicine was barely a professional concern during the nineteenth century. The location of the premises, on the other hand, was considered much more significant. Van den Berghe’s decision to buy a house near the railway station facilitated accessibility for patients from outside Ghent and from abroad. They had only to cross the street to find the practice. The accommodation provided by general practitioners in Britain was often limited and the provision of waiting rooms was deficient. Working-class patients were forced to wait outside, middle-class patients were better off and were allowed to wait in the doctor’s private rooms.\textsuperscript{70}

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{appointment_card.png}
\caption{‘Appointment Card’, 1882. Private Archive Gustave Van den Berghe}
\end{figure}

Van den Berghe’s patients probably did not have to wait outside, but their social standing did determine their hours of consultation as well as the position of their waiting room. He advertised, at the end of the 1860s, that poor sufferers could walk freely into his practice at the Muinkkaai for the duration of one hour in the morning and that paying patients were welcome in the afternoon during two hours.\textsuperscript{71} Moreover, the practice in Statiestraat, from 1871, 

\begin{itemize}
\item \textsuperscript{69} Digby, \textit{The Evolution of British General Practice}, 136-137.
\item \textsuperscript{70} Ibidem, 139-140; Digby, ‘A human face to medicine’, 95.
\item \textsuperscript{71} Cf. Chapter 2, 48-49.
\end{itemize}
had two separate entrances. One on the main street, Rue de la Station, and one from an alley next to the house, Petite rue de la Station (Figure 1). The main entrance was meant for affluent patients, the side entrance for the poor working classes. Moreover, Van den Berghe, in the course of time, reserved more time for new poor patients than he did for his well-to-do clientele.

Thus, Van den Berghe preferred that his poor and his affluent patients did not come across each other. The specific social division he made in the consultation hours suggests that he wanted to meet the demands of higher middle and upper classes by separating them from the lesser, and perhaps even contagious, lower classes. He spent less time, initially, on his new poor patients than on the treatment of new clientele from higher social classes. However, later, he met the needs of his 'popularising' practice by extending the consultation hours for his growing new clientele of lower middle and working class patients and by reducing the 'walking in' hours for people of means to one-and-a-half hours.²²

If sufferers wanted to be treated by Van den Berghe they had two possibilities. They could consult him on his own medical territory, or they could request treatment at home. It was far from unusual for Van den Berghe to visit the ill. Paying a house call was an intensive matter, absorbing more time than the consultations taking place in his practice. The house-bound patient sent a relative or friend to ask for him. The homoeopath then grabbed his coat, hat and doctor's bag and walked to nearby patients or, perhaps, visited them by tram. He might also have taken his own carriage, if he owned one, but this is unknown. Some enterprising city doctors displayed a sense of 'modernity' and made use of a bicycle to visit their patients.²³ It is unclear whether the sick had to be a patient already to be eligible for a house call. Furthermore, it is unknown if payment had to be made immediately for the house calls or if payment could be made afterwards.

The knowledge about Van den Berghe making house calls is derived primarily from case descriptions in publications, saying 'appelée à lui donner mes soins' (called to render him my care), 'appelée dans une maison' (called to a home), or 'date de ma première visite' (date of my first visit). Occasionally, the casebooks confirm that patients were visited in their own private setting.²⁴ After returning from the visit Van den Berghe made notes on the patient as it does not appear that he carried the large casebook with him. The house calls did not take place at fixed hours; they could take place at any time, although night visits have not

²² Cf. Chapter 4.
²³ E.g. Digby, The Evolution of British General Practice, 146.
²⁴ E.g. Casebook 4 (1871-1873): p. 125. 'en visit ne fait constater …' (on visit at home, could not establish …)
been found. Yet, Van den Berghe, as an obstetrician, sometimes had to turn out in the small hours to stand by women in labour.

Figure 2. Patient file, Casebook 8 (1881-1882): p. 82. Private Archive Gustave Van den Berghe

The biggest number of encounters between the homoeopath and his patients took place in his home surgery. The new patient, having passed through the waiting room, was welcomed into the surgery and asked to be seated. Then the actual consultation started. Van den Berghe turned to a fresh, empty page in the casebook and began to write (Figure 2). At the top of the file the personal data of the new patient were registered: name, age, place of residence (nommé, agé, demeurant) and, occasionally, an address or occupation. The line beneath it was reserved to note when the patient had fallen ill (est malade depuis), followed by the possibility to note the diagnosis (diagnostic). The rest of the
The Ailment, the Patient and the Doctor

page was divided into two columns, a small one to note the consultation date and the prescription (traitement), a broad one to note the symptoms and memories (symptoms & commémoratifs). Financial remarks were written between the personal and medical data. The symptoms-part of the file reveals the patient’s ailments but, occasionally, also gives a view on the individual’s experiences with other medical options, previous suffering and ideas, hopes and fears about health and illness.

After the patient was given extensive time to tell their story, it was Van den Berghe’s turn to contribute to the medical encounter. It seems as if Van den Berghe often did no more than listen to the patient’s account, write out a prescription and then arrange the next appointment. The new appointments are only known by date and not by time. Thus, how did the patient as well as the doctor remember at what hour they were supposed to meet again? Some patients needed further examination, in addition to merely looking at them, either of their pulse or urine, or by auscultation, percussion and palpation. This means that Van den Berghe had some medical equipment. A microscope is needed to examine urine and, for auscultation, a stethoscope is essential. The lung ‘murmurs’ Van den Berghe found by auscultation, irrefutably indicated that the patient had a serious condition such as TB or pneumonia. Microscopic examination of urine confirmed or ruled out that a patient was diabetic, and abdominal pain could be caused by the bladder or blind gut.75

The case taking always took place in French, even when the patient was Dutch-speaking.76 It was not always easy for Van den Berghe to report on sensations that people portrayed in Dutch because some expressions did not have a French equivalent. He then noted literally what the patient had said. Van den Berghe noted, in Dutch, on a two-year-old girl who often smacked her lips, that she was doing so ‘as if she was thirsty’.77 A Dutch-speaking patient, suffering fainting fits, reported to Van den Berghe that every time he lost consciousness his parents said to him: ‘gij zijt wederom weg, nietwaar?’ (You are out again, aren’t you?).78

When the anamnesis was finished, the physical examination had taken place and the drug therapy was decided upon, Van den Berghe wrote out a prescription, which was to be picked up at the pharmacist, and then the patient was expected to pay for the service he just had received. It is said that Van den Berghe died a rather poor man but there is no evidence for this.79 He treated a

75 Cf. Shorter, Doctors and Their Patients, 85.
76 Cf. Chapter 2, 51.
77 Casebook 5 (1873-1876): p. 1054. For the original Dutch text, see Appendix 2.
78 Casebook 17 (1898-1901): p. 316.
79 It is his great-grandson, Jean-Francois Vermeire who discussed his great-grandfather’s relative poverty at the time of his death. However, I was, unable to trace a testament or other documents drawn up by a notary.

189
number of patients for free and also often met with difficulty in collecting the money to which he was entitled. The fixing of medical fees was based on various grounds. It depended on when the medical service was rendered, day or night; whether it was an emergency or not, which medical procedure was carried out and where the consultation took place, a house call or in the doctor’s practice. Furthermore, it was based on the social status of the patient.80

This status determined not only the length of a consultation but also the fee. His charges for a house call are not known, but a homoeopathic consultation in his practice varied from 1 to 5 BF.81 Patients were expected, as a rule, to get the prescribed medication at the apothecary, but if they received any during the consultation the costs were included in the consultation fee. The son of a landlord paid 5 BF per consultation, Louis Andelhof, a grocer, paid 3 BF and Hippolytus Magerman, a furniture maker’s apprentice, paid 1 BF for each consultation. Hippolytus was not so fortunate in his homoeopathic experiment; less than four months after his last consultation he died.82 Confirmation has been found in one case that Van den Berghé did not trivialise a deterioration of a patient’s financial situation but, instead, adjusted his fees. When the Meirsmans entered Van den Berghé’s clientele in 1899 they were expected to pay for their treatment. The head of the household, Emile, was treated first for tuberculosis. His condition developed into an advanced phase and he died on 21st January 1901. Emile’s wife decided to continue her treatment and that of her only son, Franciscus; and, as of that day, they consulted Van den Berghé free of charge.83

The question of failing payments is of importance in the relationship between patient and doctor. It created an economic dependency on the side of the physician that made subtle and careful contact with the sick indispensable. Van den Berghé was not firm in insisting on payments and it was far from easy


81 Until the last quarter of the nineteenth century an average worker had to sacrifice 75% of his day payment for a consultation. Cf. Vandenbroeke, ‘De medische consumptie’, 154-156.


83 Casebook 17 (1898-1901): p. 53. Emilius Gustavus Meirsmans (1865-1901) was married to Maria Catherina VanRoosbroeck (b. Wynckel 1865, d. Ghent 1902). They would have six children between 1887 and 1899. For three of them, of which Franciscus (1899-1902), life ended prematurely. DSG, Bevolkingsregister Gent, Straatnamenregister 1891-1900: Vredestraat 22, district 8.
for him to get his money, unlike Hahnemann who made his patients pay in advance or demanded cash payments at the time of treatment. Some people were always a couple of consultations behind on their payments; others just never paid. Yet, Mrs. Janssens (age 30) who met Van den Berghe once did not have any money with her at the time but returned a month later to settle her debt.

Some patients paid Van den Berghe a certain amount of money at their first consultation, like an advance and, subsequently, no mention of payments is ever made. He noted the amount and the words fr. R or fr. D. Thus, he differentiated between patients who paid one consultation at the time or afterwards and others who used a type of medical subscription for which they had paid in advance. Van den Berghe agreed that Victor Berte would pay 2 BF every two weeks. Berte apparently thought that he was going to consult the homoeopath more often and for longer than he actually did. After five weeks and four consultations his gonorrhoea had not improved, but he postponed treatment anyway. Flax worker Hortence DeMoor did not pay anything at the beginning of her consultations with Van den Berghe in 1898. She gave him a twenty francs piece halfway through the treatment which was the only payment she ever made. She visited Van den Berghe twenty-five times, so she paid the small fee of less than one franc per consultation. It is rather surprising that she paid so little as she and her husband were both employed and the number of children was not excessive. Other people living in lesser socio-economic circumstances often paid more. Another patient paid only 3 francs for five consultations.

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85 Casebook 4 (1871-1873): p. 1847. It took her more than a month to pay the money because she did not live in Ghent.

86 R meant Reçu (received). D meant Devant (in advance).


88 Casebook 16 (1896-1898): p. 553. Hortensia Maria DeMoor-DeSmet (b. Mariakerke 1870, d. Ghent 1946) was Van den Berghe's patient between April 11th and November 9th, 1898. She began earning a living by doing factory work, but later on she became an innkeeper. Her husband Polydore DeMoor (b. Ghent 1872, d. Mariakerke, 1935), whom she had married in March 1895, earned a living as successively day-labourer, city gardener and gravedigger. Between 1899 and 1905 they would have five children. In 1895 a girl had been born, Augusta, but she died in January 1897 of an accident. DSG, Staatnamenregister 1891-1900: Groendreef 196, district 6.

It was worthwhile for two or more people to consult Van den Berghe at the same time; one patient was charged relatively higher fees than two people visiting together. A female patient paid 3 francs for a private consultation but, if she was treated together with her husband, they were requested to pay 4 francs.\textsuperscript{90} Foreign patients, who did not consult Van den Berghe in person, will often have paid by postal order or they could pay in their own currency. A female patient from Stavenisse (province of Zeeland, the Netherlands) consulted Van den Berghe in Ghent. She did not pay for each separate consultation but, instead, waited until she had reached a considerable amount. She paid in Dutch guilders, as the casebook reveals: 'ontvangen 50 gulden, blijft 5 gulden' (received 50 guilders, remaining 5 guilders).\textsuperscript{91}

\textit{The Medical Encounter: Cooperation, Commitment and Compliance?}

The doctor-patient interaction altered during the last decades of the twentieth century, at times leaving patients discomforted, dissatisfied and misunderstood.\textsuperscript{92} Yet, this interaction is not always as uni-directional and unbalanced as has been suggested and present-day doctors are not released completely from the patients' demands that their nineteenth-century colleagues experienced. Medical discourse, far from a one-sided process initiated and enforced by medical experts, now as well as then, emerges from a dynamic exchange of ideas between professionals and lay-persons, physicians and patients. A number of studies, sociological and linguistic, have shown that patients do shape partly physician's attitudes and contribute to the definitions of certain diseases.\textsuperscript{93}

The suggested cure, i.e. medication, has to make sense for sufferers to accept medical treatment. Their compliance depends on whether the prescriptions correspond with their ideas about what is wrong with them and whether the treatment seems reasonable in relation to the explanations they attach to their suffering.\textsuperscript{94} Patient and doctor exchanging and sharing views, trust and understanding undeniably benefit the healing process. The extent of

\textsuperscript{90} Casebook 17 (1898-1901): p. 31.
\textsuperscript{91} Ibidem: p. 563.
\textsuperscript{93} Cf. Gunnar Stollberg, 'Patients and Homoeopathy: an Overview of Sociological Literature', in: Dinges (ed.), Patients, 317-329, q.v. 319-321; Hilary Arksey, 'Expert and Lay Participation in the Construction of Medical Knowledge', Sociology of Health and Illness 16 (1994), 448-468. Arksey shows how RSI sufferers (repetitive strain injury) attempt to persuade health professionals of the existence of RSI complaints and that they were often better informed than the physicians that treated them.
\textsuperscript{94} Cf. Helman, Culture, Health and Illness, 122.
compliance of patients is influenced also by the way the treatment choice was made; what motivated people to apply for certain medical care. As sociology contributes to the creation of patient profiles, for example, by researching the general features of contemporary homoeopathic patients, medical anthropology has been very helpful in determining the paths of choosing between treatment options, from the ‘demand perspective’, i.e. the standpoint of the patient.\textsuperscript{95} Besides the general condition of availability of medical care, personal considerations shape such choices. As examples, the costs of treatment, previous successful or failing experiences, the sufferer’s perception of what is wrong and the seriousness of the suffering, and that same judgement made by others within the same environment, form selection criteria.\textsuperscript{96} Treatment choices in Mexico reveal that individuals made use of two ways of arranging these choices; the pattern of probability of cure and the pattern of cost ordering. The first pattern starts from the likelihood of cure, costs are considered irrelevant. The second pattern places the expenses for treatment as the most important consideration. Those following this pattern rank treatments according to the costs; first the cheapest methods are tried and further spending starts only when no satisfactory results have been obtained.\textsuperscript{97}

Motivations to turn to Van den Bergh or homoeopathy have been distinguished. Socio-economic considerations, the affluent trying homoeopathy based on awareness of status and the less fortunate because the treatment was offered for free. Dissatisfaction with previous health care when patients had tried all types of other cures before turning to Van den Bergh. These, at times, formed part of the reasons to consult this homoeopath. However, the assessment of conditions suffered did not reveal a decisive pattern. Van den Bergh’s patients were afflicted with both harmless and lethal conditions which were endured for ages or for hours. Yet, how could the relationship that developed between a patient and Van den Bergh best be defined? Was he able to formulate medical instructions understandable for the average patient and did they, in their turn, feel that the doctor listened to them? Was the patient-doctor relationship a matter of an ‘equation of responsibility’?\textsuperscript{98}

Samuel Hahnemann held clear views on the power within the relationship between physician and patient. The patient had to surrender

\textsuperscript{95} Cf. footnote 4.
\textsuperscript{97} Matthews, ‘Illness Classification and Treatment Choice’, 188.
himself, more or less, to the Father of homeopathy who requested strict obedience and compliance with his demands and prescriptions. Yet, the possibility for patients to call in the help of other health professionals, the issue of competition in the medical market, often forced physicians to let their patients be in command. Van den Berghe had to deal with rather self-confident patients who adopted a 'not wait, but do' attitude in their own healing process. Many participated vigorously, thinking along with the doctor, making suggestions on the necessary treatment and, at times, deciding if new medication was needed. Patients writing to Van den Berghe that they needed to replenish the supply of pills, powders or globules, frequently did so without telling him how they were doing or without making an appointment. ‘[...] écrit pour avoir les mêmes poudres sans me dire comment elle va.’ (Writes to get the same powders, without telling me how she is doing). It was almost normal for patients to regale Van den Berghe with personal ideas and demands, to make suggestions for treatment and, sometimes, even change treatment to try other avenues or, bluntly, to ignore the doctor's prescriptions and orders. A male elderly patient, for example, after six days of taking homoeopathic medication, took up again his purging habit.

Self-medication had been, or still was, the main form of healthcare for many of Van den Berghe’s patients. He had to treat his patients with care if they were to avoid sabotaging their chances for recovery, by suddenly postponing treatment or interchanging homoeopathy with other therapies. Moreover, he had to prevent any loss of clientele. Actual collisions with patients are not noted but he very rarely wrote down his judgement of character. Camille Bollaert was not one of his favourites. This unmarried factory worker (age 36) suffered abdominal complaints from the day her mother died in her presence in January 1885. She waited more than a year before she applied for homoeopathic care and she was treated free of charge. Van den Berghe did not like her noting that she was bad tempered. On July 15th 1887 he wrote literally: ‘quelle femme méchante!!!’ (What an obnoxious character). He had to cope with her for four and a half years, she consulted him 223 times or nearly every week.

The time that patients stayed with Van den Berghe (paragraph 6.3) did not confirm a permanent choice in favour of homoeopathy. Their behaviour,

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100 Casebook 10 (1884-1885): p. 919.

101 Ibidem: p. 707. DSG, Straatnamenregister 1881-1890: Nieuwland 147, district 3; Voor- muide 131, district 3H (Sept. 1886-March 1888); Land van Waasstraat 2, district 7 (March 1888-Nov. 1888); Land van Waasstraat 10, district 7 (Nov. 1888-1890). Camilla Bollaert (Ghent, 1849-1922) died eventually in the Old Women Hospice, St. Antoniuskaai 10, district 2.
whilst under Van den Berghe's care, also belies a true commitment. His medical authority was seriously questioned at times and patients started to be their own physician. Many sufferers, instead of covering up this behaviour, discussed it openly with their homoeopath. Van den Berghe's prescriptions were not always followed. There would be usually an initial deterioration of their condition when homoeopathic medication is first taken. This means that the physician, in 'homoeopathic language', had found the proper medication; it was normal progress in the healing process. The patient, however well informed by Van den Berghe, understandably could not find any positive meaning in the worsened condition and sometimes fell back on earlier medication that had an effect. A return to medication prescribed earlier by Van den Berghe rather than taking the last he had advised on was not unusual, just as making the decision to change personally to another homoeopathic medicine.¹⁰²

The continuing use of other remedies, therapies and healers, besides ignoring Van den Berghe's prescriptions, was admitted on many occasions. Sufferers frequently made use of the possibility of choosing both their own doctor and their treatment.¹⁰³ Although an 'equation of responsibility' principally formed part of the relationship between Van den Berghe and his patients, their self-willed ways of acting gave them a rather dominant position. It was the patient who decided to employ, between times, other treatments. It was the sufferer who continued home remedies alongside homoeopathic prescriptions. The patient, by doing so, had great influence over his own treatment and, consequently, occupied a prominent place in the responsibility for the results.

One long-term sufferer, Joannes Branquart (45), whom Van den Berghe suspected to have skin cancer, continued his leeching habit after he had become a patient. After his first consultation he had his ulcers treated elsewhere as well.¹⁰⁴ Sometimes, the treatment was interrupted, for example, when people were admitted to hospital. Camille Goedertier became Van den Berghe's patient in June 1900 when she needed treatment for kidney stones. Homoeopathy did not improve her condition and on the day of her third consultation with Van den Berghe (June 22nd) she was admitted to hospital. She was not operated on, but lost the stones after swallowing daily fifteen droplets of Harlem Oil for two weeks. In November she re-started treatment because, although the stones were gone, she still suffered micturition pain and also was slightly incontinent.¹⁰⁵ The taking of purgatives, predominantly to

avoid congestion, was a constantly recurring story and behaviour that Van den Berghe mostly tried unsuccessfully to discourage in his patients. A female patient who was persuaded to give up her purging habit found herself being constipated.\textsuperscript{106}

The use of other cures and doctors/practitioners went further than applying orthodox medical methods alone. Interchanging between Van den Berghe and homoeopathic self-treatment or other homoeopaths also formed part of the search for recovery. Joseph Roels consulted Van den Berghe between October 1871 and July 1874. He did not make use of him in the next four years and, when he returned in the summer of 1878, he had first consulted Rayé. The unmarried Mademoiselle Dubois, age 38, who felt miserable because she was losing her hair, switched from Van den Berghe to Rayé and back.\textsuperscript{107}

Successful treatment, however, was no guarantee that patients would return immediately if other conditions arose. People traded in homoeopathy for allopathy and \textit{vice-versa}. Octave Van Houcke (age 24) received homoeopathic treatment in 1889 for pain on his chest and coughing, and recovery was soon obtained. Yet, in spite of his speedy recuperation, he decided to consult some allopaths when he was affected by the same ailment again in 1893. Van den Berghe was only consulted at a later stage when his orthodox colleagues failed to cure the patient.\textsuperscript{108}

Van den Berghe needed the complete story from his patients for adequate treatment, including to what they attributed their suffering. Yet, not all individuals were that communicative. They merely wanted a prescription, a bottle of medicine or some pills, instead of spending much time, costly time, as it kept them from work.\textsuperscript{109} Occasionally, another person, an acquaintance or relative, stepped into the doctor-patient relationship to elaborate on the circumstances behind the suffering. These mediators were not always that beneficial to the healing process, as some people felt rather embarrassed or uncomfortable to talk about certain things in front of someone they knew.\textsuperscript{110} A young lady, for example, was not pleased with the contribution her aunt made to her anamnesis. This relative told Van den Berghe that her niece was suffering because of amorous adventures. The patient quickly set things

\textsuperscript{106} Casebook 9 (1882-1884): p. 543.
\textsuperscript{108} Casebook 12 (1887-1889): p. 890. 'Il me revient p.c. qu'on [parce-que, AH] on ne peut le guérir'. (He returned to me because they could not cure it).
\textsuperscript{110} Cf. Chapter 5. Children who were accompanied by a parent will, at times, have felt restrained to speak frankly.
straight at the following consultation and assured Van den Berghe that her illness was not caused by being disappointed in love.\textsuperscript{111}

It has been suggested that patient-doctor encounters differed according to the status of the patients and the nature of the practice.\textsuperscript{112} Yet, besides the variation in fees, there is no more corroborative information. The cases of non-paying patients were not less or more precisely or thoroughly noted. If files were short, this applied to the same extent to patients from various strata of Ghent's society and seems to have been based on how busy Van den Berghe was, instead of on the patients' social background. More so, the longer patients stayed with Van den Berghe the less the notes became, only mentioning the prescription given.

The decision to consult Van den Berghe because of the 'likelihood of cure' was seldom given as a motivation. On the contrary, doubts about the efficacy of homoeopathic treatment were expressed. Clemence Mariscal declared a minimal dose of faith in Van den Berghe's healing abilities.\textsuperscript{113} Another female patient (56), suffering severe emotional problems, believed she would never be cured, fearing she would go mad and often thinking of killing herself.\textsuperscript{114} An eighteen-year-old man stopped his treatment because 'he was convinced that there was no remedy for his aching'.\textsuperscript{115} Those, in particular, who suffered a long illness and had tried many remedies previously were, occasionally, without confidence. Their turn to Van den Berghe had been inspired by the dissatisfaction with other remedies, but exactly this discontent often made them enter his practice with hesitation and reservations about the probability of success.

Nevertheless, Van den Berghe also met many who trusted him. They were friendly, polite, satisfied and willing to comply with his suggestions for medical treatment. Amelie DeRese, for example, a \textit{gratis} treated patient, consulted Van den Berghe with complaints of weakness that she had had for ten years, the time of her first delivery. When she could not keep her appointment, she politely cancelled: '\textit{ne peut venir elle-même aujourd'hui}' (cannot come herself today). How she did that, by sending someone, by letter, by telephoning, by herself, is not noted.\textsuperscript{116} Other patients purposely returned to Ghent, if they were not residing there, to thank Van den Berghe personally for their recovery. Some patients totally ignored advice on lifestyle issues such as

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\textsuperscript{111} Casebook 4 (1871-1873): p. 42. \\
\textsuperscript{112} Digby, \textit{The Evolution of British General Practice}, 232. \\
\textsuperscript{113} See Chapter 4, 111. Cf. Dinges, 'Men's Bodies 'Explained'' , in: Dinges (ed.): \textit{Patients}, 97-98. \\
\textsuperscript{114} Casebook 13 (1889-1891): p. 497. \\
\textsuperscript{115} Casebook 14 (1891-1894): p. 971. 'decouragé il avait cessé son traitement, convaincu qu'il n'avait aucun remède pour son mal.' \\
\textsuperscript{116} Casebook 6 (1876-1879): p. 834. \\
\end{flushright}
giving up smoking, stopping drinking coffee and giving up heavy meals. However, on many other occasions, patients were well aware that such changes could particularly contribute to their healing and they co-operated with the doctor.

Although it appears contradictory, the honesty sometimes displayed about deviant medical behaviour whilst being Van den Berghe's patients underlines a willingness to co-operate. Sufferers persisted with what they were used to doing, taking purgatives for example, but, at the same time, acknowledged that this could interfere with the progress of homoeopathic treatment and, therefore, 'confessed'. Homoeopathic treatment for them will often have meant that they were expected to adjust in more ways than they initially could have thought. Some sufferers already had past experiences with homoeopathy and their continuance with Van den Berghe implies that they had faith in homoeopathic therapy. Moreover, some families, after making the first uncertain steps into his practice, eventually threw off their reservations and became steady and dedicated patients. The introduction to homoeopathy for some sufferers had marked the beginning of a new era of 'medical experience'; they became solely and completely devoted to homoeopathic medicine. They were entirely committed to Van den Berghe, to homoeopathy or to both and would never revert to old habits of self-treatment and other remedies with which they had grown up.

6.5 Recapitulation

The choice for homoeopathy, or the decision to turn to Van den Berghe, was far from based exclusively on the length of existing suffering. Every day he met the long-term afflicted as well as those who recently had fallen ill. Lengthy sufferers were not more likely to turn to this homoeopathic practitioner, just as acute sufferers did not refrain from seeking his advice. The 'illness periods' of the patients show that the ability to manage suffering, or to admit to being ill, was a pre-eminently personal affair dealt with individually. Dissatisfaction with other forms of healthcare, besides the length of suffering, was a significant reason to consult this homoeopathic physician, taking into consideration that many patients spoke about their previous unsuccessful experiences with other non-homoeopathic treatments.

Furthermore, Van den Berghe's clientele did not distinguish itself by perceptions regarding the nature of suffering. Study of the complaints and ailments of Ghent patients reveals that he was not consulted specifically for supposedly 'serious' conditions. Some thought that they could be suffering from a potentially lethal condition, whereas others knew that they had a minor ailment which, nonetheless, needed medical attention. Men, women and children could share the same conditions, but gender-related illnesses were
present as well. Men often consulted Van den Berghe about conditions of the respiratory organs; women, apparently, were prone to abdominal suffering. Yet, that more women suffered abdominal conditions than men could be gender-specific, as belly ache, for example, was often caused by specific female conditions such as menses, pregnancy or uterus failure. Although it was possible to denominate carefully relations between gender and certain ailments, the possible correlations between suffering and social class were much less clear. However, as Van den Berghe, in the course of time, became predominantly a working-class physician it might be tentatively concluded that the poor were at higher risk of falling ill than the upper classes. On the other hand, the growing standards of living towards the end of the century undoubtedly will have enabled a labourer to make use of professional medical care.

Earlier medical treatment seeking behaviour of the people who became Van den Berghe’s patients disclosed their tendency to shop around, to experiment with what suited and soothed them; seeking the best, least harsh or even cheapest cure. This conduct seems rather arbitrary and opportunistic, preventing people from becoming truly convinced of the possibilities of a particular type of treatment. Some of these shoppers, for example, might have adjusted their behaviour to become true adherents of homoeopathy. Yet, the ways in which people behaved after they became acquainted with Van den Berghe do not provide firm evidence of any conscious or permanent choice for homoeopathy. The question presents itself if non-homoeopathic doctors, more than Van den Berghe, fulfilled the position of general practitioner or, if the phenomenon of the family doctor was not widespread. The number of people visiting him on just a few occasions suggests that they were searching still for a remedy for their ill health. The consultation frequency and period of the average patient shows that Van den Berghe was merely another healing option. They consulted him for on average ten times and then, whether or not they fell ill again, disappeared from the practice. As poor sufferers tended to stay on for a longer period of time, the financial advantage of not having to pay seems to have formed part of their ‘loyalty’ towards Van den Berghe. However, the short-term relationship of most patients with Van den Berghe does not eliminate the possibility that, as long as they were in his care, there was careful and devoted co-operation and compliance.

The relationship between patient and doctor was one of mutual dependence. The patient had to adjust to the doctor’s regulations to enhance the chances of healing, the doctor, on his part, had to offer the patient treatment that was sensible and comprehensible to avoid miscommunication, diminishing commitment and, eventually, the loss of clientele and, thus, income. Van den Berghe offered a patient, at the first consultation, the opportunity to speak
extensively, without any time-constraint, about the condition.\textsuperscript{117} The doctor wanted to know about the patient's condition, not just from his own often limited examination, but also from the significant perspective of the sufferer. Nevertheless, this interest in the patient as an individual and not merely as an afflicted object did not result in a more permanent clientele or more obedient patients for Van den Berghe. The often precocious behaviour of patients blurred the responsibility they shared with their doctor. The patient was often in command by disregarding advice, interfering in the treatment by deciding which medicines to take or not, continuing the old habit of self-treatment, consulting other physicians or medical practitioners, making late or no payments, giving insufficient information but still demanding new prescriptions and, finally, sudden postponement of treatment. However, the honesty of those patients who narrated their medical escapades confirms that they were willing to co-operate and to acknowledge the necessity of compliance. Moreover, many found recovery or, at least, improvement of their suffering with Van den Berghe and will have become enthusiastic and supportive of his abilities to cure. Finally, the three per cent of patients who stayed with Van den Berghe for at least ten years were, if not convinced adherents of homoeopathy, 'loyal' to this physician. Loyalty, principally by the poor, which, at times, was inspired by the economic benefit of free treatment.

Patient power was very much alive in the practice of this Ghent homoeopath at the end of the nineteenth century. Sufferers were little impressed with the advances of medical science, they even complained about it and, therefore, searched for healing options outside the official circuit. Women and men from all social classes tried such an option with Van den Berghe, but not by handing over completely the responsibility for their precarious health. They were willing to co-operate with the doctor to some extent, but the availability of other treatments or remedies constantly remained appealing.

\textsuperscript{117} Dinges has pointed out that the homoeopathic manner of case-taking, rather than other medical therapies, may have been attractive to 'body conscious' patients, but that definitive answers can only be given after more comparative study of patients' letters. Cf. Dinges, 'Men's Bodies 'Explained'', in: Dinges (ed.), Patients, 108.
7
Dealing with Diseased Bodies.
Gender and Attitudes Towards Illness

Coming closer to the patient, from being part of a doctor’s clientele to being an individual sufferer, enables an analysis of the coping strategies for illness in the past. The previous narration of patients’ individual suffering and their personal stories about illness reflected on the ailments, behaviour during treatment and the relationship patients entered into with Van den Berghe. An even stronger ‘micro-perspective’ of dealing with illness is now offered.

A supplement to gender history of suffering ‘from below’ is attempted, a line of research that seems to be in its infancy. Gender history can be studied from three angles, as a history about women and femininity, as a history about men and masculinity or as a history about men and women and their shifting concepts of femininity or masculinity. This last category of gender history, resulting in an integrated study of the perceptions and experiences of women and men about illness and their bodies, has received comparatively little scholarly attention. Studies of attitudes towards health, illness and healing from a gender perspective focus predominantly on women. However, experiences and testimonies of suffering women have been barely highlighted.

The interest in male experiences of health, illness and the body is making headway, although only recently, contributing to an understanding of male responses, knowledge and conceptualisation of health-related issues. Nevertheless, most knowledge of the impact of gender on illness and body perceptions has been established, in general, either by studying solely women and femininity or by concentrating exclusively on men and masculinity. The

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2 Cf. Paragraph 3 of this chapter.


201
masturbation discourse of the eighteenth and early-nineteenth century, as an example, aimed solely at eradicating this debilitating and even life-threatening deed from human life. Men formed the primary, but not the exclusive target of warnings and advice; that women engaged in this act was virtually kept hidden. Medical and social discourse on masturbation in men and its consequences for health has been well-studied; the experiences of the individual female masturbator have not yet been taken into account.4

It will be possible, by combining the views of men and women, to ascertain to what extent gender may have generated or contributed to particular ideas, attitudes and behaviour as the differences and similarities of suffering between men and women are examined. It is known that distinct differences exist between men and women with regard to the state of their general health as well as their individual experiences of being ill.5 This was and is related to hormones, but also to work circumstances and behaviour. Men and women display distinctive conceptions of illness, body perceptions and self-images in their suffering. The difference or conformity in male and female conceptions, awareness, understandings and attitudes as regards health and illness, thus, will be studied.

Firstly, how sense was made of suffering for both men and women will be discussed. Secondly, men and women will voice their experiences with sexually transmitted diseases and sex-related ailments. Most venereal suffering was endured and expressed by male patients, hence the impact of sexuality on the body will be told mainly by men. Although women like men consulted Van den Berghe about conditions other than gender-related complaints, the female patient finally finds her voice in the experiences and ideas regarding the impact of menstruation, pregnancy and delivery on a woman's health and body. These typically feminine affairs left on the body, besides the physical traces, the psychological consequences of having a suppressed menses, enduring miscarriage or unwanted pregnancy, and failing to become pregnant.

The women in Van den Berghe's clientele have received more attention than the men.6 The methodological aim of continuous and systematic comparison between the experiences of men and women may appear

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6 Also in the use of secondary literature.
Dealing with Diseased Bodies

unsatisfactory. Why not assess how male and female patients responded to having the same, not-gender related, illness such as an affection of the respiratory organs? The women patients told or, possibly were asked by Van den Berghe, considerably more stories of their personal experiences than the men.7 Therefore, except in cases of venereal disease or sex-related ailments, it is rather problematic to compare the narratives of men and women. Moreover, the emotional impact of illness was communicated predominantly by women. The casebooks noted that women dreaded the loss of a child or a yet unborn child, but the grieving of a father was hardly mentioned.8

7.1 Making Sense of the Suffering: Reasoning Physical and Mental Hardship

Individuals often started a search for explanations to grasp what was happening and to make sense of their suffering. A definition of the source of distress made the ailment understandable and, for some, facilitated the management of the pain. The causes stated by the patients were considered essential by Van den Berghe for the results of treatment and he made inquiries about their ideas on the origin of the ailments.

Health care seeking decisions, in favour of a particular practitioner or treatment, depend primarily on the 'lay theories of illness causation'. The sufferer's idea about the causes and nature of the symptoms are the main components of the therapeutic choice. Those suffering acute illnesses in Taiwan, for example, consult professional practitioners, whereas those with chronic disabilities visit 'folk' healers.10 An explanatory model, in anthropological terms, would be helpful in ascertaining the illness theories of Van den Berghe's patients.11 The ideas held by all the participants, sufferer and practitioner, on the illness period and its treatment would be examined within this model. Lay ideas are influenced strongly by cultural factors, including medical knowledge, and by personality; whereas licensed practitioners, orthodox and others, tend to maintain their professional pattern of thought.

7 For a discussion on the perspective in the sources (casebooks), cf. Introduction.

8 This is an interesting subject that, amongst others, reflects the consequences of suffering for personal well-being and that of the individual's environment. At the end of this chapter, the female patients' stories of gender-specific suffering have been selected rather than attempting to present an incomplete discussion of the way in which men and women dealt with another particular disease. Nevertheless, as will become clear, the male patients will still receive the ample attention that they also requested from Van den Berghe.


11 Kleinman, Patients and Healers, 104-118; Helman, Culture, 94-113.
This explanatory model provides for four different types of illness explanation. Individuals blame themselves for having fallen ill; the natural environment, including accidents, is considered as the cause of the ailments; others in the social environment have inflicted the illness, witchcraft, magic etc.; or supernatural powers, ghosts, gods, ancestors, are at work. The first two explanations, personal responsibility and natural environment, are the most common ones in the modern Western world. However, the anthropological explanatory model cannot be projected simply on to Belgian society. It has been designed for non-Western traditional societies in which religion and spirituality are omni-present. Although religion, at times, still played an important role in the lives of nineteenth-century Ghent people, persistent belief in the supernatural was not common. Stories regarding witchcraft, magic or other supernatural forces as the cause of illness were not told, apart from an occasional exception. Moreover, the model passes over the possibility of patients explaining their ailments as resulting from coincidence. Finally, those suffering ill health did not always point out one single cause, but considered it to be the result of a combination of factors.

If Van den Berghe's patients offered an explanation for their suffering, the causes can be fitted into one or more of the following illness theories: illness caused by emotional factors, illness resulting from natural or medical factors and suffering originating from personal conduct. Emotional factors consist of situations through which people became affected emotionally resulting in temporary or permanent physical or mental deterioration. Natural or medical explanations are those cases in which working and living conditions as well as other medical disorders or situations are mentioned as causing the affliction. Suffering originating from personal conduct refers to patients stating that their own behaviour had led to their illness. Some patients, obviously, had developed complaints after they had been afflicted simultaneously with several of these ill-making factors.

Many a patient reported that emotional states like 'colère' (anger, rage), 'saisissement' (fright, terror) and 'chagrin' (grief, unhappiness) had triggered the ailment. Yet, why patients became angry, frightened, and unhappy or upset was not always specified. Grief was often connected to the loss of loved-ones such as parents or children. Hortence VandenDriessche (38) told Van den Berghe that she often suffered from fear and melancholy resulting in all types of ailments. The unmarried Hortence lived with her mother and her brother Polydore and his wife, who had four small sons. Three of her nephews died in 1883 and her brother passed away suddenly in 1887, leaving her in great anguish. Finally, Hortence had to cope with the death of her mother in 1895.

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12 There is nothing in the casebooks to support sustained supernatural belief.
She was extremely upset about this loss and told Van den Berghe that she thought she was going mad.13

The experiences of frightened and shocked patients differed markedly. A reference to the supernatural has been found in one case. Gerard Cazier (36) told Van den Berghe that he had suffered from asthma since the night he had seen a ghost in his bedroom five years previously. Another male patient had an attack of fear when he passed through the great Alps tunnel and, subsequently, had been suffering from mental alienation. Catharina Douliez (34), a mother of seven, remained more 'down to earth'. She consulted Van den Berghe in 1895 with a menstrual disorder and told him that she had a suppressed menses because of 'd'une colère au sujet du socialisme' (rage regarding socialism).14 He did not note what she meant but, in 1895, the trades unions had been active in the Ghent textile industry and a strike broke out at one of the largest factories.15 Catharina's husband, Franciscus, was a day labourer in a cotton factory and, perhaps, she was afraid that he would lose his job. He did change jobs in 1897 and became a typesetter. François Bloqué quoted a combination of factors as the cause of his cardiac complaints.16 He had lost his wife in August 1881 and was overtaken by so much grief that he had started drinking. Other sufferers narrated accidents that had caused fits of fear; the swallowing of a button, a brush falling on someone's head and relatives tumbling down the stairs.

Natural and medical factors were raised also as causes of illness. Accidents, hard work, bad living conditions, food and climatic circumstances could be a source of a diversity of ailments. Individuals suffering a cold were often caught in the rain or were forced to work outdoors in cold and humid circumstances. Others, on the other hand, were working in too warm and dusty environments that caused their suffering. A thirty-six year old woman told Van den Berghe that she was happy in her housekeeping, but that her shop brought her worries because of defaulted. The miserable domestic circumstances of many of the working class created other diseases as humid dwellings were considered to endanger health.17

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Occasionally the patient had been the victim of another’s behaviour; assault or a fight had caused the suffering. Hortance Baele was a victim of domestic violence. She had a painful contusion on her foot that was inflicted by her drunken husband. Stories about ailments resulting from rape are rare but, in such cases, the injured party suffered twice. One case of sexual child abuse was recorded in the casebook: a girl of eight with leucorrhoea and a painful vagina told Van den Berghe that her ailments were the result of a sixty-year-old man having intercourse with her. Accidents as a source of suffering were told more frequently. Petrus Lievens, a forty-two year old shopkeeper, had a bad fall and needed treatment for a sore left knee. Three consultations and treatment with arnica improved his condition. Fractures were never directly taken to Van den Berghe but those with pain complaints after the fracture had healed consulted him at times. Mr. Duchène, a cavalry captain, had an ‘industrial accident’ when he fell off his horse causing him pain in his loins and left leg.

Rosalie De Mil, a living-in barrister’s servant of twenty-five, was convinced that she was still facing the consequences of a vaccination received seven years earlier. She claimed that her constipation, insomnia, lack of appetite and occasional skin eruption all had their origin in that one experience. The pocks resulting from the vaccination became ulcerated and produced abscesses on her entire arm. Subsequently, she suffered from time to time a rash, palpitations, agitation and similar conditions. That her abuse of purgatives could harm her general state of health apparently did not occur to her. She continued her self-dosing during Van den Berghe’s attempts to improve her gastro-intestinal condition. Other medical conditions mentioned as the source of suffering illustrate lay knowledge on medical issues and demonstrate an ability to ‘diagnose’. Many current complaints were considered as the remnants of or the result of a previous ailment.

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18 Casebook 17 (1898-1901): p. 798.
19 There is one case known, that of a nineteen-year old girl suffering pain on the external parts of her vagina since a stranger forced her to have sex with him. Cf. Casebook 16 (1896-1898): p. 412.
21 Casebook 4 (1871-1873): p. 505. DSG, Straatnamenregister 1867-1880: Hamstraat 4, district 7. Petrus Franciscus Lievens (Olsene, 1829, Ghent 1909). In 1871, the year of his visits to Van den Berghe, Lievens was married to his second wife Joanna Catharina Breusegem (1825-1880), the first one had died in 1865.
23 Casebook 13 (1889-1891): p. 349. DSG, Straatnamenregister 1881-1890: Hoofdkerkstraat 3, district 1. Rosalie De Mil (b. Moortsek, 1865 – d. ?). She left Ghent in 1896, hence the unknown date of death. She was Van den Berghe’s patient from July 1890 to March 1893, not consulting him in 1892.
Dealing with Diseased Bodies

An occasional complaint about the ill-making effects of non-homoeopathic medicines was not uncommon. Jeanette Verdonck-Daes had developed piles, resulting from giving birth to a daughter, Maria Francisca, at the turn of the year 1894. She started taking allopathic drugs (remèdes allopathiques) to counteract this uncomfortable condition. Four years later, in August 1899, she consulted Van den Berghe as the medication had caused chronic diarrhoea.24 One male patient was suffering the negative side effects of drug taking. As a syphilis sufferer he used mercury intensively, causing all types of other ailments.25

Some were concerned particularly about contamination. Patients who had taken care of ill family-members, or who had continued sleeping next to their terminally ill spouses, were very anxious about catching the same disease. When Ivo VanBastelaere (31) visited Van den Berghe in January 1879 he had just lost his wife to tuberculosis.26 He had some of the symptoms, suffering from a cough, expectoration and an impeded respiration and he was afraid that his wife had contaminated him. A year later VanBastelaere returned with tooth-ache. On this occasion, no emotional or natural explanations were offered for this dental ailment. Ivo looked upon the ailment from a behavioural point of view as, during a trip to Brussels, he became drunk and fell asleep on the street.

Explaining illness as the result of emotional or natural/medical causes demonstrates the patient’s perception of illness as outside their control, beyond their own responsibility. Behavioural considerations, conversely, give an insight into a sense of being personally accountable for their precarious health. Not eating properly, forgetting to take medication, excessive behaviour in relation to alcohol, sex and work, were all within individual’s control and, if illness was the consequence, these were the result of personal failures about health. Patients blamed themselves for not being more cautious or alert, as they were aware that certain behaviour could lead to specific conditions. This becomes particularly clear in the stories of people afflicted with sex-related disorders, such as venereal ailments, or with other ailments considered to be induced by sexual activities such as masturbation.27

24 Casebook 17 (1898-1901): p. 323A. DSG, Straatnamenregister 1891-1900: Zwijnaardsesteenweg 250, district 5H. Joanna Maria Daese (1869-1904) had married Frederik Verdonck, who became Van den Berghe’s patient in 1900, on February 3d 1894. They had one child still living in 1899.
27 See the next paragraph.
An analysis of the relation between patients' behavioural explanations and certain disorders, however, does not produce many conclusive findings. Men and women gave a variety of explanations for very diverse conditions, yet some illness theories were more frequently used than others. Natural and medical explanations (43 per cent) predominated in the explanatory stories, but emotional alterations (38 per cent) were also the basis of many instances of illness (Appendix 9). Anecdotes were less frequently recorded on how personal conduct had resulted in suffering (19 per cent).

Although diverse ailments were explained by equally diverse reasons, some conditions were more often ascribed to a particular cause than others. Men, for example, attributed their sexual and venereal ailments exclusively to personal behaviour. Furthermore, those afflicted with mental problems developed their complaints after emotional mishap which had thrown them off balance. A little over fifty per cent of the patients suffering a cough and/or expectoration exclusively explained their condition by natural and medical causes. Some of these coughing patients offered a more specific diagnosis and attributed their condition to influenza. An unmarried factory worker, August Claeijs, of twenty-four consulted Van den Bergh during the winter of 1898. He was constantly coughing and had brought up large amounts of blood. The patient said he thought he had influenza (suite dit-il de influenza), but the homoeopath drew an additional conclusion. The presence of a 'tubercular point' in his right lung confirmed that pulmonary consumption had joined the influenza. The patient would not recover, dying on 1st April 1899, four months after his last consultation with Van den Bergh.

Abdominal and intestinal complaints, although often resulting from 'ordinary' medical conditions, were explained predominantly from an emotional viewpoint. This is most likely because women were more prone to gastro-intestinal conditions than men and because female patients displayed a tendency to explain suffering by an assault on their emotional state of health. An analysis of the suggested illness theories from a gender perspective implies that the sexes displayed differing perceptions about the origins of their ailments. Of the 1,826 sampled Ghent patients, 181 men and women (or ten per cent) told Van den Bergh explicitly to what they attributed their suffering. Although it is not possible to make any generalisations, the following can still be conceived as an outline of male and female inclinations in explaining illness. Male sufferers attributed their ailments predominantly to behavioural or


\[29\] Cf. Chapter 4.
Dealing with Diseased Bodies

natural/medical causes, whilst women hardly ever spoke about their personal responsibility, i.e. their conduct, as the source of evil. As Julie Baeckeland (25) formed an exception as she suspected that she had enjoyed herself too much. Her armpit hurt, she had trembling and burning sensations, she coughed, had an impeded respiration and was constipated; all since she had celebrated the carnival with exuberance. As male natural/medical causes often referred to environmental factors of life and work; female natural/medical explanations predominantly mentioned gender-specific health circumstances, such as pregnancy, child bearing and nursing, as causes of suffering. Furthermore, one-half of the female patients considered their suffering to be the result of emotional situations, compared with less than one-quarter of the men.

Patients' perceptions, therefore, of the origin and nature of their suffering were, at times, gender related, but this does not provide confirmation that explanations influenced the decision to make use of Van den Berghe or homoeopathy. His patients barely displayed extraordinary perceptions of their afflictions which may have influenced their decision to try homoeopathy. One type of explanation for suffering was found more than any other, but remarkable differences were not noticed. However, to make further statements it would be necessary to make comparison with the illness perceptions of patients in a nineteenth-century orthodox practice.

7.2 Masculinity and Femininity: Sex and Venereal Ailments

The existence of venereal ailments, although often considered as shameful and resulting from promiscuity, was not hidden. Many developed venereal disease, at least once in their lives, and sought treatment. Van den Berghe regularly met sufferers from the consequences of venereal disease. Those can be distinguished rather easily within Van den Berghe's clientele, despite the lack of

<table>
<thead>
<tr>
<th>Men</th>
<th>Women</th>
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<tbody>
<tr>
<td>BE</td>
<td>29 (36.3%)</td>
</tr>
<tr>
<td>EE</td>
<td>18 (22.5%)</td>
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<tr>
<td>NME</td>
<td>30 (37.5%)</td>
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<tr>
<td>CE</td>
<td>3 (3.7%)</td>
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</tbody>
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80 men and 101 women mentioned the following explanations. BE (=Behavioural explanations), EE (=Emotional explanations), NME (=Natural and medical explanations), CE (=Combination of explanations).


Why women were inclined to attribute their conditions to a contemporary decline in mental stability is an interesting question that will be considered in the third paragraph.

unequivocal diagnostics. In some cases, a single symptom, such as a venereal abscess (chancre), is sufficient to identify the disease; in other cases, a wide range of symptoms are described. Nevertheless, it is relatively easy to infer the nature of the ailment of the five hundred patients afflicted with venereal conditions, over two hundred can be diagnosed unmistakably as suffering from gonorrhoea, syphilis or genital herpes.

**Sexuality in Society: Religious, Medical and Social Views**

Whilst it is true that, during the Enlightenment, Christian conceptions of sexual sin and virtue were replaced gradually by scientific approaches to sexuality, long-standing moralistic sexual norms were never entirely overthrown by the *philosophes.* The proper place for sexual activity remained the conjugal bed, and any act not focused on legitimate procreation, such as masturbation or intercourse based on lust, was judged sinful and perverse. These basic moral beliefs and a related repulsion towards free, unchecked sexuality clearly affected medical discourse.

Orthodox medical views on sexual matters warned against the evil of excessive sexual behaviour and masturbation, which were considered physically dangerous as well as morally pernicious. This vehement resistance against ‘self-pollution’ was not a nineteenth-century invention. The famous Swiss doctor Samuel August Tissot had introduced it to the medical agenda a century earlier, but he based his *L’Onanisme* (1760) on much older ideas. Male masturbation was denounced primarily because of its debilitating effects on the body. The deed in itself was considered a disease, but it could result also in other dangerous illnesses such as consumption, madness and even death.

Semen was seen widely as an essential and vital body fluid; its wastage in acts of masturbation damaged physical and emotional strength. Health guides and educational literature, therefore, were punctuated with warnings against the dangers of excessive sperm-loss through intercourse and ‘self-abuse’. The message of anti-masturbation discourse was one of self-control.

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Dealing with Diseased Bodies

propagating respectability and character. A Dutch brochure, published in 1886, offers the following admonitions:

Premature excesses in love and outside of marriage shortens life; male strength will be lost! One will become ill, weak, miserable and old before time and one exposes oneself to venereal infection, the terrible poison that is spreading and that takes people away secretly.

The active interest in sexuality in the nineteenth century had strong social components and was based on ‘wider social anxieties’. Notions of sexuality were linked intricately to class, gender and public health issues. The middle classes used sexual morality as a standard for differentiation from both the aristocracy and the lower classes. Public health campaigns were aimed primarily at the urban poor. ‘Sexual immorality was understood as a class issue, specifically linked to the habits and living environment of the urban poor and seen in direct relation to the themes of disease, filth, depravity, overcrowding, bad housing, crime and disruptive behaviour in working class culture.’ Ideas on sexual behaviour also were strongly gendered. Men were considered to have a strong animalistic sexual urge, never fully controllable. Moderation and abstinence were strongly advised, but could hardly be expected. Women, on the contrary, were regarded as asexual beings, with a weak sexual drive and no need for erotic gratification.

Serious grounds existed for sexual anxiety and sexual fear in the nineteenth century. Venereal disease lay in wait everywhere and became more prevalent. Although conclusive statistics are not available, it has been estimated that five to ten percent of the Belgian population had suffered from venereal disease during the period in question. Social concern about venereal disease and sexual behaviour was considerable in Belgium as in other European

39 Anonymus, Volksgeneeskunde, of meer dan 500 van de beste huisgeneesmiddelen tegen 145 ziekten der mensheid (Utrecht: P.J. Diehl; 17th edition, 1886), 6. For the original Dutch text see Appendix 2.
41 Oosterhuis, Stepchildren of Nature, 30.
42 Ibidem, 30-31.
43 Hall, Hidden Anxieties, 32.
Venereal disease was regarded as a social evil that had to be wiped out just as tuberculosis and alcoholism.

Prostitutes were widely perceived as the source of 'venereal evil' and a threat to the nation at large. Brothel-visiting men introduced gonorrhoea and syphilis into the conjugal bed, infecting wife and offspring. Medical discourse echoed and fed these anxieties, warning against the dangers of inherited venereal disease. Declining fertility and a growing number of unhealthy new-borns would soon produce widespread social degeneration according to many doctors. Syphilis, alcoholism and tuberculosis were often depicted as the ills of society, initially affecting the individual, but eventually affecting the entire nation. The practice of prostitution was cordoned off in specially designated areas to protect public health, and medical inspection of prostitutes was made compulsory. However, from the 1880s, the regulation of prostitution came under attack in Belgium and throughout Europe as controls had not curtailed venereal disease, but only institutionalised sin and vice. Even though Belgian doctors played a substantial role in the public debate on the war against immorality and prostitution, they did not make great efforts to provide sex education for the young. They wrote little on the subject until the 1920s unlike

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their colleagues in other European countries. School physicians were preoccupied mainly with school hygiene and infectious children's diseases such as smallpox, measles, whooping cough and ophthalmia.48

Venereal disease and masturbation were surrounded, in general, by fear and shame. Men and women suffering a venereal disorder were stigmatised as sinful and immoral; many hospitals refused them admittance and health services usually denied any compensation of their expenses. Most of the country's health funds, according to one Belgian physician, denied medical or pharmaceutical services to patients whose ailments resulted from their own 'misbehaviour'.49 Venereal patients not only shouldered the entire financial burden of their treatments, but also were forced to seek treatment from physicians intent on avoiding the stigma of treating them. Conventional physicians in England, for instance, were not prepared to treat venereal disease and patients were forced to seek unorthodox practitioners.50

The pre-occupation with the impact of venereal disease on health was not only an 'allopathic' matter. Homoeopathic practitioners also contributed to the publication of material on venereal disorders. Hahnemann was concerned with these 'maladies secrètes' and left behind instructions on the proper treatment of venereal disease.51 Nineteenth-century Belgian homoeopaths, in contrast with their foreign colleagues, do not seem to have published specifically on the subject. They published thirty medical guides and handbooks between 1874 and 1914 but none of these were concerned directly with venereal ailments. Nevertheless, there were other sources of information for those intent on finding them.52


49 Quoted in: Velle, 'De syfiliskwestie', 337. 'Les règlements de la plupart des caisses de secours des sociétés industrielles, des associations mutuelles et même des administrations de l'Etat portent, en effet, que les affections provenant de l'inconduite ou de rixes sont exclues de droit aux soins médico-pharmaceutiques et aux indemnités de chômage.'

50 Hall, Hidden Anxieties, 34-35; Velle, 'De syfiliskwestie', 337-338.

51 B. Laborier has made a study of Hahnemann's ideas regarding venereal disease as exposed in his writings. Furthermore, Laborier explored the way in which these ideas were brought into practice by studying some patient files from the Paris practice. See: Bruno Laborier, 'Les maladies sexuellement transmissibles et leurs traitement selon Samuel Hahnemann', available on http://homeoint.org/site/laborier/mst.htm.

52 In the library of the Institute for Medical History of the Robert Bosch Foundation various homoeopathic publications on venereal disease are available. Edward P. Anschutz, Sexual Ills and Diseases: a Popular Manual Based on the Best Homoeopathic Practice and Textbooks (Philadelphia: Boericke and Tafel; 2nd ed., 1910); Jean Philibert Berjejau, The Homoeopathic Treatment of Syphilis, Gonorrhoea, Spermatorrhoea and Urinary Diseases (Philadelphia: Boericke, [around 1880]}; Jonathan Braun, Die Krankheiten und Schwächezustände des männlichen und
Men and women suffering from venereal disease in Van den Berghe's Ghent had few treatment options open to them and many reasons to seek help outside official channels. Orthodox nineteenth-century medicine was barely effective in averting a venereal crisis. Therapeutic possibilities still offered little hope despite a considerable expansion in the body of knowledge on venereal diseases during the course of the century. Traditional treatments were very painful, often causing more suffering than the disease itself, and hospitals and physicians were far from eager to treat these patients.  

The shame and disgrace surrounding venereal disease also increased the appeal of home remedies and of medical options outside the official channels. Some of Van den Berghe's patients came to him after attempting to relieve their ailments themselves. Others reported trying numerous remedies and consulting various practitioners, without ever finding a cure. Advice on the prevention of venereal disease in self-help guides focused primarily on ways of avoiding sexual temptation. Sports, physical labour and avoiding heavy meals or alcohol were all recommended as ways of resisting sexual urges. If the excitement was too strong, intercourse could be blocked by rubbing the penis with a special ointment. How women could avoid venereal disease was never a subject of discussion.

The Patient Speaks: Sexual Activity and (Venereal) Illness  

While most of Van den Berghe's patients were aware of the physical and moral dangers associated with sexual excess, sexual abstinence was not a reality in daily life. Many patients reported frequent sexual activity, not always necessarily within marriage. Stories about intercourse with lovers, extra-
marital relations or children born out of wedlock and unmarried motherhood are not uncommon. Moreover, men as well as women maintained multiple sexual contacts.

Although women were believed to be sexually non-desirous and, perhaps, even forced to be so, the casebooks show otherwise. They disclose that women, despite the risk and shame of getting pregnant, had intimate sexual relations without being married. When Eugenie Holleck consulted Vandenberghe for the first time in 1870, she had already two children but no husband. She did have a relationship with the biological father of her children but they married only three years later. Another unmarried woman, seeking treatment for a vaginal ailment, reported that she engaged regularly in intercourse, about twice a week. These two women were no exception.

It was very common for a husband to engage in sexual relations with someone other than his wife. A man with a tumour on his testicles told Vandenberghe that he had developed the ailment after having intercourse with a woman who was not his wife. Lack of gratification within the confines of marriage was not the excuse for these affairs as the casebooks do not record a single case where a man explains his unfaithfulness on these grounds. Sometimes, something more may be learned about the sexual feelings between spouses as the casebooks include instances in which ailments resulted from matrimonial sexual activities. A forty-four year old man forced himself onto his wife whilst drunk and she 'let him have his way'. However, he could not ejaculate and was left with a painful and grazed penis. The 'letting him have his way' sheds light on the power relations within nineteenth-century marriages. This husband demanded sex from his wife and, instead of resisting him, she submitted to his will. Indeed, the law itself stipulated that a married woman was entirely subordinate to her husband. As head of the household, the nineteenth-century Belgian man was free to discipline his wife, sexually and

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56 Casebook 3 (1870-1871): p. 356. DSG, Archive Bevolkingsregister Gent, filing cards; DSG, Archive Burgerlijke Stand Gent, marriage certificate 773/1873. Eugénie Holleck (1844-1894) married Auguste Wille (b. 1835, d. ?), manufacturer, in 1873. Both their children were born and had died in Ledeberg.


58 Archival research attests that many women conceived and bore children without being married.

59 There are no accounts in the casebooks of married women being unfaithful.


otherwise. In another case recorded by Van den Berghe, a husband developed an inflamed testicle after frequent relations with his wife.

Housing conditions also could lead to awkward situations and literally disturbed sexual relations between spouses. M. visited Van den Berghe in 1894 with an ailment of the ureter. He thought the disorder was the result of an interrupted intercourse when his children had knocked on the door just as he was about to ejaculate. Some husbands were very worried about their inability to perform the sexual act, their failure to ‘serve their wife.’ A thirty-one year old joiner was unable to make love to his new bride. When he consulted Van den Berghe for the first time on 29th December 1895, he was a newly-wed. He was plagued by complete impotence in addition to severe backache and pain in his loins. The patient remained under treatment for nearly two years, but his condition did not improve, and the couple remained childless. A twenty-nine year old barrister tended to blame his wife for his sexual ‘failure’, elaborating on his frustrations after two years of marriage. However, it is likely that the insufficient erections and inability to have intercourse were the consequences of gonorrhoea for which he had been treated before marrying. After six months of treatment with Van den Berghe, the barrister reported that the medication produced desires of the flesh (de desirs charnels) and ejaculations, but no erections. After an additional year of treatment, his sexual performance had not improved.

Some men who had been diagnosed with a venereal disease continued to expose their families to danger by keeping silent about their condition. One poignant example is that of the A. family where two young girls were infected by their parents. At first, Van den Berghe treated the two girls; the younger one, aged only four, was suffering from a vaginal ulcer and an eye-infection resulting from gonorrhoea (ophthalmie gonorrheïque). Both the girls would be cured. The two parents were less fortunate and faced a re-occurrence of the disease. How these adults became infected, how all members of the family experienced the disease, or how it affected their daily life is not known. Patients seemed aware of the contagious aspects of venereal disease in other

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Dealing with Diseased Bodies

cases. Several husbands were very worried about the possible consequences of their infection; they were honest and told their spouse.

The extent to which there was an awareness of the diseases being carried or the potential of transmitting them to offspring is unclear. Van den Berghe, in one case, treated a baby of ten weeks who suffered from constitutional syphilis, probably a victim of his parents' ignorance. This baby boy was covered with a rash, had swollen feet, was extremely emaciated and his face looked 'like that of an old man'. Van den Berghe noted, at his second consultation, that he was an 'enfant misérable'. The child would not return to the practice and it is not unlikely that he died of the disease.66

The casebooks yield substantial information on the subject of sexual activity and behaviour but, mostly about male patients and solely about heterosexual activities. The lack of a single mention of homosexual relations is striking. While men's sexual behaviour was the central focus of medical inquiry; for women, it was the history of their reproductive organs and their sexual anatomy. The focus, more specifically, was on their 'uterine histories' and their physical and emotional experiences during pregnancy, labour, confinement and menopause. Their 'uterine histories' and sensations were closely evaluated. Women told Van den Berghe, about, for instance, sensations of the uterus moving around and wanting to leave the body through the vagina. These perceptions are related closely to the medical belief that women were ruled by their 'irritated' wombs.67 One late nineteenth-century French author wrote that 'In women, the uterus also suffers from the numerous influences caused by emotions. Love [...] leads to a large number of damages to the sensibility of this very irritable organ'.68

Masturbation was considered the cause of a host of emotional and physical disorders, debilitating both males and females. The deed could lead to troubled nerves, general weakness, feeble sight, painful stools and loins and, even, epilepsy. Although masturbation was seen as dangerous to body, mind and soul, it was practiced widely by Van den Berghe's male patients. Patients told him that, in many cases, they no longer masturbated, but had done so extensively in the past. Some patients attributed to masturbation their

68 A. Becquerel, Traité élémentaire d'hygiène privée et publique (Paris: Asselin, 7th ed., 1883), 850. 'Chez les femmes, l'utérus ressent aussi de nombreuses influences de la part des passions. L'amour [...] entraîne à sa suite une foule de lésions de la sensibilité de cet organe si irritable.'
problems ranging from failing sexual performance and erection problems to backaches. There was no explanation for why some patients continued masturbating when they saw this as the cause of their ailments. Ceraphine Van P., for example, told Van den Berghe that he fell ill due to self-abuse. He continued to masturbate without any explanation or justification despite suffering nocturnal emissions and pain between his shoulder blades and in his loins. It is known that some doctors advised their patients to copulate to prevent masturbation. Whether patients ever received such a prescription from Van den Berghe is not known from the casebooks, but he may have said so during the consultation.

Women also were not able to control their propensity to masturbate. However, women patients did feel the need to excuse and explain their masturbation. They renounced responsibility, in many cases, by claiming that they were biologically impelled to do so. Xaveria Van B. explained that normally she had no urge to masturbate unless she was affected by a fit of vaginal itching. She ‘did have a fit at the beginning of her menstruation, forcing her to touch herself.’ She also touched herself in her sleep, an unconscious act for which she could not be held responsible. Another patient, Stephanie, sensed strong itching in her vagina, causing a fit of nymphomania and, thereby, forcing her to masturbate. She saw herself also as dominated by her physical urges.

Rosalie Vander V. (21), a patient from outside of Ghent, wanted treatment for her masturbatory tendencies. She could not abstain from the act but, afterwards, always felt nauseated. She travelled three times to Ghent in October and November 1876. Her condition improved, probably meaning that she did not feel the need to masturbate any longer, and did not consult Van den Berghe again until June 1879 when her masturbating had returned and extensively. Rosalie explained that she masturbated three times a week to avoid developing burning sensations, heart palpitations and becoming agitated. She was not the only family member who could not resist the urge to masturbate. Her sister, Emilie, had a gland inflammation in her armpit and menstruation-related complaints and, above all, she was sexually over-excited (surexcitations sexuelles). She was under treatment between 1877 and 1884 and Van den Berghe used a broad spectrum of words to depict her continuous sexual urges: masturbation irresistible, forte excitations sexuelles, encore excitations sexuelles, vives excitations sexuelles, nymphomanie, excitations sexuelles irresistible, and excitation venerienne. Emilie’s general well-being was subverted by her

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71 Casebook 6 (1876-1879): p. 527, 6th May 1877 (Xaveria); Ibidem: p. 164 (Stephanie).
72 Casebook 6 (1876-1879): p. 223 (Rosalie); Ibidem: p. 947 (Emilie).
female constitution as she always needed to masturbate after her menses and her vagina constantly itched.

Masturbation in women was considered a separate condition from that in men, and a separate term was used: *nymphomanie*. A second distinction between male and female masturbation was found in the feelings of pressure women almost always sensed in performing self-gratification. The casebooks reflect these feelings in the notation of 'she needs to...' *(elle doit)*. A woman’s shame about touching her own body is more apparent than that of a man, perhaps, because of negative considerations about female sexuality and masturbation in the nineteenth century. Masturbating women over-burdened their already weak nerves; moreover, masturbating married women invaded the sexual rights of their spouses.73

Although the casebooks contain more cases of venereal disease among men than women, this finding must be handled carefully. Ghent women also could have been inflicted frequently with gonorrhoea or syphilis yet, may have tried other means of healing than men, for instance, because they wanted to be treated by same-sex healers.74 Furthermore, it could be that the diseases were simply more obvious in men who could hardly ignore the outward manifestations on their sexual organs. Women, on the other hand, could be infected without visible symptoms; and such symptoms of venereal disease as an itching or burning sensation in the vagina easily could be mis-diagnosed. Forty-five year-old Mrs. K. came to Van den Bergh after five weeks of suffering extreme pain while urinating and having a noticeable lump in her left groin. He suspected a chancre or gonorrhoea. The woman said that her husband currently had an ulcer on his 'private part' but that she had not paid any attention to its nature.75 Her husband’s ailment was visible; her’s was not.

The visibility of the ailment must have contributed to male shame and fear of venereal disease whilst the threat of contracting gonorrhoea or syphilis contributed to the development of other ailments. One patient, for example, developed syphilophobia. 'Eighteen years ago has had a chancre, not yet completely cured. From the minute he has intercourse, he is taken over with syphilophobia'.76 Another man explained his headaches by the fear that he had been venereally infected, although Van den Berghe did not confirm his

73 Coolen, *Geschiedenis van de geheime zonde*, 100.
76 Casebook 17 (1898-1901): p. 37. "Il y a 18 ans a eu un chancre, n’a pas encore été complètement guérie. Du moment qu’il fait le coit, la syphilobie le prend".
opinion. Moreover, men were very anxious about the impact that involuntary seminal discharge might have on their general health. The number of patients consulting Van den Berghe in connection with nocturnal emissions, spermatorrhoea and semen in their urine or defecation is considerable. Another disturbing feature of venereal disease was that, once a patient passed the acute symptoms of gonorrhoea or syphilis, he might well continue being infectious. The casebooks include some heartbreaking stories of newlyweds inadvertently infecting their new spouses.

Trepidation, embarrassment and doubts about whether the ailment was definitely cured were common among sexually active men. Yet, the casebooks do not reflect a conscious change in conduct. Many male patients gave evidence of their knowledge of the connection between their sexual behaviour and their state of health and attributed their genital ailments to intercourse with prostitutes. They told Van den Berghe that they had developed the symptoms after having contact with a prostitute ('femme publique') or having visited a brothel ('maison publique'). Two young men (age 20), for example, visited the same prostitute and both became infected with gonorrhoea. Another male patient admitted he had made love to a street-girl ('coureuse'). Yet, in the perception of some, gonorrhoea not necessarily developed merely after intercourse. A young man thought he had contracted the disease after manual gratification ('laisé masturber') by a prostitute.

Prostitution is not always named directly; on many occasions the patient only mentions being with a woman, 'j'ai vu une femme'. Excessive sexual activity, not necessarily with prostitutes, was seen also as the cause of venereal ailments. Expressions like 'abus des femmes', 'exces venerien', 'exces sexuel' and 'appetit venerien' are used frequently to explain ailments, even if these emerged years after the sexual act in question. A patient suffering from impotence, he was able to get an erection but it failed him during intercourse, explained that he had been a masturbator in his adolescence.

Impure intercourse was suggested also as the source of venereal disease. Although it is not clear how the word 'impure' should be interpreted, it probably refers to women who were considered to be impure. Jean D., for instance, claimed he developed acute gonorrhoea after having intercourse with a woman with leucorrhoea. Nevertheless, his awareness of this 'impurity' did not prevent him from indulging in intercourse with her. Prolonged or repeated

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79 AVB, Symptomes médicamenteux observés sur mes malades et observations clinique, inv. no. 30, [not dated], 77.
Dealing with Diseased Bodies

intercourse is mentioned as the cause for health problems in various cases. A nineteen-year old male argued that his incontinence was due to having intercourse twice in half an hour. However, prolonged abstinence was seen also as a cause of genital ailments. One anonymous patient, who had suffered from gonorrhoea in the past, consulted Van den Bergh for treatment of excessive ejaculations ('exces d'éjaculations') and testicular pain. According to the patient, it was the result of long-term abstinence, or unfulfilled desire. The twenty five-year old E. was thought to have developed an acute inflammation of the urethra because of a single instance when a woman had powerfully excited him but alcohol had made it impossible for him to have intercourse with her ('la baiser').

Male explanations for venereal disease or genital ailments show that it was considered a matter of personal responsibility. Moreover, the prevailing professional belief that sexuality and sexual activity could harm health was also common among lay people. Van den Bergh's casebooks reflect that most male patients held themselves primarily accountable for their ailments. His female patients tell a markedly different story, they liked to put the blame elsewhere, claiming it was out of their control and taking the role of victim. Just as women patients held their uncontrollable physical urges accountable for their masturbatory habits, they blamed their husbands for infecting them with venereal disease. As women had to be of irreproachable sexual conduct the stigma of venereal disease burdened them more than men. Therefore, pinpointing the 'other' served to acquit a woman from accountability. Women suffering from venereal illnesses were depicted often as innocent preys to their lecherous husbands and it is possible that women embraced this concept solely as a way of disguising their sexual escapades. It is also likely that women patients adopted the role of victims of their own bodies and of their own husbands because this was the role that society had assigned them.

Although he treated a number of patients suffering from venereal diseases and, sometimes, also participated in professional debates on these illnesses, Van den Berghe did not advocate himself as a specialist in venereal diseases. He discussed his findings on venereal disease with colleagues during meetings of the Cercle Médical Homeopathique des Flandres and published these experiences in Union. Van den Berghe gave a case description on one occasion

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83 Ibidem: p. 1574.
84 This relation between responsibility and gender has been found also in research on present-day diagnoses of hysteria. Men are viewed generally as responsible for their actions, women are seen as 'out of control'. Cf. Laurence J. Kirmayer, 'Mind and Body as Metaphors: Hidden Values in Biomedicine', in: Margaret Lock and Deborah Gordon (eds.), Biomedicine Examined (Dordrecht, Boston and London: Kluwer Academic Publishers, 1988), 57-93, q.v. 70-71.
In Search of a Cure

to exemplify that venereal disease was not always contagious and transmissible. A young husband developed an inflammation of the urethra during the first days of his marriage. He accused his wife of having infected him, but examination revealed that she was not afflicted. Then, the husband confessed that he had suffered from the ailment before but that his physician had declared him completely cured. The insufficiently treated inflammation, according to Van den Berghe, returned as the result of an orgasm.85

Why did these patients with venereal disorders consult Van den Berghe? Patient accounts reveal that shame was one of the motives for visiting him. Some files of patients who suffered from venereal diseases are anonymous, with no reference to name, age or residence. There are also several patients who came from outside Ghent to consult Van den Berghe, probably to hide their illness from their own communities. Privacy was crucial for nineteenth-century patients who suffered from venereal disease, just as it had been for their early-modern predecessors.86 Harsh treatments, fear and shame are all plausible explanations of why patients consulted Van den Berghe. Financial considerations also may have been the basis of the decision as the poor could turn to him for gratis treatment; and workers could avoid losing their social security.87 However, although financial advantages motivated some ‘non-venereal’ sufferers to consult Van den Berghe, only a handful of patients with venereal and other sex-related ailments were treated free of charge. Whether venereal disease was of more concern to middle-class people, however, requires further examination of the social background of these patients.

The consequences were considerable whether suffering acute or chronic venereal disease, whether this was the result of sexual excesses or brought about by a partner. Venereal disease was hard to cure and symptoms varied from itching and discharge to impotence and infertility. The emotional damage also should not be under-estimated. Health-advice guides depicted excessive intercourse and masturbation as hideous and sinful acts, thus, causing anxiety, fear and shame in sexually active individuals. Moreover, the feelings of those who only discovered their partner’s marital infidelity after visiting a doctor and discovering they had been infected with a venereal disease can only be guessed at.

7.3 Women and Illness

Van den Berghe was not a specialist women’s doctor, but his growing popularity amongst women, the gender ratio changed from 80 in 1869 to 58 at

85 Anonymous, 'Comptes-rendues de Sociétés médicales homoeopathiques. Cercle médical homoeopathiques des Flandres', Union 1 (1886-1887), 76-80, q.v. 77-78.
87 Velle, 'De syfiliskwestie', 337.
Dealing with Diseased Bodies

the end of the century, cannot be overlooked. It is logical to take a closer look at women's attitudes towards health, illness, Van den Bergh and homeopathy. Women have conquered their own territory in the historiography of the social history of medicine. Yet, they are often considered as if they were the only sex. No account is taken of what women felt, thought and did about medical decisions and issues when, in practice, these were instigated often within the boundaries of their gender and influenced by their position in relation to the opposite sex. The concept of gender, the basis for formulating the 'socio-cultural construction of male and female identities' and, thus, the comparison of the behaviour of women to that of men and vice versa is often left out. However, a new agenda changed this approach and turned women's history into history from a gender perspective. This perspective has been used also in recent studies in the social history of medicine, although its output is still limited. There is also relatively limited knowledge on men and women as sufferers and, especially, on the supposed preference of women for treatments offered by unorthodox medicine in the past and the present.

Historical perceptions of women and their diseased bodies have become a fascinating research object for scholars, yet, mainly from the viewpoint of gender as a building block for social, political and cultural relations. Roy Porter wrote in 1991 that we were remarkably ignorant about how individuals dealt with pain and illness in the past and, consequently, conceived their own bodies. A decade later, Porter, although he denied credit for it, was pleased to see that scholars of diverse disciplines had followed his agenda for a history of the body, resulting in a notable list of studies. However, body perceptions of the everyday historical individual remain a complicated research category.

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88 Meaning per 100 women, 80 men in 1869 to 58 men per 100 women around 1900.
91 Gijswijt-Hofstra, 'A Sense of Gender', 40-43. In this article she gives an overview of the results of historical research on what she calls the history of illness and healing alternatives from a gender perspective.
94 During the Anglo-Dutch-German workshop on Patients Body Perceptions (Warwick University, 11-13 July 2003) only a few contributions directly aimed at the perceptions of
Even a book with the title *Feminism and the Body* implies much more than it achieves as the history of the body is studied only from a scientific point view.95

The perceptions of women sufferers are barely highlighted in research on female health and sexuality, whereas the larger context of medical-scientific notions and achievements and the impact on socio-economic discourse is examined. These studies reflect predominantly ideas on what women were, ought to be, or how they had to behave and merely echo indirectly the bodily experiences they had.96 Historians of unorthodox medicine in the modern period, in addition, have concentrated on therapies, institutional structures and legal struggles and have largely neglected the issue of gender and lay illness experiences. Even if the history of European health and medicine is explored from a gender perspective, it focuses almost exclusively on elite culture, e.g. the female doctor or practitioner.97

There are always exceptions to the rule and some attempts have been made to bring to life women's experiences with health, illness and suffering. A *History of Women's Bodies*, dating from the early 1980s, attempted to shed light on the impact of sex, pregnancy and delivery on a woman's life.98 It provides illuminating, imaginative examples and anecdotes about the consequences of sexual relations for a woman's body but these undermine absolutely the possible strength of the book. The presumption that 'for [peasant and working class] women in the past, sex was a burden to be dutifully, resentfully borne throughout life rather than a source of joy' turns *Women's Bodies*, at times, into a medical lamentation and an indictment of men who are depicted as insensitive, brutal and abusive.99 Women are portrayed emphatically as victims; they were

patients, sufferers and the like. Many papers dealt with bodies as the aims and means to create, for example, national/colonial identity, hygienism, medical categories or discourse and so forth. Body perceptions in a narrow sense, i.e. the way a person 'embodied' their corporeal existence, received little attention.

Dealing with Diseased Bodies

the 'slaves' of their husbands, their children and their biology, a picture that can be put into perspective by other empirically based research. However, this study is an extensive account of the potential diseases women could develop because of their biology; a welcome overview of the conditions women suffered in the past.

Other, more recent, historical research takes more at face-value the medical circumstances of women in the past, departing from the presupposition that women were never in control of their lives, thereby, attempting to reveal their knowledge and, at times, independent behaviour. Research on the women patients of an eighteenth-century German doctor, for example, creates an understanding of individual female attitudes, knowledge and behaviour concerning the body and its afflictions. A female patients' history 'from below' has been achieved by analysing a physician's medical casebooks. The experiences of abortion from those who underwent the procedure showed that factors such as gender and class influenced a woman's options and experiences with abortion. Lower-class women in Weimar Germany who wanted an abortion turned to other women for information and preferred lower-class female abortionists, whereas men in the Hague looking for help in the early twentieth century drew on their male networks. An oral history of birth control practice in inter-war South Wales has concluded that, especially in working-class circles, abortion was widely accepted because of its practical importance.

The daily lives of women who were unwillingly pregnant have been studied by making use of infanticide cases and lying-in hospital records in

100 As I have argued, women themselves contributed to the idea of being victims. Female venereal ill patients of Van den Bergh at times seemed rather eager to transfer responsibility onto men. Some women, thus, deliberately created the victim-role.


103 Kate Fisher, 'Didn't stop to think, I just didn't want another one': the culture of abortion in interwar South Wales', in: Eder, Hall and Hekma (eds.), Sexual Cultures in Europe. Themes in sexuality, 213-232, q.v. 213.
nineteenth-century Germany. A study of the culture of giving birth in Germany by examining the process of the medicalisation of delivery, i.e. the increasing interference of the medical profession in both childbirth and gynaecological matters, places the experiences of women at the margins. An analysis of childbirth in nineteenth-century Britain, concentrating on medical practice and perceptions regarding women suffering puerperal insanity, focuses on treatment-related developments rather than on the women enduring this ordeal. Interest in the ‘milestones’ in a woman’s life, i.e. menstruation and menopause, has expanded considerably and contributes to an understanding of how femininity was defined and, hence, influenced the relation between the sexes. However, the history of menstruation and menopause, concentrating on prevailing medical theory, tends to ignore individual female sufferers of menstrual and menopausal related complaints, apart from an occasional personal account.

Interest in the personal illness-experience of female and male sufferers has not entered the social history of Belgian medicine. Patient history is virtually non-existent, apart from an occasional attempt to explore attitudes towards hygienics and the body. The political construction of gender and the role of women’s sexuality has received more attention, mainly to determine the


Dealing with Diseased Bodies

position of women in relation to the labour movement. Socialists, like liberals and Catholics, recommended strongly that women should not carry out industrial work. A woman's proper place was at home where she could safeguard the race from degeneration and where she was protected from exhaustion as, physiologically, women were not fit for working outdoors. Labour would 'harm their constitution, destroy their health and shorten their life'. Moreover, free contact between the sexes negatively affected a girl's morality and would encourage promiscuous behaviour. The impact of medical discourse on sexual identities, relations between the sexes and perceptions about the susceptibility to illness largely have to be embraced still as research objects of the social history of Belgian medicine.

Medical Representations of a Woman's Nature

Women had been considered as 'failed' men until the end of the eighteenth century. They had the same sexual organs as men, but only on the inside. This 'one-sex model' of biologically similar men and women disappeared when the reproductive organs of men and women became to be seen as completely different. Finally, women got bodies of their own and this was used to redefine the relation between the sexes. The new model 'underlay and promoted increasing impulses to identify sex as both a biological and a political category'. A biology of hierarchy arose in which the differences of women compared to men were defined along a dichotomising line of nature versus culture, weak versus strong, body versus mind and private versus public.

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110 Quoted in: Denise Keymolen, 'Vrouwenarbeid in België omstreeks 1860. Vigerende en alternatieve opvattingen m.b.t. vrouwelijke huis- en fabrieksarbeid', TvSG 8 (1982), 3-33, q.v. 17. For the original Dutch text see Appendix 2.


112 Laqueur, Making Sex, 149-192. There has been profound scholarly debate on Laqueur's model, especially on the era when the switch from the one-sex model to the two-sex model would have taken place.

113 Lond a Schiebinger, 'Introduction', in: Schiebinger (ed.), Feminism and the Body, 1-21, q.v. 5.


227
Depictions of how eighteenth and nineteenth century scientific and medical ideas mediated sex roles and gender differences through the study of the biomedical sciences, sees the sciences as a source of symbols and metaphors of the presumed differences between the sexes and the connective effects on the development of masculinity, femininity and, consequently, sexual identity. The notion that women were closer to nature than men held numerous elements. Women were depicted as emotional, men as analytical, and they were concretely assigned distinctive work, yet this ‘served to prescribe appropriate behaviour through metaphorical associations’. Medical, the sex distinction was symbolised by a woman’s sensibility. The reproductive organs not only made women highly receptive of nervous illnesses they also determined their social, physical and, thus, public limitations. The ability to carry, bear and nurse children restricted a woman’s functioning to the private domain of home and family.

The passiveness in a woman’s nature, in contrast to male public activity, and her nervousness, in contrast to male muscular strength, both resulting from her distinctive biology, was symbolised vividly in anatomical waxes developed by the medical sciences. Such images reflected women’s weakness by almost always embodying woman in a subordinate recumbent posture. Therefore, science and medicine represented women by emphasising the ‘otherness’ from men, resulting from the female nature and assigning specific tasks, qualities and medical conditions to women.

A woman’s specific biology determined her absent role in society because her constitution made her predisposed to affliction and illness. The idea of women falling victim to all sorts of ailments due to their nature or gender was widespread during the nineteenth century. Medical science proclaimed that, as soon as girls started menstruating, their health was at stake and caution should be applied. Moreover, their weak constitution not only made them more susceptible to illness but also contributed to an inability to easily resist or recover. One Belgian doctor wrote:

A woman is more easily influenced by disease, and her organism responds less energetically against it. On the other hand, her tasks and her genital organs are the sources of excessively common illnesses.

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116 Jordanova, Sexual Visions, 58.

117 Sovet, Manuel d’hygiène publique et privée, 180. 'La femme est plus facilement influencée par les causes de maladie, et son organisme réagit moins énergiquement contre elles. D’un
The womb was given decisive power over women’s lives, thereby, determining her social status of housekeeper and caretaker. Female orgasm was no longer a necessity in procreation, thus, creating the passionless woman. The ovaries, or female testicles, determined the nature of women and were responsible for their sexual urges and other ‘deviations’ such as hysteria. The removal of the ovaries, a procedure that became popular from the 1870s, should release a woman from unladylike tendencies.¹¹⁸

This medical line of reasoning turned women into helpless beings unable to guard against the urges that nature, i.e. their female body, imposed. All they could do was to restrain from all ‘unhealthy’ impulses generated by their sexual organs and nervous system. However, the view that women were more prone to suffering than men was, not so much a natural given, but a human construct and, therefore, resulted from the social cultural meaning assigned to the feminine gender.¹¹⁹

The Female Body and its Vices: the Consequences of Menstruation, Pregnancy, Miscarriage and Delivery for Women

The women who became patients of Van den Berghe were not suffering solely from typical female disorders, nor did they attribute exclusively their complaints to their sexual organs. More than ninety per cent of the women consulted him with complaints other than those specifically bound to their gender.¹²⁰ However, this is not to say that these women never referred to their hard lives as mothers and wives to explain their current state of health. It indicates merely that these female urban inhabitants attributed their suffering to more than their biological state. Though female patients shared many conditions with their male counterparts, their ‘natural’ destination to reproduce contained, at times, serious repercussions on their health.¹²¹ The statement that ‘the pregnant state, is a natural state, since woman has been created for reproducing the species’ led women to suffer physically and emotionally.¹²²

autre côté, les fonctions et les organes génitaux des femmes sont pour elles des sources de maladies excessivement communes.’

¹¹⁸ Laqueur, Making Sex, 175-177.

¹¹⁹ Jordanova, Sexual Visions, 4.

¹²⁰ Based on the sample of 1,826 patients of which 1,056 were women: see Appendix 6. The number of women suffering sexual ailments, pregnancy, post-birth complaints, and menstrual and female disorders adds up to 90 (8.5 per cent).

¹²¹ This is in accordance with the views of Shorter.

¹²² Fl. Dubois, Le médecin de soi-même, moyen sur et peu couteux de se préserver et de se guérir de toutes les maladies, d’après la méthode de M.F.-V. Raspail (Brussels: Imprimerie de la Société des Beaux-Arts; 5th edition, 1844), 98. ‘L’état de gestation (grossesse), est un état naturel, puisque la femme a été créée pour la reproduction de l’espèce’.

229
Inquiries into the course and regularity of the female patients' menstrual cycle was a normal procedure in Van den Berghe's anamnesis. It formed part of women's medical histories, whether or not changes or irregularities had taken place decades previously. Even though entirely different complaints could underlie the decision to consult Van den Berghe, a woman's gender-specific experiences of menstruation, pregnancy, delivery and the like formed an essential part of his decision on the proper treatment.

Women had to guard themselves on two fronts. There existed, on the one side, the health risks of being human, risks that women shared with men and, on the other side, there were the dangers of being a woman, diseases which had their origin in their female organs.123 Women who needed treatment for 'human' conditions had often suffered one female disorder or the other in the past. The medical histories describe many women who had lived through emotional states such as worrying about menstruation, the fear of or longing to become pregnant, apprehension during pregnancy as miscarriages occurred frequently, and anxiety about the forthcoming delivery. Perceptions of the arrival of the baby included ideas of ruptures (laceration), prolapses, extreme bleeding and even death which remained obstinately in the mind of the future mother. Forceps had been used frequently to end deliveries, causing extreme pain and uterus deformations, leaving a woman with all sorts of ailments, future delivery difficulties and, sometimes, chronic health problems. Miscarriages also seem to have been a matter of course, some occurred spontaneously, some caused by accidents or even mistreatment. Finally, multiple pregnancies, difficult deliveries and long breastfeeding in the past frequently interspersed the grievances of women about their general health and ill-health.

Jeanette Schelfaert (age 39), residing in Ledeberg bordering Ghent, was miserable because of the six miscarriages she had in two-and-a-half years. She was often losing blood during pregnancy and, especially, after having intercourse. When she consulted Van den Berghe in September 1886 she had just had her last miscarriage three months earlier. She had a foul-smelling red discharge (des pertes rouges), or a mixture of white and red, which he was unable to relieve and she was diagnosed with uterine cancer.124

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123 This does not mean that men and women shared the same experiences of a disease. Moreover, current biomedical research has found unsuspected differences between men's and women's bodies resulting in a different response to drugs, different symptoms in the same disease and different degrees of suffering. Cf. Schiebinger, 'Introduction', in: Ibidem (ed.), Feminism and the Body, 3.

Dealing with Diseased Bodies

Hélène Schepens, an unspecified trader, applied for treatment for an irregular menstrual cycle that had indisposed her for one year.125 The amenorrhoea was a source of suffering, causing pain on her breastbone and the impossibility of sleeping on her left side as it gave her stomach-ache. Hélène was very specific about the composition of her menstrual blood and the course of her menstruation. If she had her period the blood was black, thick and normally decreased after she had been menstruating for three to four days. Van den Berghe committed to paper on the day of her first visit:

Mlle Hélène Schepens, age 20, Ghent
Nov. 29, 1900
Irreg. menses with much pain. Always late, often 2 to 2½ months. Always has pain in loins and lower belly after her menstruation has passed. The pain preceding her menses is not particularly greater. As soon as her menstruation flows [she] is much better. Abundant yellowish leucorrhoea, currently it is 7 weeks since she had her menses. Very agitated, palpitations, a little vertigo.126

Hélène philosophised on the origins of her irregular menses and attributed it to a malfunctioning of the uterus as she ‘believes to have gained this disturbance in the functioning of the womb after doing the laundry, having helped doing the laundry.’127 This seems a rather peculiar cause of menstrual problems as many women were responsible for doing the laundry for their entire family without ever having menstrual complaints. Yet, a persistent popular belief was that water posed a threat to menstruating women because it could result in personal ill health or could influence the flow of blood.128 Hélène, later on in the treatment, added more information about the particular event. She was in the middle of her period when she was carrying out the household chore and felt a sharp rage to which she attributed her illness (sa maladie). Whether she was angry about having to do the laundry or there was some other reason remains hidden but, ever since that emotional outburst, her period ceased to occur properly.

125 Casebook 17 (1898-1901): p. 907. DSG, Straatnamenregister 1901-1910: Onderstraat 25, district 1. Hélène Anna Francisca Maria Schepers (b. Sleijdinge, 8 December 1879, d. ?).
126 Casebook 17 (1898-1901): p. 907. ‘Règles irreg. avec beau. de doul. tjs. en retard qqf. 2 mois à 2½ mois. a tjs. des doul. ds reins x bas ventre qd. le temps des règles est passé. Le mal avant ses règles n’est pas sensiblement plus grand. Dès que les règles coulent [elle] est beau. mieux. Leucorrhée jaunâtre abondante, actuellement il y à 7 semaines qu’elle n’a eu ses règles. très agitée, palpitations, un peu de vertiges.’
127 Ibidem. ‘croit avoir gagné ses troubles dans le fonctionnement de la matrice après avoir lavé, aider a laver’.
Hélène Schepens considered her irregular menses to be the source of her suffering, all other ailments being side-effects, and she hoped that Van den Berghe would be able to restore her menstrual cycle. She consulted him on sixteen occasions between November 1900 and April 1901 by which time she was feeling less well. She was becoming overweight and she still had not had her menses. As there were no more consultations she had either lost faith in Van den Berghe and/or homoeopathy and suspended the treatment, or had suddenly regained her menses, thus, no longer needing treatment.

The case of Hélène is one of many telling us about the preoccupation of women with their monthly flow of blood. They knew it had to happen each month and considered irregularities as signs of something wrong. Was a suppressed menses an illness in itself or an indication that some other condition was about to break out? Were women merely worried about a possible pregnancy if they did not menstruate, or were they not at all aware of the possibility of carrying a child although their menses had ceased several months previously?

Although doctors in eighteenth-century Britain diagnosed amenorrhoea after two to three weeks, women often waited six months before seeking treatment. Many of Van den Berghe’s female patients with menstrual disorders also took their time before requesting his help. Leonie Bello had not menstruated for three months when she turned to homoeopathy in August 1876. In addition to the failing menses, she had strong leucorrhoea, lumbago pain, insomnia, headaches, an impeded respiration and was extremely tired. Leonie told Van den Berghe, after the enumeration of symptoms, that she was sexually active, having had intercourse with her lover three months ago (a fait le coit avec son amant il y a trois mois). She suspected, probably, that she was pregnant. Leonie consulted Van den Berghe three more times in August and September but then postponed further treatment until the following Spring. Van den Berghe did not confirm nor deny that she was pregnant but, in March 1877, Leonie returned with post-partum complaints of considerable uterine blood loss.

Leonie Bello considered the possibility of being pregnant as, for her, the notion of the link between being late and having sexual relations i.e. being pregnant was not unfamiliar. Not every woman appeared to have such

130 Casebook 6 (1876-1879): p. 126. DSG, Straatnamenregister 1867-1880: Nieuwe Wandeling 11, district 2. Leonia Maria Bello (1846-1878). At the time of her first consultation Leonia lived with her parents. On January 3, 1877 she married her lover Gustavus Maria Crommelinckx (b. 1847) with whom she moved to the Hovenierstraat 10, district 2. Seventeen days later their child was born: Elvira Antonia (20.02.1877-19.12.1877, bronchitis).
knowledge or, at least, pretended to be innocent. Bulalie Servais needed medical care for what she thought to be an abdominal ailment. She had not felt well for the previous eight-and-a-half months with nausea, vomiting and headache and a lack of her menses. Her legs were now swelling as well. Yet, she was taken by surprise when Van den Bergh told her that he was not going to prescribe anything as she was facing the consequences of pregnancy.

It will have been rather difficult for Van den Berghe, at times, to provide the right diagnosis as some women, who were unwillingly pregnant, gave quite confusing complaints. Unmarried Octavie Veekman, for example, consulted him because she had not had a period in six months and because she had belly-ache and felt a bump on the left side of her body. Van den Berghe could also feel a bump in her lower belly and noted ‘a big tumour like a child’s head’ (une tumeur grosse comme une tête d’enfant). Octavie said that she had never courted a man but, nevertheless, he observed that she was pregnant. Some women visited the doctor hoping to be with child. Nathalie VanderCruyssse will have been very confused after consulting Van den Berghe. She came to see him with, what she thought, were pregnancy-related complaints. Seven months prior to her first consultation she suffered metrorrhagia (haemorrhagic bleeding) whilst, as she thought, again being pregnant. Since she was bleeding four to five days a week, her accoucheur had assured her that she was pregnant and expected the baby to come in a month. Meanwhile, she continued to bleed and to have colic and diarrhoea. She came to see Van den Berghe as she was not at ease and he explained that she was not with child. Her belly was sonorous, not stretched and only slightly voluminous.

The women were not worried about or ignorant of being pregnant in most cases of menstrual discomfort but, instead, were concerned about the effects on their health. They thought that not menstruating or having an irregular menses could lead to other, more serious ailments which needed to be avoided. They wanted Van den Berghe to achieve one single goal, restoring their period. Women with a regular, but uncomfortable, period wanted to be freed from their suffering during those days of the month. A regular cycle, of course, facilitated avoiding pregnancy as there could be abstinence from sexual relations during the fertile period. This was the only means of protection for many women yet, even medical science was in error about a woman’s fertile period and advised that it was safest to have sex during the middle of the

131 Lidy Schoon has noted stories of women who deliberately concealed or denied their pregnant state. Cf. Schoon, De gynaecologie, 81-82.
menstrual cycle. However, the worries about not menstruating may have concerned also the fear of infertility and, hence, of not being able to fulfil the true feminine task of becoming a mother. British culture, for example, valued women for their ability to produce offspring, whilst menstrual irregularity posed a threat to that destiny as mothers. Menstruation, although the uppermost sign of femininity, was surrounded by connotations of illness and disorder. A regular menses was perceived as a pathological indisposition, the failure to menstruate also was considered an illness and a symptom of deficient femininity.

The casebooks reveal nothing about Ghent women feeling failed, but whether or not the anxieties of not menstruating were inspired by cultural expectations, some lived in agony because they could not conceive. A thirty-eight year old anonymous patient was zealously longing for a child and thought she was pregnant as she had a very irregular menses for four months when she consulted Van den Bergh. Yet, she still had some blood loss from time to time but other symptoms such as a swollen belly and breasts explained her expectation. The patient not being sick nor having to vomit is noted but nothing about a pregnancy. A woman of thirty who had been married for two years was near to desperation because she had not become pregnant. She longed intensely for a child and submitted herself to taking medication to become a mother.

The consequences of having a new baby, sometimes, were more than a woman could bear physically and emotionally. Van den Bergh functioned as a 'mental coach' for those who had trouble adjusting to the responsibility of caring for an innocent, dependent new baby in addition to rendering treatment to women with post-birth complaints directly related to the delivery. The nursing of a child, at times, led to mammary gland infection, sore nipples and a suppression of menstruation. The latter was welcomed as a source of contraception but was seen also as the cause of health complaints. Moreover, raging hormones resulted in a state of emotional imbalance. Five months after she had given birth Mathilde Meire (38) was afraid of dying, crying

139 Casebook 16 (1896-1898): p. 116. ‘ ... se soumet a prendre des remèdes, dans le but de devenir mère’.
140 Cf. G. Van den Bergh, 'L'Arnica Montana dans les suites des couches', JBH 2 (1895), 204-207; AVB, Notes on the application of arnica during pregnancy, inv. no. 47, 5 cases, from 1870.
141 Cf. Nelly Oudshoorn, 'The Birth of Sex Hormones', in: Schiebing (ed.), Feminism and the Body, 87-117. At this time, not known about or, of course, used as an explanation of behaviour.
Dealing with Diseased Bodies

inexplicably, and was constantly trembling. Marie VanHelder (28), a butcher’s wife, consulted Van den Berghe with complaints of anxiety and fear of dying. She felt very weak and, furthermore, was unable to sleep except at the beginning of the night. She had given birth recently to a daughter and, perhaps, Marie would be diagnosed, nowadays, as suffering from post-natal depression.

Older female patients with failing menses often were confronted with the forebodings of menopause, the ‘âge critique’. The casebooks reveal little about the psychological consequences for women who saw that day of older age rapidly coming nearer. It was a period of anxiety as the hot flushes and palpitations followed each other in quick succession. Some historical studies provide insight into women’s menopausal perceptions, but with opposite conclusions. Menopause was perceived in general as a serious danger to health as, in the view of many women, menstruation served the evacuation of poisonous humours. Women feared that, with the cessation of menstruation, bad fluids would accumulate in their bodies causing great suffering. However, the one study claims that post-menopausal women had lost their femininity and, therefore, ceased to be socially valuable. The other concludes, conversely, that a ‘positive re-evaluation of the postmenopausal body’ took place at the beginning of the nineteenth century. Women broke loose from the chains of their reproductive organs with the passing of menopause to become physically stronger. The womb’s decline in dominance led to female stability.

It is a pity that the casebooks keep quiet about the ideas women held regarding the social, biological or even physical meaning of the cessation of menstruation. They do not answer interesting questions on what post-menopausal women thought about their social status; whether they were regarded as older, ‘wiser’ and stronger women or, if they were looked upon as women without femininity. Neither do they give evidence on if women would

144 E.g. Stolberg, ‘A Woman’s Hell’; Strange, ‘Menstrual Fictions’.
146 Strange, ‘Menstrual Fictions’, 612.
have welcomed eventually the loss of fertility as they did not have to worry any longer about the consequences of sexual relations. Nor is anything learnt about whether these women truly pitied their new status as older women and feared the loss of beauty.

Van den Berghe frequently attended to ‘disturbances’ of leucorrhoea and vaginal itch or pains. Non-menstrual vaginal discharge was of great concern to women. Such complaints were described in the casebooks with the medical term ‘leucorrhoea’ (leucorrhoea) or the lay-term ‘pertes blanches’ or ‘fleurs blanches’. Women reported in detail the smell, density, colour and structure. The discharge was mentioned, at times, as a secondary symptom to other conditions but, it could be also a primary cause of suffering. Women were able to make a distinction between ordinary, yet unwanted, vaginal discharge (‘the whites’) and other abnormal vaginal emissions. The term ‘leucorrhoea’ was never employed in the latter case but the emissions were referred to as ‘pertes’ (loss) or ‘écoulement’ (discharge). Camille V., for example, wanted Van den Berghe to free her from abundant purulent vaginal pertes. Nathalie B. described her vaginal ailment as purulent écoulement. She told Van den Berghe, when asked, that her husband had nothing abnormal on his ‘male member’ (verge). Clearly, the physician thought that a venereal disease might have affected Nathalie. She developed a swollen, grazed and callous left labium during the treatment and she began to bring along her husband as now he had developed also an abrasion, a superficial ulceration on his prepuce. Van den Berghe had been right.

Nathalie’s worst nightmare probably came true. The discharge was a venereal affliction, a disorder that most women received unknowingly from their husbands. Women, although it rarely represented life-threatening diseases, therefore, dreaded vaginal discharge. The causes could be multiple, venereal disease, post-delivery infection, or damage from childbearing. The ultimate result was infertility. Thus, it made women extremely aware of their bodies. Discharge, moreover, affected the relationship between the sexes. The foul smell and pain during intercourse obstructed the joy of the sexual act and, at the same time, revealed a spouse’s infidelity as well as his dishonesty if the discharge signalled the presence of venereal disease. Vaginal secretion also upset many women as it could indicate that the body’s reproductive functions were in danger.

Although a few women actually complained that the leucorrhoea limited sexual relations as it caused pain, none of the women grumbled that they had been refused sex because their husbands considered it unhygienic or

149 Ibidem: p. 981.
150 Shorter, Women’s Bodies, 256-260.
Dealing with Diseased Bodies

inappropriate. Thus, women hardly used the vaginal emission as an excuse to avoid sex and men were not held back by a little discharge. Moreover, although men consulted Van den Bergh because of sexual impotence, virtually no woman visited him because of direct difficulty with the sexual act. An exceptional twenty-three year old non-paying patient let herself be treated in 1877-1878 for painful intercourse: ‘at the insertion of the male member she experiences great suffering’ (en introduisant le membre virile elle éprouve de vives souffrances). Sexual failure was directly perceptible in men because their genitals literally let them down. Women were not unable to have intercourse yet, at times, suffered unbearable pain. Moreover, it appears that, even if a woman knew that sex would result in suffering, the thought of abstaining from intercourse barely crossed her mind.

The typical female disorders suffered by Ghent women and the consequences for their health and life, at times, becomes abundantly clear from the casebooks. Yet, how women looked upon their bodies, their perceptions of bodily functions and of their role in relations with men is rather less obvious. The vivid depiction of the movements of the uterus and ovaries means that, for women, the functioning and health of these organs were connected closely with perceptions on causes of illness. However, not all women related their suffering to their reproductive organs but, instead, held different opinions on the origins of their ailments. Women thought also that their bodies were more than vehicles for reproduction. Sexuality was an integral part of life, inside and outside of wedlock, and not only to satisfy the needs of men. Leucorrhoea might have hindered normal sexual relations. The presence of a serious ailment, at times, was indicated by too strong or deviant-coloured discharge, perhaps unknowingly transmitted from a partner, but was considered also as a sign of impurity.

Women tended to explain their suffering differently from men but why? The answer partly can be reduced to the nature that society had assigned to women and the emphasis that medical representatives put on a woman’s sensibility. In 1883 a male doctor formulated it as follows:

General differences exist bound by a larger dosage of sensibility in women. Impressions are more vivid, habits are weaker, and, consequently, less energy exists to resist moral causes that ceaselessly affect us. In women, furthermore, much more nervous disorders are seen, and these complications always have more vile

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152 Whether women continued to have sex because they wanted to or out of obligation cannot be determined by the present research.
153 See the first paragraph.
In Search of a Cure

In her, the genital apparatus plays a much larger role than in us, and the aberrations in sensibility manifested in her result in a mass of lesions that are entirely unknown to us.\(^{154}\)

A woman’s nature made her not only increasingly susceptible to physical suffering but also implied that she was vulnerable to the slightest emotional event, thereby, causing even more suffering. This notion of female emotional weakness as a cause for disease seeped through to the perception of ordinary women who used it as a means of explaining what was happening to them. Men, as sensible beings less influenced by emotional matters, were more likely to justify their affliction by rational causes. All of this is linked with social backgrounds and, correspondingly, the level of education. As men were generally more literate than women, their chances of grasping and reading medical topics was greater. Moreover, an occupied working-class mother would not have had the luxury, in terms of time and money, of becoming as emotionally affected as an upper class woman with private means. Women from the lower classes had less time to let their menses interfere with their daily routine than their more well-to-do sisters who could afford restricted activity during menstruation.\(^{155}\)

Was the presumed mildness of homeopathic treatment an important factor in a woman’s decision to consult Van den Berghe and/or to try homeopathy?\(^{156}\) The casebooks do not provide absolute evidence for such an assumption. Men and women complained about the negative consequences of

\(^{154}\) Becquerel, *Traité élémentaire*, 851. 'Il y a des différences générales tenant à une plus grande dose de sensibilité chez les femmes. Les impressions sont plus vives, les habitudes plus molles, et, par conséquent, il y a moins d’énergie pour résister aux causes morales qui nous affectant sans cesse. Aussi voit-on beaucoup plus de désordres nerveux chez les femmes, et ces accidents ont toujours de plus fâcheux [sic] résultats que chez les hommes. L’appareil génital joue chez elles un bien plus grand rôle que chez nous, et les aberrations de sensibilité qui se manifestent de ce cote entraînent une foule de lésions qui nous sont entièrement inconnues.'

\(^{155}\) Strange, ‘Menstrual Etiquette’, 257. However, this assertion cannot be substantiated by data from Van den Berghe’s women patients with menstrual and other gender-related disorders, because of only a few of them the social background could be assessed. More than half of the twenty who suffered from menstrual and sexual complaints came from the lower middle and working classes.

orthodox medicine which made them more ill than they had felt before. The wish for humane, or holistic or ‘soft’ treatment, in a sense, was expressed by both sexes. This homoeopathic physician hardly, if at all, exposed his patients to a physical examination which could have appealed to women with very intimate conditions. However, the greater part of the women consulted Van den Berghe with non-gender-related complaints. Personal explanations for becoming one of his patients are rather scarce. If they are available, the patient usually said that there was a recommendation from an acquaintance, friend etc. or that they had tried unsuccessfully other healing options and now wanted, whether confident or not, to try Van den Berghe and his homoeopathic treatment. Moreover, during the treatment, women and men did not see the need to abstain from their purging habit. So, even if they liked the near-absent side effects of homoeopathic medication, patients continued to submit themselves to harsh treatment.

Is there no indication at all for a preference for the holistic aspects of homoeopathy? There is still the fact that his practice, in the course of time, became a predominantly female business, with the new clientele including more women and fewer men. If, at the end of the nineteenth century, orthodox practitioners managed largely male clienteles then it is conceivable that the choice between orthodox and unorthodox healing methods was gender-related. Indications have been found that men attached less value to the psychological/emotional backgrounds of their suffering. Their primary focus was the eventual elimination of the conditions. However, women (51 out of 101) offered twice as often than men (18 out of 80) emotional explanations for their hardship. The holistic approach of homoeopathy, its basic assumption that physical suffering is symptomatic of psychological distress, the interconnection between body and mind, may have made them feel more comfortable.

7.4 Recapitulation

First, a sufferer’s sex influenced perceptions about the nature and causes of the suffering and illness. Second, a discrepancy existed between knowledge and actual sexual behaviour. Men and women expressed their awareness of the possibly negative impact of excessive sexual behaviour and so-called immoral sex, not aiming at procreation, on their body and health. However, knowing and acting upon this awareness were not he same. Third, male and female patients equally enjoyed sexual relations but feared the potential consequences. However, men and women experienced and elucidated such adverse effects differently because of their distinctive body perceptions.

Illness could result from three different circumstances in the experience of Van den Berghe’s patients. It could be caused by emotional factors, the
illness could result from natural or medical factors, or the suffering could originate from personal conduct. These emotional, natural/medical and behavioural observations were not always separated sharply from each other; some patients explained that they had been confronted at the same time with several of these 'ill-making' factors. Although these types of explanations were given for all types of conditions and, as such, were not 'ailment-specific', men and women did not mention them equally. Women were more inclined to explain illness from a psychological point of view, stating that emotional events had caused the complaints, whereas men tended to explain their conditions from a medical/natural or behavioural perspective. The fact that women considered themselves, more than men, susceptible to the 'ill-making' effects of emotional changes was related to contemporary notions of woman's nature. Her weak and highly sensible natural constitution, resulting from the specifics of her female body, made a woman particularly vulnerable and susceptible to suffering. Men, as subjects of rationality, were influenced far less easily by emotions.

Men were aware particularly of the possibly 'ill-making' consequences of masturbation and unbridled sex. They expressed, for example, medical conceptions of sex-related disease and were aware very much of the condition of their semen. Yet, they hardly ever decided to abstain deliberately from sexual relations and neither did they feel the need to elucidate or to excuse this continuance. However, at the same time, they could never fool themselves as ulcers, grazes and impotency formed clear, visible bodily signs that something was wrong. Men were rather anxious about these conditions, not only because they feared the loss of manliness as their body could not engage in the blessings of intercourse, but also because of the uncertainty about whether the venereal condition had disappeared. It would have been very unpleasant to discover that a loved one had been infected unintentionally and unconsciously. The invisible, still infected male body, thus, at times, seemed a time bomb waiting to explode by revealing its ailment on another body.

Women also did not abstain from sexual indulgence, in spite of the medical and social views depicting women as weak, vulnerable and a-sexual. Stories about intercourse without being married and pregnancies and children outside of wedlock, indicate that unmarried women were sexual creatures to whom physical pleasures were alluring. Married women were, according to the casebooks, faithful to their tasks of beloved wives and mothers, putting their bodies at procreation's disposal but, thereby, risking becoming venereally infected by their unfaithful husbands. Women worried about their bodies disguising the true nature of their abdominal suffering from syphilis or gonorrhoea. Such ailments were visible in men but not in women. Therefore, it was not uncommon that women unknowingly had numerous miscarriages.
Dealing with Diseased Bodies

because of venereal disease or gave birth to syphilitic children, one of medicine’s great concerns as this was considered to lead to the degeneration of the human race.

Finally, although it was generally accepted that sexual excesses could lead to premature deterioration of a man’s body, it was not thought realistic for men to abstain. However, women should never undertake any form of excess as her irritable nature, resulting from her female biology i.e. uterus and ovaries, would be ruined by over-excitement. A woman’s biological body dictated her well-being. The state of a woman’s sexual organs and the features of femininity such as menstruation, bearing children and menopause already posed such a burden on her body that any other excitement would lead inevitably to more physical and psychological suffering.

These notions of masculinity and femininity, men having an animalistic urge, women having no such need for sexual gratification, become abundantly clear in the stories about masturbation. Men and women were aware of the possible dangers arising from masturbation, i.e. numerous bodily and mental signs of ill health, yet, their narratives on the origins of such behaviour clearly differed. Men never excused their masturbating activities, apparently considering it as a logical outcome of the male sexual urge. Women, on the other hand, always claimed that a physical sensation had forced them to touch themselves. Self-gratification resulted from the specifics of their bodies, usually a fit of vaginal itch, and, as such, women renounced all responsibility by claiming that they were biologically impelled.

Women and men had a natural, physical propensity for masturbation although women never justified that behaviour in sexual terms. Male explanations for venereal disease and masturbation considered it a matter of personal responsibility and an outcome of their natural passions. The female patients claimed that it was out of their control and, thus, they took the role of victims. Men had visited prostitutes, thereby risking venereal infections. Women blamed their husbands for infecting them. Men just simply masturbated whilst women, instead of being sexually aroused, were forced by their bodies to do so. However, although, at times, women suffered greatly from the consequences of menstruation, pregnancy, delivery, menopause and other gender-related conditions, they did not complain constantly about the ‘burdens’ of their body. The vast majority of Van den Berghe’s women patients consulted him with other than gender-related ailments. Thus, women attributed their suffering to more than their biological state and not all of them considered themselves to be the victims of their husbands, their own bodies or their femininity. The stories of Van den Berghe’s female patients reveal histories of suffering as well as accounts of joy.
Conclusions

Gustave Van den Berghe died rather unexpectedly on 18th May 1902, nine days after his sixty-fifth birthday. He had been indisposed for only a few days and neither the care and assistance of his sons nor the aid of his colleagues could protect him against apparent consumption. The practice came to a sudden standstill; Van den Berghe had seen his last new patient on the day of his death.1 The news of his death reached his colleagues as well as his clientele very quickly. Some of his patients seemed more disconcerted about the loss of repeat prescriptions than that of their ‘personal’ physician. Arthur Pot, for instance, felt compelled to convey his condolences to Van den Berghe’s son, Ferdinand, but was more interested actually in how to get his future prescriptions.

Renaix 22 May 1902

Monsieur,

As I arrived in Ghent this morning it was with great regret to hear that Monsieur Le Docteur, your father, has passed away and I permit myself to write to you, because they have told me that you will continue his business. [Could you] send me the medication of before last time, I think they are better than the last ones. You may send them to me cash on delivery or I will pay you at my next visit. I look forward to receiving your reply.

Sincere condolences

Arthur Pot2

Pot’s interest in homoeopathy was situated in the therapy itself rather than in the person who was prescribing it. Therefore, he needed to ascertain if Ferdinand was going to take over his father’s practice and, if so, whether he would adopt his father’s custom of mailing the medication. Arthur Pot would continue with homoeopathy after Gustave Van den Berghe’s death. Other patients would not as, for them, the use of homoeopathy may have been largely

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1 After that the casebooks fall silent for two months.
2 Casebook 17 (1898-1901): p. 835. Letter from Arthur Pot to Gustave Van den Berghe, dated 22 May 1902. ‘Je suis venu ce matin a Gand et c’est avec regret que j’ai entendu dire que Monsieur Le Docteur, votre père est venu de mourir et je me suis permis d’écrire car on m’a dis que vous alliez continuer les affaires. Veuillez avoir […] me renvoyer les médecines comme l’avant dernière fois je les trouve meilleurs que les dernières. Vous pouvez me les renvoyer conte remboursement ou bien je vous paierai la prochaine visite. Dans l’attente d’avoir une réponse’ ....
an expression of trust in this particular physician, of the need or wish for *gratis* treatment or of both.

This study has reflected upon the patients of the homoeopathic physician Gustave Van den Berghe, who practised in Ghent between 1869 and 1902. He had earlier offered homoeopathy to sufferers in his home town of Zwevegem, in West-Flanders. However, his homoeopathic career truly advanced with his move to Ghent. He treated more than 22,000 patients from home and abroad for over thirty years and for six days a week. Patients lived in Belgium, France and the Netherlands, they were young and old, male and female, rich and poor, they were suffering from a simple cold or, sometimes, near death.

Two distinctive methodological approaches of the historical patient have been applied. Firstly, a patient-related approach, in which patients are presented as part of a larger entity, i.e. a homoeopathic physician’s clientele. Secondly, a patient-specific approach, introducing patients as individuals. Analysis of the composition of Van den Berghe’s clientele ascertained general transformation patterns in his practice and revealed the impact of socio-economic and culturally related circumstances on those consulting this particular homoeopathic physician. A reconstruction of patients’ personal stories of suffering resulted in insights into health care-seeking behaviour and personal perceptions and experiences of illness, health and healing from the patients’ perspective. Furthermore, it has shed light on the doctor-patient relationship, by examining patients’ individual behaviour towards Van den Berghe during the clinical encounter.

The results are founded, to a large extent, on the interpretation of Van den Berghe’s private casebooks, in which he noted, besides medical information on illness, medication, physical examination etc., the individual stories of his patients. They had the opportunity to speak from a personal point of view about the experiences and causes of their suffering. Patients’ own understanding of being ill and the ways in which they dealt with bad health received his thorough-going attention. Therefore, the casebooks can be read as both a homoeopathic physician’s ‘medical memory’ and as a patient’s diary of daily life experiences with illness and (self) treatment. The casebooks can enhance knowledge and understanding of historical experiences with illness and the body from a patient-specific perspective. Casebooks symbolise more than a particular physician’s medical practice. They, at the same time, represent the individuals who received the treatment and illustrate their personal approach towards illness, health, healing and their relationship with the physician.³

³ The main conclusions will follow regarding Van den Berghe’s nineteenth-century Ghent patients and their experience with homoeopathy. As the research into particular topics has yielded rather more questions or voids than results, suggestions for future research will be given as well.
Van den Berghe's clientele underwent three major changes in terms of numbers and composition of new clientele, specifically as regards gender and social background. These transformations demonstrate that the choice to consult Van den Berghe, and/or to use homoeopathy, in part consisted of social-cultural considerations.

Gustave Van den Berghe was known beyond the borders of Belgium. Although most of his patients resided in Ghent or direct vicinity, he treated also sufferers living in France and the Netherlands. This was not unique; other nineteenth-century homoeopaths were consulted also by patients from other countries. The obstacle of distance was counter-acted by the custom of written consultations. Patients wrote to the physician, as in the case of Van den Berghe, about their condition and, in return, would receive medication and advice by mail. However, writing to their physician was not restricted to those who lived at a distance. Ghent patients consulted and informed Van den Berghe by letter.4

Two per cent of Van den Berghe’s patients were registered as living in another country, particularly in the department of Pas de Calais (in the north of France) and in the province of Zeeland (in the south-west of the Netherlands). Both areas directly bordered Belgium, the southern part of Zeeland even bordering East-Flanders. These ‘foreign’ patients were often not foreign at all; many Belgians fled their home country in times of economic and social decline or political unrest and settled temporarily in the areas where Van den Berghe’s ‘foreign’ patients were known to live.5 Roubaix, in particular, where many ‘French’ patients resided, was renowned as the ‘Belgian colony’. Some of the ‘foreign’ patients were not only probably of Belgian origin but were Ghent inhabitants; seasonal labour in France was popular amongst Ghent workers. ‘Foreign’ patients hardly ever consulted Van den Berghe about their children’s ill health. Men predominated among the Dutch patients. Moreover, the further away people lived, the less often they requested his assistance. The distance to the practice negatively influenced the need or wish for treatment, in spite of the custom or the possibility of written consultations.

The composition of Van den Berghe’s Ghent clientele confirms that his practice was open to everybody and was visited by sufferers of diverse economic and social backgrounds and age-groups. Nearly twenty per cent of his patients were children, aged sixteen or younger, the rest were adult women and men from all social strata. The clientele can be considered as a cross-section of Ghent’s population, except for the higher average age of the patients. However, the clientele gradually, yet considerably, changed over time. This transformation of the clientele occurred predominantly in terms of gender and of social class of the new patients.

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4 Most of these patient-letters, unfortunately, have not passed the test of time. It is, therefore, impossible to determine how often and for how long patients in general consulted Van den Berghe via letters.
5 Cf. Chapter 2.
Conclusions

There was an overall transformation in Van den Berghe’s clientele in a reversion of the enlistment of new patients and a growth in the request for treatment from sufferers living outside of Ghent. He had to deal with a clear waning of new clientele at the end of the century. In his first entire year of practice in Ghent (1870), he recruited 1,432 new patients, adults and children, including non-Ghent patients. Thereafter, he would never have so many new patients in one year and, in general, the new clientele gradually, but steadily, decreased. The decline in the number of new child patients, though, was far less pronounced. Thus, new adult patients registered far less often at the turn of the century, whereas care takers continued to engage professional homoeopathic help for their children. It is uncertain why the number of new children remained rather steady, but it coincides with a growing number of new female patients. However, not only mothers but also fathers took their children to Van den Berghe over the entire period.

Van den Berghe’s new clientele fluctuated depending on particular events. However, it is remarkable to see that the outbreak of epidemics in Ghent did not lead automatically to more new clientele. A smallpox/typhoid epidemic in 1871, with a mortality rate of nearly thirty-eight per cent, did not yield a substantial growing new clientele, nor did an attack of influenza in 1889-1890. Ghent’s population was startled by a mild outbreak of cholera between 1892 and 1894, a disease that was dreaded in the popular mind, but the number of new patients stayed virtually constant.

Other incidents did have a more distinctive impact on the growth or decline of new clientele. When he moved his practice, after buying another house in Ghent in 1871, Van den Berghe treated fewer new patients. Firstly, the change of address was not announced publicly and, secondly, the move to new premises took time from being able to practice. Van den Berghe’s publication of *De Homoeopathie en hare tegenstrevers* in 1881, on the other hand, boosted the size of his clientele. 888 new patients consulted him, of whom fourteen per cent received treatment free of charge. Although his book was hardly meant for laypeople, the extraordinary decision to write in Dutch contributed, at least, to the accessibility of knowledge about homoeopathic principles. Perhaps, it even led to ordinary people changing their attitude towards doctors as language barriers ceased. Nevertheless, it is not unthinkable that the stagnation in growth of new clientele must have worried Van den Berghe. He may have had a more reasonable and workable arrangement for his practice days, but only a small part of his patients became steady visitors. The majority only consulted him on a few occasions which may have contributed to financial troubles.

It seems that homoeopathic practitioners lost their initial ‘magical attraction’, be it based on personality, homoeopathy or free treatment. At the same time as medical science began to show its first therapeutic successes the

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6 This research did not follow-up the patients after they had ended their treatment with Van den Berghe and, therefore, they may have continued to make use of homoeopathy - either personally or with another practitioner
appeal of the 'softer alternatives' diminished. Fewer new patients found their way to his practice. Sufferers' fading interest was seen also in the decline in the number of Belgian homoeopathic physicians.\(^7\) No clientele, no business. Moreover, medical competition expanded. Whereas the number of homoeopathic physicians stagnated, the number of orthodox professional practitioners grew. Sufferers had more practitioners to choose from and the proximity of an orthodox practice may have diminished the number of potential patients for Van den Berghe. Yet, at a personal level, the patients who did try homoeopathy with him, still partly explained this decision out of discontent with orthodox medicine at the end of the century.

As the demand of Ghent citizens for Van den Berghe’s treatment diminished, that of people living elsewhere increased. The distance and time spent did not prevent them from personally consulting him, besides writing letters. Belgium, as one of the first industrialised countries on the Continent, had invested enormously in the infrastructure and better transport opportunities reduced travelling times.\(^8\) Thus, for those living elsewhere, social-economic progress enlarged their options for healing. Women, in both the non-Ghent and the Ghent clientele, outnumbered the men but they consulted Van den Berghe less often than the men. It remains rather difficult to find a satisfactory explanation for the difference in consultation behaviour (i.e. the number of consultations) of non-Ghent men and women. Women were not discouraged to undertake a journey for treatment, yet hardly travelled alone. Therefore, it seems that their dependence on a fellow traveller, at times, will have been an hindrance to their need or wish to consult personally Van den Berghe.

Women predominated in Van den Berghe’s clientele during all his years of practice. This female surplus continued to increase, considerably transforming the gender balance of his practice. Most of his foreign homoeopathic contemporaries had a male dominated clientele whereas, amongst Van den Berghe’s patients, the female preponderance continued to expand.\(^9\) The sex-ratio of his Ghent clientele, the number of males per 100 females, changed from 80 in 1869 to 58 around the turn of the century. Such a female over-representation is common in twentieth-century homoeopathic practices. Therefore, Van den Berghe’s practice may be considered as representing a transitional period, hovering between the ‘old’ male dominated and the ‘new’ female dominated homoeopathic practice.

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\(^8\) Cf. Chapter 2, paragraph 3, 63-73; Chapter 3, paragraph 1, 76-85.

\(^9\) Information regarding Belgian or Ghent colleagues has not been found. Cf. Chapter 2, 51-52.
The predominance of women in Van den Berghe's practice, at first sight, is hardly surprising as Ghent's population displayed a similar pattern.\textsuperscript{10} Ghent's textile industry traditionally employed many women workers and, therefore, the city's population consisted of more women than men in the nineteenth century. Yet, the share of women inhabitants did not increase to the same extent as that of Van den Berghe's female patients. Thus, the over-representation of female patients only reflects partially the population structure. However, it does indicate that women were more willing than men to call in the help of a homoeopathic health professional. A possible explanation for this readiness was discovered in the ailments for which women sought treatment and their stories of the suffering they had endured in the past.\textsuperscript{11} Women, besides being at risk to the general health threats of being human, were confronted also with the 'dangers' of being females. Even when women currently consulted Van den Berghe with such ordinary, 'human' conditions, they seldom refrained from telling him about previous pregnancies, difficult deliveries, an occasional miscarriage and menstrual problems. Problems which had influenced their general state of health and well-being. His female Ghent patients, in general, had struggled physically or were struggling more than the males. Moreover, social, medical and religious views of women portrayed the female gender as weak, vulnerable and irritable by nature because of their specific biology, the female constitution. The reproductive organs, the uterus and the ovaries, which caused great suffering in women, ruled the female body and mind.\textsuperscript{12} Van den Berghe's female patients spoke about their specific constitution in relation to their ill health; they had adopted these general ideas that, in a sense, excused women from being sickly and expected them to be ill more often than men.

Although women may have been more prepared to call in the help of Van den Berghe or of homoeopathy, this does not explain the considerable expansion in the number of female patients. Moreover, it is unknown whether the composition of Van den Berghe's clientele deviated from that of his orthodox colleagues practising in Ghent. If orthodox practices did consist predominantly of male patients, then a gender gap did exist in choosing orthodox or unorthodox treatment in the nineteenth century. However, this has not been currently established, although, for the twentieth century, women tended to choose homoeopathy more often than men because of its perceived mildness (also for their children) and the convenience of home treatment.\textsuperscript{13} This research has not revealed any conclusive information as both men and women complained about the 'cruelty' of orthodox medicine.

\textsuperscript{10} Cf. Chapter 3, 76; Chapter 4, 113-114.
\textsuperscript{11} Cf. Chapter 6, paragraph 2, 169-178; Chapter 7, 229-230.
\textsuperscript{12} Cf. Chapter 7, 227-229.
\textsuperscript{13} Cf. Chapter 4, 117; Chapter 7, 238-239.
The other transformation concerns the gradual shift in the patients’ social background: from middle and upper class domination to a ‘popularisation’, an over-representation of working- and lower middle-class patients. Patients from all social strata of Ghent’s society used Van den Berghe and/or homoeopathy, yet the reasons for their interest seemed culturally shaped. The absolute poor did not have the financial means to respond to instances of illness in any way they liked. They were dependent on poor relief and, thus, forced to use the public offers of therapeutic support. Yet, public medical support was strictly restricted by eligibility criteria. Some of Van den Berghe’s patients, although destitute, probably did not meet these criteria; others refused to go through the demeaning procedures for applying. Although, in many cases, the gratis treatment was the over-riding influence in the choice to consult Van den Berghe, some destitute patients were drawn by his specific homoeopathic treatment which was not available through charity or public poor relief.

The affluent, whose share in Van den Berghe’s clientele diminished considerably in the course of the century, initially may have been influenced partly by the sense of exclusiveness surrounding homoeopathy.\(^\text{14}\) At the same time as the number of working- and lower middle-class patients and the number of people applying for free treatment increased, noble and other upper-class patients ceased to come to the Ghent practice. For them homoeopathy may have lost its attraction as a status symbol. However, upper class patients may also have turned away from homoeopathy because of the advances of orthodox medical science at the end of the nineteenth century. None of these patients personally told Van den Berghe that they did not appreciate him treating poor patients or, at least, he never made such notes. In the case of one noble former patient it is known that the homoeopathic tradition was continued at home. The physician had lost his attraction but not the medical method. Did the affluent, with growing public accessibility to homoeopathy, withdraw from homoeopathic physicians’ clienteles, yet remain loyal to the therapy at home?

The survey of the socio-economic background of the Ghent clientele relating to the conditions with which they consulted Van den Berghe did not yield any significant results. The decision to consult Van den Berghe or to try homoeopathy was barely influenced by patients’ perceptions of the seriousness of their illness.

Ghent citizens lived in changing times during the second half of the nineteenth century. The population was startled regularly by social-economic turmoil, political unrest and epidemic threats. Such events were more difficult to cope with for some people than for others. The upper strata of society were barely affected by economic crises and food shortages yet, felt the threat of the

\(^{14}\) This has been concluded by P.A. Nicholls regarding the interest in homoeopathy of the English upper classes. Cf. Phillip A. Nicholls, ‘Class, Status and Gender: Toward a Sociology of the Homoeopathic Patient in Nineteenth-Century Britain’, in: Martin Dinges (ed.), Patients in the History of Homoeopathy (Sheffield: EAHMH, 2002), 141-156.
Conclusions
destitute working classes. Economic crises led to unemployment which, in turn, could easily spark social protest, strikes and even revolts.

Ghent had two faces. The one side reflected the splendour and grandeur of cultural prosperity; the nobility and other affluent families living in lovely, clean and green neighbourhoods. The other side demonstrated the hazards of the enormous expansion of Ghent’s textile industry; industrial workers crammed into dark, small and dirty blocks, without sewerage or running water. These districts were particularly vulnerable to outbreaks of cholera and typhoid which spread easily and caused many fatalities. These unsanitary living and unsafe working conditions of the enormous industrial work force eventually led the government to start improving the most notorious districts in the town. There was the fear of contamination of the higher classes which was countered by the education of the masses to protect bourgeois interests. Yet, maybe foremost, there was the pressure from the increasingly strong and growing labour movement. Ghent was still ranked first amongst Belgium’s twelve largest cities for poor hygiene by the end of the nineteenth century, but the average industrial worker no longer needed to apply for public poor relief.15

This was the situation in which Van den Berghe’s Ghent patients lived. However, whether rich or poor, or in between, disease did not take account of social status. Assessment of the ailments that Van den Berghe treated did not yield any conclusive correlations between socio-economic background and susceptibility to particular ailments. It was known, for example, that textile labourers, who spent long hours in secluded badly ventilated spaces, were prone to lung and respiratory conditions. Van den Berghe had considerable numbers of textile workers in his clientele but they did not complain more than others about these types of ailments. However, his patients were only a small part of Ghent’s population.16 Another noteworthy finding is, that Van den Berghe’s lower-class patients were not condemned exclusively to living in specifically working-class districts. Instead, many of them, lived near to his practice and, therefore, seemed attracted by his proximity. Van den Berghe’s clientele becoming predominantly working class coincided with the economic progress of the last quarter of the nineteenth century. Lower-class families finally gained also more financial scope for medical consumption, as the increase in the new lower-class clientele did not coincide with an increase in the number of new patients treated for free.17

The men, women and children in Van den Berghe’s clientele suffered from a wide variety of conditions, many of which were not grave. Patients, at times, expressed concerns about their health or contamination, for example,

15 Chapter 3, 85.
16 Therefore, generalisations about the clientele cannot be conceived as representative for Ghent’s population at large. A larger sample or different research may yet yield other insights.
17 Systematic inquiry into Ghent citizens’ health seeking behaviour will be needed, for deeper insight into the relation of social status-susceptibility-therapeutic choices.
when they had attended a seriously ill family member who eventually died. However, the use of homoeopathy or consulting Van den Berghe seems not to have been instigated by the supposed gravity of the illness. Individuals were more likely to feel uncomfortable in their daily lives. Patients were interested primarily in how the defect could be mended rather than in what they were actually suffering from; they requested a prescription for recovery to return to normality.

Parents actively monitored and promoted their children's state of health, but seeking professional treatment yet was far from standard behaviour when a child had fallen ill. Moreover, the use of homoeopathy or consulting a homoeopathic practitioner for their children was only motivated partly by the wish for 'soft' treatment, yet it was inspired especially by wanting to safeguard children from suffering with whatever remedy was available.\(^\text{18}\)

Parents or care-takers were alarmed easily when a child showed the first signs of a cough or of diarrhoea. Moreover, they did not adopt a wait-and-see attitude but, instead, often undertook immediate action when they considered their child was at risk. They were aware that their offspring were extremely vulnerable as child mortality was high and most parents had lost at least one child. The conditions Van den Berghe treated in his child patients mostly were far from lethal from a medical point of view, yet considered serious enough by parents to consult this physician. One out of five children younger than eleven had typical children's diseases such as diarrhoea, measles, scarlet fever and whooping cough.

Adults, particularly on behalf of young patients, frequently communicated the suffering of a child. Therefore, this study has yielded merely indirectly insight into the illness-experiences of the children themselves. However, it has shown that the well-being of parents and of children was closely linked. A mother or father could fall ill because of the distress caused by the suffering of a child; children's health could be affected by the misconduct or maltreatment by or the death of an adult. Moreover, parents were concerned as much about the ailments of their daughters as of their sons. The gender of a child did not matter when that child was in danger. Van den Berghe treated an almost equal number of girls and boys, the girls being slightly in the majority. Finally, although some may have considered their offspring as merely a provision for their old age, the mutual dependence between children and their parents, already underlined by a large number of children taken to Van den Berghe, reflects the existence of a 'love-affair' between a couple and their offspring.

Parents did not choose exclusively professional help in case of illness, despite the keen monitoring of their children and the care with which they were

\(^{18}\) Cf. Chapter 5, paragraph 1, 138-149.
Conclusions

surrounded. Home medicine was often applied first; children were administered purgatives and vermifuges on a remarkably large scale. Therefore, the suggestion that parents, especially mothers, may have preferred homoeopathy for their children because of its ‘mild nature’ is not confirmed by their behaviour. Some parents continued their own private medical care during Van den Berghe’s treatment despite his explicit orders. Furthermore, twenty per cent of the children were treated free of charge and, hence, choosing Van den Berghe seemed based partly on financial advantages. Yet, between 1897 and 1902, the percentage of children treated for free declined from thirty-one to eleven per cent. However, that nearly one-third of the children consulted or were taken to Van den Berghe only once, proves that the trust of parents in him or in homoeopathy was often temporary. Van den Berghe’s treatment was just another attempt to combat the latent threats of illness and death, as other medical methods and practitioners had been tried before.

Members of one family could easily influence each other in trying Van den Berghe or homoeopathy, but it remains largely unclear which member decided primarily on the best therapeutic course to be taken.19

The review of entire families who became patients of Van den Berghe reinforces the idea that the decision in favour of Van den Berghe or of homoeopathy was really a choice in favour of his free medical support, despite the fact that even poor families eventually may have found better results from homoeopathy than from any other medical method. It is noteworthy that, notwithstanding any particular motivations, Van den Berghe developed into a true family physician for some families. He treated all the members of one household and was consulted later by offspring of the earlier patients. Children who had grown up and, sometimes, had moved out of Ghent, for example, occasionally would return to Van den Berghe with their own children. When, in particular, they were living in cities where homoeopathy was widely accessible, the return to Van den Berghe must have been inspired by the good personal relationship they had with him. More so, when they had paid always for their consultations. However, even when all family members were treated over a lengthy period of time, suggesting that they had become really dedicated to Van den Berghe and/or homoeopathy, the habit of trying homoeopathic self-treatment or other healing methods often persisted.

Nevertheless, the casebooks have shortcomings when attempting to approach illness as a family affair, who exercised authority in decisions regarding health, illness and healing? The use of other sources, e.g. advertisements (aimed at women and/or men?) or more personal testimonies in diaries, letters etc., could enlighten an understanding of the relations between the sexes, between husband and wife, on the division of responsibility regarding their children’s health. The files on Van den Berghe’s patients barely

19 Cf. Chapter 5, paragraph 2, 149-162.
reveal the patterns of decision-making processes within a family, if at all. It is impossible to say whether it was the head of the household, the father, or the mother, who had primary responsibility for the decision on which medical option to use in case of illness. The family histories do not give evidence for any gender-specific circumstances for making homoeopathy or consulting Van den Berghe a family affair. Indeed, both mothers and fathers were the first to consult him, with their families following afterwards. The exception was child-patients who, in their adult lives, continued to consult Van den Berghe for themselves or their children; they were girls/women. However, the registration of new children in Van den Berghe’s clientele remained virtually the same, whereas new male clientele decreased considerably over the years. Thus, women increasingly, apparently, gained influence over the therapeutic choices for their children. Moreover, it is clear that individuals did not wait passively for the suffering to cease but that they took their fate into their own hands and started the search for a cure.

Gender was a decisive factor regarding (1) ailments for which treatment was requested, (2) illness and body perceptions and (3) views on the origins and nature of the suffering. The male and female patients in Van den Berghe’s clientele shared many conditions, but the genders also seemed more vulnerable to particular diseases. Socio-cultural notions engendered different illness and body perceptions in men and women. Male and female patients held different views on the origins and nature of their suffering and varied in the ways they perceived their bodies. Finally, these lay sufferers’ notions on health and illness reflected prevailing social concepts of femininity and masculinity.

The adult Ghent men and women who consulted Van den Berghe, at times, were extremely capable of depicting in detail what was wrong with their bodies or their minds. Patients made a clear distinction between what they considered the essence of their suffering and the matters of secondary importance. Nowadays, homoeopathy is employed and appreciated predominantly by chronic patients. However, his late-nineteenth-century patients were far from being exclusively long-term sufferers; half of them had been afflicted for less than six months. Nevertheless, there seemed to be a limit on the time that sufferers could cope with continuous affliction. Nearly twenty-five per cent of Van den Berghe’s patients started to consult him after they had been ill for one to two years. The majority had first tried to overcome their suffering by self-treatment or by consulting other, often, orthodox practitioners. Thus, they decided to make use of yet another healing option, Van den Berghe’s homoeopathy, after a period of time. Patients were not necessarily seriously ill by then, they were not burdened exclusively with dangerous incurable conditions. These sufferers did not fear for their lives, they knew that their ailment was rather innocent. However, they concluded that it was not going to

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20 Chapter 6, 168.
Conclusions

disappear straightforwardly and, if they wanted to end the discomfort once and for all, they should try Van den Berghe and/or homoeopathy.

Men and women did not exhibit dissimilar characters on their capability of coping with lengthy suffering. However, there are differences in the male and female susceptibility to particular diseases and the ways in which men and women in Van den Berghe’s clientele explained and perceived their physical and mental afflictions. Men and women, besides gender-specific disorders related to the reproductive organs, had to take account of the gender-related circumstances of their health complaints. A distinctive pattern has been discovered regarding the ailments for which men and women requested treatment.21 Many male patients were affected by respiratory disorders whereas, more women complained of gastro-intestinal suffering. Skin complaints were expressed primarily by female patients; sexual and venereal ailments were essentially a man’s business. Yet, as these women apparently suffered more often from abdominal conditions it was, in some cases, most probably gender-related. Uterine disorders or child-bearing complaints, at times, were communicated and explained by women as resulting in gastro-intestinal conditions. The picture of men’s apparent larger propensity for developing sexual ailments, at the same time, also can be distorted. These ailments were clearly visible in men, in women they were not. More importantly, although venereal suffering in both men and women was surrounded by shame and disgrace, female patients were even more reluctant to acknowledge and to explain that they had developed a condition of such nature.

Men and women, by and large, held different views on the origins of their suffering. Thus, the explanations for the symptoms were marked by the gender of the bearer. Three different illness theories were distinguished: (1) illness caused by emotional factors, (2) illness resulting from natural or medical factors (other conditions or erroneous treatment) and (3) suffering originating from personal conduct.22 Patients who spoke about the first two explanations indicated that the ailment had developed outside their own control. If they referred to their own behaviour as a cause of the suffering, they were acknowledging, in as sense, that they had brought it on themselves. There does not seem to have existed a positive correlation between the illness theories and certain conditions, a correlation that was found in the case of gender. Men and women displayed differing perceptions on the origins of their ailments. Women generally tended to explain their suffering from an emotional point of view, with anger, fear, anxiety, grief and sorrow causing all types of ailments. Women used such explanations twice as often as men. The male patients most frequently offered explanations of a behavioural or natural/medical nature. These natural/medical explanations for men often meant that they had worked

21 Cf. Chapter 6, paragraph 2, 169-178.
22 Cf. Chapter 7, paragraph 1, 203-209.
too hard, too long or in an unhealthy environment. Women, in this case, complained about gender-specific circumstances such as pregnancy, delivery etc.

The stories of the Ghent patients on the origin of ailments and their body perceptions infallibly reflect the impact of the social-cultural context on sufferers' personal ideas, knowledge and comprehension. Prevailing medical, social and religious notions of femininity and masculinity, ideas on proper behaviour in men and women, fostered by the perceived functioning of one's biological constitution, filtered through to the minds of lay-people, as communicated and reflected upon by Van den Berghe's patients. This has been elaborated by the example of male and female attitudes about sexuality, venereal disease and the body.23

Although men and women were involved equally in sexual activities, the language used for their behaviour diverged. Women, at times, met the social criteria of what it meant to be a woman, a-sexual, susceptible and weak. Some women freely expressed that they had sexual urges but married women, especially, made it appear that sexual intercourse was merely putting their bodies at procreation’s disposal. Their bodies were not their own but served to bear, deliver and nurse children or to satisfy their husband’s needs. Women, in a sense, felt that they had no control over their bodies. Men, in contrast, felt in charge of their bodies and, hence, took responsibility for whatever harm they might do to it. If a man was afflicted with venereal disease he pointed out that his own conduct was the cause, women usually blamed their husbands. Women, apparently, could not choose to deny sex to a visibly venereally affected husband, although their spouses will have infected them.

Accounts of masturbation reflect also the impact of social-cultural gender views of the consequences of this act. Although the propensity to masturbate was considered harmful in both men and women, as it was considered to result in a range of ailments, the deed of gratification was clarified in substantially different ways. It was a clear sexual act for men yet, never amplified. They were aroused, masturbated, developed certain conditions of which they wanted to be freed, and that was all. Women, on the other hand, never explained their masturbatory behaviour in sexual terms but, instead, claimed that they were forced to the act by their bodies. A physical sensation had forced them to touch themselves. Men and women, thus, largely accepted the general concepts of sexuality and gender; men declaring that they were behaving according to the standard of natural male passion and inability to abstain; women who acted ‘abnormally’, as they were perceived to have no sexual needs, denied responsibility for their behaviour and blamed their husband or their bodies.

However, the women in Van den Berghe’s practice were far from complaining constantly about the burdens of the female body. They attributed their suffering to more than their biological constitution. Nonetheless, it

23 Chapter 7, paragraph 2, 209-222.
Conclusions

remains largely unclear whether a patient’s social class influenced the perception and experience of and explanations for their suffering, as there is little information about patients’ backgrounds. The social background could be assessed of only a few women who consulted him with gender-related ailments. Yet, it has been convincingly argued that working-class women, in contrast with women from the upper strata, could hardly afford in time or money to allow emotional events or the ‘monthly malady’ to interfere with their daily affairs. Reflections on Van den Berghe’s female patients’ who suffered women’s illnesses correlated with their social background should provide more insight. The same type of questions should also be asked of male sufferers. Does a correlation exist between social background and illness experience? Nevertheless, it is known, at least, that men and women perceived their bodies and experienced their illnesses quite differently.

It has been argued that, although interest in the historical body has yielded a wealth of publications in the last decade, daily dealings with the body and corporality of the historical individual have remained some what neglected. This research has resulted in important findings because systematic attention has been paid to the patients’ personal perspectives on their bodies and because both sexes have been examined simultaneously. The interpretation of Van den Berghe’s casebooks made it possible to compare and to distinguish male and female attitudes towards health, illness, healing and the body.

Ghent sufferers, at random and haphazardly, experimented with whatever healing options available in the medical marketplace. There did not exist for most of them a ‘single, unequivocal ‘best buy’ for restoring their health. The results of this research challenge the pre-supposition in Anglo-Saxon studies that the principle of free choice and free use of options for healing was lost when the medical profession gained control over healthcare services and medical science had achieved clear progress at the end of the nineteenth century. It is highly debatable whether these developments changed distinguishably the experiences, perceptions and behaviour of sufferers. A declining new clientele confronted Van den Berghe but, in terms of therapeutic

25 See Chapter 7.
255
behaviour, the patients continued to use freely unorthodox medicine, healers or self-treatment. Sufferers continued to test all options for healing that they had at their disposal, despite therapeutic improvements, for example with the discovery of the tubercle bacillus in the 1880s, and restrictions on the unbridled practice of medicine by lay-people. Van den Berghe's patients still could and would select from a variety of healing methods, home medicines and unlicensed practitioners. However, the behaviour of his clientele is not necessarily typical of the entire Ghent population. Unfortunately, the extent of other Ghent citizens' experimentation in the medical marketplace remains unknown.

The therapeutic past of many of Van den Berghe's patients demonstrate that they had 'shopped around' in the medical market, instead of clinging rigorously to one particular healing option. There did not exist one single 'best buy' for them. Van den Bergh recorded numerous stories of the earlier use of home medicine, consulting licensed practitioners, or applying for treatment by unlicensed or unorthodox healers. Occasionally, a patient let it be known that an appeal to God or the saints to be released from the suffering had been made. Yet, Ghent society displayed already strong signs of secularisation. Sufferers apparently had more faith in medical personnel, professional or otherwise, or self treatment, than in the Creator to combat disease despite some unique instances of renewed devotion, for example, with the outbreak of serious epidemics. It is also possible that patients deliberately never told Van den Berghe about their attempts with religious medicine. It is of significance that, notwithstanding the general perception and experience of orthodox medical treatment as being harsh and largely inadequate, the majority of Van den Berghe's patients had made an appeal previously to practitioners in the field of professional licensed medicine. Many patients had allowed themselves to be bled or leached on a large scale, even at the end of the nineteenth century.

*Patients were active agents in their own healing process: the relationship between patient and doctor was largely patient-dominated and independent of the social status/class of the sufferer.*

If a sufferer wanted to be treated by Van den Berghe, he could apply during the office hours that the homoeopathic physician had established. The consultation hours depended on social background; new well-to-do patients were welcome in a two hour period in the afternoon, new poor patients had one hour in the morning. Another indication of a differing patient-approach based on social class was found in the fees charged, in addition to the specific division in his office hours and the creation of two separate entrances. Patients were expected to contribute according to their income.

Nonetheless, the relationship that developed between patient and doctor was barely influenced by social background, except that *gratis* treated and, therefore, social-economic patients of lower status displayed a little more perseverance in their consultation behaviour. Experimentation with all types of
treatment hardly changed after contact with Van den Berghe. Seventy per cent of the new patients would disappear from the practice within three months of the first consultation, more than twenty five per cent consulted his practice only once. The number of consultations and the period of treatment indicate that only a few truly or permanently committed themselves to this homoeopathic physician. Moreover, commitment to Van den Berghe or to homoeopathy is not evident from the attitude that the patients adopted during the clinical encounter.

Several studies on the doctor-patient relationship in the nineteenth century have argued that the balance of power between doctor and patient had changed by the end of the nineteenth century, as the doctor became 'the authority' and the patient turned into 'the admirer'. This research contests that assumption. Van den Berghe's patients were active agents during the clinical encounter. They exhibited a dominant attitude; if the treatment was considered insufficient or inadequate they would postpone or disappear from his practice. Van den Berghe dealt with self-confident patients who were only willing partially to turn over responsibility for their health. Patients did try to follow his orders on diet, or the way of taking the medication. However, if they felt that their health was not improving, suggestions were made easily for other treatments. Patients, at times, not only bluntly ignored Van den Berghe's prescriptions but also continued the use of other remedies or healers. He did not, or would ever, hold sole authority over them, and such self-willed ways of acting put them in command. This 'patient-domination' is clear from the patients' therapeutic histories, revealing the lack of trust in one type of treatment or healer and the custom of dealing with illness on a personal level, based on the advice of families and friends. Van den Berghe could not overcome this, nor could his orthodox colleagues who, at the end of the nineteenth century, still struggled to be the one and only medical authority. Sufferers were not yet impressed by the progress of orthodox medical science, they even complained about the treatment they had received previously and, thus, often continued to search for healing options outside of mainstream medicine.

Patients' choice in favour of homoeopathy or of Van den Berghe was seldom supported by a perceived 'likelihood of cure'. Van den Berghe, on the contrary, at times, was told directly that a patient doubted the efficacy of his treatment or disbelieved generally that recovery would ever be obtained. Yet, such sceptical honesty about his skills or admitting the continuing use of other remedies reflects, at the same time, a willingness to co-operate or an understanding of the necessity to co-operate or comply. The bulk of Van den Berghe's patients, in terms of number and period of consultations and behaviour whilst being in his care, cannot be portrayed as dedicated users of

28 Cf. Chapter 6, paragraph 4, 181-198.
homoeopathy and/or faithful patients of Van den Berghe. However, the group of patients that belonged to his clientele for over ten years were, if not wholly convinced adherents of homoeopathy, at least, highly committed to Van den Berghe.

The use of homoeopathy was seldom a deliberate choice, inspired by the wish for a holistic (more humane, softer, milder) approach to health, illness and healing. Other considerations predominantly influenced the decision-making process.

Nowadays, homoeopathic medicine is praised often by patients for being holistic, for the deep attention given to the patient in relation to their suffering. The sick person is not merely a defect machine, of which the symptoms are the sole sign. The patient consists of body and mind, one influencing the other, and, hence, a personal approach to the patient is employed to unravel the causes of the illness. Users of homoeopathy today often refer to this holism as the appeal of homoeopathy. The personal relationship with the homoeopathic physician or healer, who pays lengthy attention to psychological and individual circumstances, and also the relative mildness of homoeopathic medication compared with the supposed side-effects of biomedicine, persuades sufferers to try homoeopathy.

Van den Berghe’s casebooks offer a detailed insight into illness-experiences and body perceptions as well as into therapeutic careers. Yet, the particular and unequivocal motivations for seeking the help of homoeopathy and/or Van den Berghe are only occasionally seen. The extensive reasoning of the paths to homoeopathy and to Van den Berghe or the preference for this healing method necessarily had to be deduced from ‘circumstantial evidence’, probability, possibility and likelihood.

The nineteenth-century Ghent patients of the homoeopathic physician Van den Berghe, barely seem to have cared for the holistic aspects of homoeopathy. Patients, more women than men, regarded body and mind as one, as borne out by the accounts of patients explaining that emotional events had triggered off their physical suffering. Humoral pathology, thus, had not yet left the lay mind at the end of the nineteenth century. Illness occurred when the four body fluids (humores), blood, phlegm, yellow and black bile, corresponding with a sanguine, phlegmatic, choleric or melancholic temperament, became disturbed after, for instance, emotional upheaval. Health would be restored after the fluids had been re-balanced. Therefore, sufferers continued to endure the orthodox practice of bleeding and leeching. Van den Berghe’s patients had not sought systematically for practitioners who could attend to their psychologically/emotionally related bodily signs of illness, nor was this what they particularly looked for in Van den Berghe. The patients’
Conclusions

'routes' to Van den Berghe were rather contingent; the decision-making process being influenced largely by other than holistic considerations.30

Patients' social networks, the advice of family, friends and neighbours, were raised often as the reasons for consulting Van den Berghe. This decision had been based, in some cases, on sheer coincidence. Moreover, the proximity of Van den Berghe's practice to where sufferers lived played a role. Geographic analysis revealed that his proximity influenced the decision to consult him, even within the city limits. Financial considerations for others, at times, lay at the basis of the decision, as Van den Berghe exempted the poor from payments and treated them pro bono.

Occasionally, a story was found of sufferers wishing to conceal their health problems and, therefore, consulted this homoeopathic physician who practised outside the official medical circles. Patients, especially those having socially 'unacceptable' ailments, venereal disease or sex-related conditions (masturbation), at times, appear to have preferred some privacy.

Discontent with orthodox medicine was another reason for sufferers to consult Van den Berghe. Patients criticised orthodox medicine, allopathy as labelled by homoeopaths, and only had started to consult him after repeated, unsuccessful and often painful attempts with orthodox medicine. Nevertheless, being Van den Berghe's patient did not tend to change the attitude of 'I'll try whatever needed'. The 'shopping around' continued and many persisted in using self-medication or other therapies and healers. Occasionally, a patient turned into a true adherent.

Finally, patients had no deep knowledge of the medical concepts of the therapy being tried. As an example, an initial aggravation of the condition, meaning that the medicines are 'doing their job' in homoeopathy and that the homoeopath had prescribed the correct medication, was often responded to by the patient by postponing the treatment (not taking the drugs anymore) or by taking other 'allopathic drugs'. Although some had tried homoeopathy prior to consulting Van den Berghe, knowledgeable patients were the exception in his clientele. However, it was said that many working-class patients had read his book on homoeopathy, the only Belgian homoeopathic publication written in Dutch. The remarkable increase in the number of new patients after the book had been published in 1881 suggests that this induced sufferers to try homoeopathy.31 They were probably not impressed so much by the promises made for homoeopathy but rather by the criticisms of orthodox medicine, objections that many of them had experienced in person.

30 Cf. Sociologists Frank and Stollberg have come to the same conclusions in their studies on the motivations of German present-day users of Asian medicine (Ayurveda and acupuncture). Robert Frank and Gunnar Stollberg, 'Ayurvedic Patients in Germany', Anthropology and Medicine 9 (2002), 223-244; Robert Frank and Gunnar Stollberg, 'Medical Acupuncture in Germany - Patterns of Consumerism among Physicians and Patients', Sociology of Health and Illness 26 (2004), in print.

31 The research did not reveal the number of purchases by members of the working-class.
Yet, Van den Berghe as a true follower of Hahnemann strictly followed the rules for homoeopathic case-taking and, indeed, took into account the personal perceptions of the causes of and reasons for the affliction. He offered patients the opportunity and time to tell their life story and he listened attentively to them.\textsuperscript{32} Van den Berghe, in his opinion, could only obtain recovery in his patients, when all relevant details of bodily symptoms, psychological causes or results, personal situation and medical history were reviewed. Patients may not have labelled this approach as holistic, but they must have enjoyed or appreciated the time, compassion and interest Van den Berghe took in their entire being.

\textsuperscript{32} Except in the different number of office hours during which new affluent and poor patients could apply for treatment, Van den Berghe does not seem to have made other 'social' distinctions. The length of the files strongly suggests that time reserved per patient depended on the pressure of work and not on a patient's social status.
Appendix 1:  
Letters by Mr. Van Caemelbeke to Gustave Van den Berghe, 1899  
(Introduction) 

First letter by Mister Van Caemelbeke, dated 11 January 1899
In Search of a Cure

Pour en avoir la confirmation, je fus en compagnie d'un tombeau et des miettes. La maitrise était mise au père, qui reposait d'une manière la plus sauvage et mélancolique. Il pouvait être en tous cas disposé à recevoir la délicatesse de la mère.

Faisant sa conférence au monde, il disait, soulevait ses empoignements de la mer, de l'air, de l'eau. Il se lançait au cœur du silence. Son énergie, toutefois, en faisait un peu de Falsberg aux cheveux, elle parlait plus résolument.

Recommandant de se faire bénir, il appelle à l'essence de cette bénédiction.

Puis, il m'a expliqué les possibles ! De la cour dessinée à la chaîne.

Il ne pouvait pas pourtant en faire d'autres. Il faut se dire que l'essence de l'aubépine est une épreuve.

On ne sait pas que cette aubépine, qu'elle se donne à la mond qui ramène que nous l'avons presque, la cour de tort, l'inévitabilité, comme la démission, mais que Jean a peine !
Cher [nom],

Monsieur l'Inspecteur

L'attention de [titre]

Veuillez agréer,

[Variation signée]

[Oubli de date]

Sokoloff 11/11
Monsieur le curé,

Je veux voir à peu s'égarer, et je suis la
restriction et profoundi elle a descendu, que
de loin de ce qui est fermé ou ouvert. En faveur
eut ressort intérieur et margin plus certain que ca.
Dans la première belle, elle se voit,

Carquois le régime est strict,

Et il a dépassé l'identification et

Dans les phénix, pueblo, matinée
(Varies par l'apparence du jour) car, car,

Ce qui est vrai d'un autre autre,

Bièvres, elle souffre en plus moindre
bruit dans le que la capacité pour emploi
le même, bénéfique et causes,

Tes chefs ont par ici très abon-
dentar/sans le 3 jours et pas de peu

Ces jours du capot, maire comme cert.

Rienement, vous pouvez appeler qu'il a

C'est même, elle est très abondante.
Appendices

C'est donc bien la greue, vous le savez nu.

Pour constater que le dépôt, un dépôt si minuscule,
qui formait maintenant l'oeuf, qui dit si minuscule, exprime un certain respect.

Sur la carte, cette série, une carte.

Remarquez, en haut, rien qui ne soit

d'emblée, plus de fleurs de couleurs plus intenses.

Ce qui est tout à l'encontre de ce que

Le départ. Je ne saurais pourtant

L'analyse pour vous en dire de

Le matin.

Il ne restait plus maintenant qu'à rétablir, qu'il trouve la greue une chose

particulière. Que ne puis-je définir.

L'admettre, il ne saurait

être particulier. Qu'elle ne saura. Elle ne

choisit comme elle le saura. Non.

Il ne saurait, elle saura. Non, pourtant. Elle ne saura pas.

rien de contre.

265
Appendix 2:
Quotations Formulated Originally in Dutch

Chapter 1

Page 28, footnote 16:
Uit het diepst van zijn hart kwamen de woorden die hij uitsprak, en zij waren vlaamsch, echt vlaamsch, trouwens mijn vriend was ook een rechte beminnaar van onze schoone moedertaal, die mij, die ons allen zoo nauw aan het hart ligt.

Page 39, footnote 60:
Homoeopathische Geneeskunde.
Doctor Vandenberghe [sic.], Muinkkaai 42, te Gent, maakt ruchtbaar, dat zijne geneeszaal voor behoeftigen open is alle dagen, van 7 tot 9 uur des morgends. Zijne bijzondere raadplegingen geeft hij van 11 tot 1 uur.

Chapter 3

Page 75 footnote 1:
Het ondervoede volk leeft in erbarmelijke omstandigheden en loopt met gruwelijke kwalen rond. Bedorven longen, zwerende of ontstoken ogen, vergroeiingen door te langdurig en eenzijdig werk en aan flarden gedronken maagwanden zijn aan de orde van de dag. Epidemieën maken tienduizenden slachtoffers. Tering is een nationale kwaal!

Page 80 footnote 23:
[...] eenerzijds lucht, ruimte en een voorraad gezondheid; aan den anderen kant alles wat het leven vergiftigt en verkort, eene opeenhoping van huizen en gezinnen, de duisternis, de zwakte, de verpesting.

Page 83 footnote 36:
[...] netheid en zuiverheid waren een uiting van plichtsbesef en solidariteitsgevoel, van orde en welvoeglijkheid.

Page 97 footnote 83:
Ofschoon men nooit moet afkeuren dat de zieken de hulp van den godsdienst inroepen, gebeden aan zekere heiligen opdragen, of zelfs goedvinden eene zekere bedevaart te doen; moet zulks echter geschieden, zonder den loop der behandeling te stooren en nadat zy in alle geval de raadgevingen van eenen geneeskundigen hebben ingeroepen.
Chapter 6

Page 165 footnote 1:

Ghent 28 April 1899
Mijnheer
No. 63, boek 17. Ik [voel mij] wat beter; de dwalingen zijn weg, maar kan de kamer niet verlaten voor de geweldige hoofdpijn en de zwakte in de benen, ook Mijnheer ben ik zoodanig gepakt dat ik bijna geen adem kan halen al mijn ademsorganen piepen, en nog eten of drinken kan bijna passeeren van den stuk die zit van in de keel tot in de maag. Ook mijn ... is langs binnen ruw, ik denk Mijnheer ik een weinig kon fluimen, ik wat zoude verlossen. Appetijt heb ik nog niet, ook heb ik sedert maandag niet naar het gemak geweest. Ziedaar Mijnheer hoe ik mij gevoel en U voorop bedankende ...Mijne beste groeten Bernard Pesant. N.B. Mijne maag kan hoegenaam niet opwerpen; en alles blijft kroppen.

Page 165 footnote 2:
Mijnheer. Ik heb bij vergissing in eens een geheele poeder ingenomen ik doe anders niets dan braken en beven help mij als u belieft. Met achting Bernard Pesant Boek 17 n 63.

Page 189 footnote 77:
[...] dikwijls smekken gelijk of zij zoude dorst hebben.

Chapter 7

Page 211 footnote 39:
Door vroegtijdige uitspattingen in de liefde en buiten het huwelijk verkort men het leven, de mannelijke kracht gaat verloren! Men wordt ziek, zwak, ellendig, oud voor den tijd, men stelt zich bloot aan venerische besmetting, het vreeselijke vergif dat steeds meer en meer verspreid wordt en in het verborgen de menschen wegneemt.

Page 227 footnote 110:
[...] hun gestel te schaden, hun gezondheid te vernietigen en hun bestaan te verkorten.
## Appendix 3:

Known Licensed Practitioners Mentioned by the Patients, 1869-1902¹

(Chapter 3)

<table>
<thead>
<tr>
<th>Name of practitioner, as noted in the casebook</th>
<th>Actual name of the physician (or other health professional)</th>
<th>Type of practitioner</th>
<th>Further information</th>
<th>Place of practice</th>
<th>Number of times mentioned</th>
<th>Year(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Rayé</td>
<td>Ch. Rayé (1811-1882)</td>
<td>Homoeopathic physician</td>
<td>He was working also as a homoeopath in foreign countries.</td>
<td>Vilvoorde</td>
<td>44</td>
<td>1869 (3), 1870 (5), 1871 (3), 1872, 1875 (10), 1876 (6), 1877 (8), 1878 (3), 1879 (4), 1880</td>
</tr>
<tr>
<td>Dr. Libbrecht</td>
<td>Auguste Libbrecht (1833-1894)</td>
<td>Oculist (allopathy)</td>
<td>Founded the <em>Institut Ophtalmique</em> in 1867. Libbrecht himself financed completely this ophthalmic clinic was. In 1893 he retired.</td>
<td>Ghent</td>
<td>12</td>
<td>1869 (2), 1870, 1871 (3), 1872, 1879 (2), 1885, 1891, 1900 (1)</td>
</tr>
<tr>
<td>Dr. Moureman</td>
<td>Joseph Moureman (1803-1874)</td>
<td>Homoeopathic physician</td>
<td>Moureman founded dispensaries all around the country; the most significant one was the Hahnemann dispensary in Brussels. In the years 1870 he was hardly active anymore, because of health complaints.</td>
<td>Brussels</td>
<td>1</td>
<td>1869</td>
</tr>
</tbody>
</table>

¹ Based on information shared by patients in the Ghent practice (both living in Ghent and elsewhere).
<table>
<thead>
<tr>
<th>Name</th>
<th>Date of Birth/Death</th>
<th>Profession</th>
<th>Details</th>
<th>Location</th>
<th>Year(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. DeNeffe</td>
<td>1835-1908</td>
<td>'Allopathic' physician</td>
<td>In 1873 he became professor specialising in diseases of the eye. Moreover, he was elected to the city council twenty-four times where he fought for the building of hygienic and aesthetic houses.</td>
<td>Ghent</td>
<td>1869, 1870, 1871, 1872, 1873</td>
</tr>
<tr>
<td>Jorrez</td>
<td>1826-1894</td>
<td>Homoeopathic physician</td>
<td>He studied in Brussels. From 1874 probably he was hardly practising homoeopathy or had even retired.</td>
<td>Limbourg</td>
<td>1870, 1872, 1873</td>
</tr>
<tr>
<td>Dr. Thibaut</td>
<td>Joseph Thibaut (1848-1912)</td>
<td>'Allopathic' physician</td>
<td>Doctor in medicine, surgery and obstetrics practised in Ghent until at least 1890.</td>
<td>Ghent</td>
<td>1870</td>
</tr>
<tr>
<td>Dr. DeCooman</td>
<td>Germain De Cooman (b. 1879, d. 1889)</td>
<td>Homoeopathic physician</td>
<td>Besides medicine, De Cooman wanted a political career and became mayor of Oosterzele.</td>
<td>Oosterzele</td>
<td>1870, 1883, 1889</td>
</tr>
<tr>
<td>Dr. Gailliard</td>
<td>Delphin L.E. Gailliard (1838-1898)</td>
<td>Homoeopathic physician</td>
<td>Doctor at the Hahnemann dispensary in Brussels, ardent defender of homoeopathic principles and zealous writer for l'Homoeopathie Militante.</td>
<td>Brussels</td>
<td>1871</td>
</tr>
<tr>
<td>Dr. Amand</td>
<td>Ad. Amand (1874-1892)</td>
<td>Homoeopathic physician</td>
<td>Between 1874 and 1892 he practised homoeopathy in Gavere, around twenty kilometres southwest of Ghent.</td>
<td>Gavere</td>
<td>1871</td>
</tr>
<tr>
<td>Mr. Blitz</td>
<td>Isaac Jules Samuel Blitz (1859-1881)</td>
<td>Dentist</td>
<td>From 1859 Blitz practised dentistry in Ghent. He would continue until, at least, 1881. In 1869 his wife consulted Van den Berghe about pregnancy related complaints (Casebook 2, p. 544). Remarkably, Van den Berghe consulted Blitz with regard to a patient with dental complaints (Casebook 4, p. 713).</td>
<td>Ghent</td>
<td>1872</td>
</tr>
<tr>
<td>Dr. Scheepens</td>
<td>Prosper Schepens (1836-1908)</td>
<td>Homoeopathic physician</td>
<td>In 1875 he arrived in Ghent and started practising homoeopathy privately. His interest in Hahnemann’s medical therapy dates from the early 1870s.</td>
<td>Nazareth, Ghent</td>
<td>1872, 1877</td>
</tr>
</tbody>
</table>
### Appendices

<table>
<thead>
<tr>
<th>Name</th>
<th>Information</th>
<th>Location</th>
<th>Year(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Jahr</td>
<td>Georg H.G. Jahr (1800-1875) Homoeopathic physician (1872)</td>
<td>Brussels</td>
<td>1872</td>
</tr>
<tr>
<td></td>
<td>when he followed (Dr. Jahr's) lessons in Brussels together with Van den Bergh. He had studied homoeopathy with Hahnemann. In the 1830s he stayed in Liège, but in 1870 he settled down permanently in Belgium. He was head of the Brussels Hahnemann dispensary until his death.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Jacobs</td>
<td>David Jacobs [1883-1914] ‘Allopathic’ physician (St. Jean Hospital)</td>
<td>Ghent</td>
<td>1872</td>
</tr>
<tr>
<td></td>
<td>St. Jan de Deo, the hospital where he was appointed, cared for old and mentally defective patients. Between 1883 and 1914 he practised in Ghent. From 1876 until, at least, 1914 he held practice in Ghent.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Dumont</td>
<td>Henri Dumont [1876-1914] ‘Allopathic’ physician (Ghent)</td>
<td>Ghent</td>
<td>1872 (2), 1883</td>
</tr>
<tr>
<td></td>
<td>He studied homoeopathy in Brussels, after Van den Neucker had introduced him to homoeopathy, around 1870. He was mayor of Ledeberg, member of the provincial government and member of several medical associations. Dumoulin was, besides a medical practitioner, a professor, member of the Provincial Medical Committee from 1870 and he had been a member of the city council.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Van Oosteghem</td>
<td>Adolphe Van Oosteghem (1835-1908) Homoeopathic physician (Ledeberg)</td>
<td>Ledeberg</td>
<td>1873</td>
</tr>
<tr>
<td></td>
<td>He studied homoeopathy in Brussels, after Van den Neucker had introduced him to homoeopathy, around 1870. He was mayor of Ledeberg, member of the provincial government and member of several medical associations. Dumoulin was, besides a medical practitioner, a professor, member of the Provincial Medical Committee from 1870 and he had been a member of the city council.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prof Dumoulin</td>
<td>Nicolas Chrétien Hubert Dumoulin (1827-1890) ‘Allopathic’ physician (Ghent)</td>
<td>Ghent</td>
<td>1873, 1879, 1881, 1884</td>
</tr>
<tr>
<td></td>
<td>He studied homoeopathy in Brussels, after Van den Neucker had introduced him to homoeopathy, around 1870. He was mayor of Ledeberg, member of the provincial government and member of several medical associations. Dumoulin was, besides a medical practitioner, a professor, member of the Provincial Medical Committee from 1870 and he had been a member of the city council.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Van Peene</td>
<td>Etienne Van Peene [1874-1890] Homoeopathic physician (Ghent)</td>
<td>Ghent</td>
<td>1874</td>
</tr>
<tr>
<td></td>
<td>Between 1874 and 1884 he practised homoeopathy in Ghent. Then he returned to orthodox medicine again, which he practised until 1890.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr. Delstanché Crock</td>
<td>‘Allopathic’ physician (Brussels, Tournai)</td>
<td>Brussels</td>
<td>1874, 1899</td>
</tr>
<tr>
<td></td>
<td>In 1889 he arrived in Ghent, where he continued to practice homoeopathic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr. Van den Neucker</td>
<td>Pierre Van den Neucker (1826-1909) Homoeopathic physician (Ghent)</td>
<td>Ghent</td>
<td>1879</td>
</tr>
<tr>
<td></td>
<td>In 1889 he arrived in Ghent, where he continued to practice homoeopathic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Harelbeke, Ghent</td>
<td></td>
<td>1876, 1886, 1900</td>
</tr>
</tbody>
</table>

271
In Search of a Cure

| Dr. DeMoor       | Eugène De Keghel [1874-1914] | 'Allopathy' Homoeopathic physician | medicine (he had done the same in his previous place of residence). | ? | 1 | 1882
| Dr. De Keghel    | Julius L.J.M. Denobele (1865-1946) | 'Allopathic' physician | He studied homoeopathy at the Hahnemann dispensary in Brussels and began his own practice in Ghent in 1874. | Ghent | 2 | 1882, 1900
| Dr. Denobele     | Jules Gaudy (1835-1899) or Léon Gaudy (1834-1888) | Homoeopathic physician | He graduated from medical school in 1891, after which he started his own practice. | Ghent | 2 | 1882, 1899
| Dr. Hijman       | Jan Frans Heijmans (1859-1932) | 'Allopathic' physician | Jules had been active temporarily in the army and he worked in the Hahnemann dispensary in Brussels. He was practical, i.e. more interested in results than in doctrine. His brother Léon studied homoeopathy with Mouremans and is said to have founded several dispensaries. | Gooik, Ghent | 1 | 1883
| Dr. Decocq       | Adolphe J.M. De Cock (b. 1848, d. ?) | 'Allopathic' physician | From 1891 he practised in Ghent as a doctor in medicine, specialising in pharmacology. He had a medicine repository also. He held several offices, such as dean and secretary of the medical faculty, and vice-president of the Association against Tuberculosis. In 1874 he graduated in Ghent. Two years later he became head of the obstetric clinic. In 1884 he was appointed extraordinary professor, two years later he became ordinary professor. | Ghent | 2 | 1886, 1891
| Dr. Verriest     | Alberic Rogman (b. ?, d. 1905) | 'Allopathic' physician Oculist ('allopathy') | Arrived in Ghent in 1888, where he became the director of the institute for | Kortrijk, Ghent | 1 | 1887
<p>| Dr. Roggeman     |                           | | | 1891, 1893, 1898 |</p>
<table>
<thead>
<tr>
<th>Name</th>
<th>Birth-Death</th>
<th>Position</th>
<th>Additional Information</th>
<th>Location</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Van Duijze</td>
<td>1852-1924</td>
<td>Oculist ('allopathy')</td>
<td>He was co-founder of the Société Belge d'Ophthalmologie (1896) and remained secretary-general until his death. From 1896 he was professor. In 1905 he died in Cologne during surgery.</td>
<td>Ghent</td>
<td>1891, 1901</td>
</tr>
<tr>
<td>Dr. Blarieau</td>
<td>b. 1826, d. ?</td>
<td>'Allopathic' physician</td>
<td>He graduated from the university of Louvain as a doctor in medicine and obstetrics in 1854. Held practice in Ghent until, at least, 1890.</td>
<td>Ghent</td>
<td>1891</td>
</tr>
<tr>
<td>Van Cauwenberg</td>
<td>1841-1911</td>
<td>'Allopathic' physician</td>
<td>Received his medical degree with the greatest distinction in 1867. He held several offices, e.g. professor, director of the clinic for obstetrics, member of the provincial medical committee etc.</td>
<td>Ghent</td>
<td>1891</td>
</tr>
<tr>
<td>Dr. Eeman</td>
<td>1856-1933</td>
<td>Ear, nose and throat specialist ('allopathy')</td>
<td>In 1892 he opened an out-patient clinic in his own house. In that year he became also chief of staff of the newly opened university clinic for ENT-diseases. Moreover, he fought for the improvement of medical education and he was a member of a Council with that objective.</td>
<td>Ghent</td>
<td>1893</td>
</tr>
<tr>
<td>Dr. Viaene</td>
<td>1868-1903</td>
<td>'Allopathic' physician</td>
<td>He was registered as a doctor in Ghent between 1868 and 1914, but he retired in 1903.</td>
<td>Ghent</td>
<td>1897</td>
</tr>
<tr>
<td>Dr. Bodourt</td>
<td>1834-1909</td>
<td>'Allopathic' physician</td>
<td>In 1855 he had obtained a degree in natural sciences; in 1858 he graduated from medical school. He was chief of staff of the Byloke Hospital and member of the administrative committee of the Public Hospices.</td>
<td>Ghent</td>
<td>1897</td>
</tr>
</tbody>
</table>
**In Search of a Cure**

| Dr. Scheurman | Léon Seutin [1875-1914] | Homoeopathic physician | Between 1875 and 1914 he certainly was a supporter of homoeopathy. He showed this by working in dispensaries in Brussels. | Brussels | 1 | 1897 |
| Dr. Martiny | Henri-Louis Martiny (1839-1902) | Homoeopathic physician | He came into contact with homoeopathy during his years as an army doctor. In 1879 he resigned to concentrate on the spread of homoeopathy. | Brussels | 1 | 1900 |
| Dr. Verstraete | Camille Verstraeten (b. 1846, d. ?) | 'Allopathic' physician | From 1874 until, at least, 1890 he practised medicine in Ghent. In 1914 the *Wegwijzer der Stad Gent* mentioned Verstraeten's presence in town for the last time. | Ghent | 1 | 1902 |

Source: Vervaeke, De sociale studie van een beroepsgroep; Nys, Geschiedenis van de pioniersfase van de homeopatische beweging in België; Van Praet, De receptie van de homeopathie in België 1874-1914; Bruggeman, Sociale studie van een beroepsgroep; SAG, *Wegwijzer der Stad Gent voor het jaar 1914*. 
Appendix 4: Complaints and Ailments of Van den Berghe’s Child Patients, 1865-1902
(Chapter 5)

<table>
<thead>
<tr>
<th>Diagnosis/complaints</th>
<th>Boys</th>
<th>Girls</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal complaints</td>
<td>3</td>
<td>8</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Abrasion</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Abscesses, ulcers, pastules, tumours and furuncles</td>
<td>4</td>
<td>1</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Angina</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Asthma</td>
<td>3</td>
<td>2</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Back troubles and joint complaints</td>
<td>7</td>
<td>18</td>
<td>1</td>
<td>26</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>1</td>
<td>3</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Colic</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Convulsions (spasms)</td>
<td>19</td>
<td>26</td>
<td>1</td>
<td>46</td>
</tr>
<tr>
<td>Cough</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Croup</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>22</td>
<td>17</td>
<td>3</td>
<td>42</td>
</tr>
<tr>
<td>Difficult digestion</td>
<td>2</td>
<td>4</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Ear, nose and throat complaints</td>
<td>7</td>
<td>4</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Easily fetches a cold</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td>6</td>
<td>4</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Emaciation</td>
<td>3</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>8</td>
<td>2</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Eye disorder</td>
<td>12</td>
<td>16</td>
<td></td>
<td>28</td>
</tr>
<tr>
<td>Female disorder</td>
<td>5</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Fever</td>
<td>7</td>
<td>3</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>General ailment, languishing, sickly glance, pale</td>
<td>1</td>
<td>3</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Gibbosity</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Gland complaints</td>
<td>3</td>
<td>2</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Goitre</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Headache, migraine, dizziness</td>
<td>2</td>
<td>4</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>Heart disorder</td>
<td>3</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Incontinency, pain during urinating</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Influenza</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Measles</td>
<td>2</td>
<td>6</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Meningitis</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Mental complaints (melancholy)</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Mouth and lip complaints</td>
<td>5</td>
<td>3</td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Nervous attacks and fits</td>
<td>5</td>
<td>1</td>
<td></td>
<td>6</td>
</tr>
</tbody>
</table>

*2 Based on all children registered in casebook 1, 8 and 17, including the Zwevegem practice (1865-1869).*
In Search of a Cure

<table>
<thead>
<tr>
<th>Diagnosis/complaints</th>
<th>Boys</th>
<th>Girls</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No appetite</td>
<td>6</td>
<td>5</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Paralysed</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Paralysed left cheek</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pharyngitis</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>2</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Prurigo</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Respiratory complaints</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Retarded, not developing</td>
<td>2</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Ringworm</td>
<td>8</td>
<td>9</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Scabies</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Scarlet fever</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Scrofula</td>
<td>3</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Skin ailments</td>
<td>6</td>
<td>4</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Spinal disorder, poor stature</td>
<td>1</td>
<td>4</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Tuberculosis, phthisis</td>
<td>2</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Vaginal abscess</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Voice extinction</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Vomiting</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Weakness, vague pain complaints, without courage</td>
<td>4</td>
<td>1</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Whooping cough</td>
<td>10</td>
<td></td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Worms</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Unknown (indistinct)</td>
<td>27</td>
<td>36</td>
<td>6</td>
<td>63</td>
</tr>
</tbody>
</table>

Total | 196 | 228 | 21 | 444 |
Appendix 5:  
Genealogical Table  
(Chapter 5)

The following data are derived from the birth, marriage and death certificates and the straatnamenregister (street name register) of the municipal archives of the city of Ghent. These records are confusing, at times, because names were written in French and Dutch. In this study the Dutch variant of names have principally been used, particularly because Ghent was a truly Flemish city, in which the issue of language and thus descent was often verbally battled. Van den Berghe registered usually the French form of a name in his medical notes, even if the patient was clearly Flemish. In the footnotes in the chapter the differences, between the names Van den Berghe noted and the correct name of the patient, have been made clear.

Explanation of signs:

X [date] Married to
?
Ununknown date and/or year of death
b. Year and/or date of birth
d. Year and/or date of death

Patient: Van den Berghe's patient from ... to ...
#
Year that the patient left Ghent
➤ Died after [year]
The Baetslé Family (1869-1902), Paying Patients, Pages: 151-153

Parents:

Franciscus Josephus Baetslé (1826-1909)
Typographer
Patient: 1869-1902; 449 consultations.
X on 04-05-1854

Nathalia Nabijd (1829-1895)
Housekeeper
Patient: 1885-1893; 16 consultations.

Children:

Emilia Josephina (1853-1933)
Not a patient. From 1873 she is registered as a seamstress. In 1876 she married Simon Braeckman (1852-1937). Emilia never was a patient with Van den Berghe, but several of her children would be:
Carolina Braeckman (b. 1877) Patient: 1880-1892; 10 consultations.
Eugenie (b. 1879), not a patient.
Maurice (b. 1881), not a patient.
Oscar Braeckman (b. 1885) Patient: 1889; 2 consultations.
Diomède Braeckman (b. 1891), Patient: 1900; 13 consultations.

Josephina (1854-?)
Not a patient. She probably died outside of Ghent as no death certificate was found in the municipal archives.

Justina (1857-1858)
Not a patient.

Victorina Clementina (1858-1862)
Not a patient.

Eugenia (1860-1883)
Patient: 1881-1882; 2 consultations.

Desiderius (1868-?)
Patient: 1871-1890; 64 consultations. Desiderius started work at age thirteen. He was registered as a farrier; but was probably merely an apprentice then. He will have been a source of sorrow to his parents. He not only displayed a gambling habit, for which he was convicted in 1886, he later on struggled also with marital problems. On 7
February 1891 he married Josephine Rhottier (b. 1871), a flax worker and he moved in with her parents on Priesterstraat (Priest Street). Their first child, Achilles, was born the next month. Five more followed, but not without difficulty. In 1893 they had a daughter, just as the year after. However, this third child died three days after her first birthday in 1895. In early 1895 Desiderius moved away from the house of his parents-in-law together with his family. They stayed in the same street, but now had their own dwellings. Shortly after baby Eugenie died, Josephine moved in with her parents again and the couple lived separately for some time. The separation ended with the birth of another child in September 1896.

Mathilda (1870-# 1896) Patient: 1872-1882; 3 consultations. Mathilda married in 1893, yet not for long. She and her husband, Polydoor Verdure, lived in with her family, but he died six months after their wedding. Mathilda remarried in September 1895 with Jean Baptiste Terbée (b. 18-06-1869), a typographer. She was pregnant at her wedding. A year later the family left Ghent and settled down in St. Jan Molenbeek. Apparently they did not live there for long, but moved to Brussels again. Mathilda had at least one child: Josephina Francisca Juliana Terbée (b. 1895) Patient: 1897-1899; 10 consultations.

THE COENE FAMILY (1876-1898), PAYING PATIENTS, PAGES: 153-155

PARENTS:

Housekeeper

X on 20 May 1868

Both Veronica and her future husband worked as servants, but she stopped working outdoors as soon as she was a married woman. In the 1880s breadwinner Joseph changed profession and applied himself to gardening and cultivation. His gardening skills were admirable; in 1902 he received a special agricultural decoration second class.

279
Josephus Coene
(Zwijnaarde, 1840-Ghent, 1927)
Gardener

CHILDREN:

Maria (1870-1951)
Patient: 1877-1895; 44 consultations. From 1891 Maria was registered as a seamstress.

Julianus (1872-1963)
Patient: 1878; 2 consultations. Julianus followed in his fathers' footsteps and from the early years 1890 he worked as a gardener.

Gustavus (1876-1876)
Not a patient.

Leonia (1878-1880)
Patient: 1878-1880; 2 consultations.

THE DE KEIJZER FAMILY (1882-1898), NON-PAYING PATIENTS, PAGES: 155-156

PARENTS:

Maria Joanna Botman
(1837-1909)
Housekeeper

Patient: 1887; 2 consultations.
Maria worked at the factory at the time of her marriage. She stopped working outdoors when he became Franciscus De Keijzer's wife.

X on 24 April 1860

Franciscus De Keijzer
(1834-1897)
Shoemaker

Not a patient.
Franciscus earned a living as a weaver when he got married.

CHILDREN:

Josephina (13.02.1861-14.10-1861)
Not a patient.

Alphonsus (b. 1862)
Not a patient. He left his parental house in 1884.

Henricus (03.03.1865-06.11.1865)
Not a patient.

Maria Josephina (1867-#1889)
Patient: 1883; 2 consultations. Maria must have been a worrisome member of the family. She left her parental house and moved in with another family at the Voetweg, only sixteen years old, in
April 1883. Maria worked at a factory and a daughter of the new household also was registered as factory worker and might have been a friend of hers. She stayed with them for little over a year and than she moved around frequently. Maria engaged apparently in love adventures, in December 1885 she gave birth to a son. The child was not strong enough and died three months later. From 1886 she worked as a servant and her sexual relations continued, resulting in the birth of two more boys. Both children died. In July 1889, four days after the loss of her last son, she married Charles Bruneau with whom she moved to Brussels. As she once took a child to Van den Berghe (in 1898), she will have had other children, or at least one, with her husband. Baby (4 months) Patient: 1898; 1 consultation.

Catherine (b. 1870) Not a patient.


Josephus (b. 1874) Not a patient. Married in the 1890s.

Petrus (b. 1876) Not a patient. Married in the 1890s.

Julia (1879-#1901, St. Gilles) Patient: 1882; 5 consultations. Julia was the only child still living in her parental house in 1897. Her father died and her brothers Josephus and Petrus moved out. She contributed to the household as a flax worker. In April 1900 she gave birth to an illegitimate son, Georges Gustave, who died in December.

---

THE DE KEUKELAIRE FAMILY (1887-1897), NON-PAYING PATIENTS, PAGES: 156-158

PARENTS:

Theodorus Marinus De Keukelaire Patient: 1887-1896; 42 consultations.
(1858-1923)
Factory worker (packer)

X on 21 May 1879

---

3 Maria moved with her parents' consent. DSG, Straatnamenregister 1881-1890: district 5: 19/4500.
In Search of a Cure

Maria Petronilla Verbeke  
(1853-1944)  
Cotton spinster  
Not a patient.

CHILDREN:

Josephus Carolus (04.03.1880-11.07.1880)  
Not a patient.

Maria Stephanía (1881-1956)  
Patient: 1889-1895; 14 consultations. At age fourteen Maria was sent out to work; from 1895 she was registered as a flax worker.

Nathalia Joanna Adolphina (1882-1969)  
Patient: 1892-1896; 10 consultations.

Sophia Charlotta (1883-1942)  
Not a patient.

Amelia Maria Josephina  
(1884-1958)  
Not a patient.

Adolphus Theodorus Marinus (1888-1940)  
Patient: 1892-1896; 6 consultations.

Baby Louisa  
Patient: 1896; 1 consultation.  
From April 1889 Francisca Verbecke (b. 1865), sister of Maria Petronilla moved in with the De Keukelaire's. She contributed to the household by earning a living as seamstress.

THE WILMOT I FAMILY, 1881-1882, NON-PAYING PATIENTS, PAGES: 159-160

PARENTS:

Peter Wilmot  
(1829-1908)  
Calico printer  
Patient: 1882; 2 consultations.

X  
on 18 November 1857

Maria Theresia Verhulst  
(Heusden, 1832- Ghent, 1908)  
Housekeeper  
Patient: 1882; 1 consultation.

CHILDREN:

Hortensia (b. 1855)  
Not a patient. Hortensia was registered as a factory worker. In 1882 she left her parental house to marry Felix De Vuijst. Her marriage was not happy. In 1889 she was convicted of
public drunkenness. That same year she left her husband to live with her parents again.

Joanna (1858-1859)  
Not a patient.

Carolus (b. 1860)  
Not a patient. In 1885 Carolus married: Maria De Raedt (1861-1941), Patient: 1882; 1 consultation. She and her husband behaved rather 'out of control' and were convicted multiple times for sound nuisance at night and slapping. Carolus went particularly too far by hitting a police officer for which he was sentenced to pay a fine of forty francs or twelve days imprisonment.

Joanna (1862-1885)  
Not a patient. She died in childbirth in 1885, less than a month after giving birth to an illegitimate son: Franciscus

Josephus (b. 1864)  
Not a patient.

Paulina (b. 1867)  
Not a patient. In 1889 Paulina gave birth to an illegitimate son, Josephus. Three years later, in 1892, she married Louis Crêhel, whom she divorced officially in 1898. Her second marriage, which began in 1902, was much happier. She and her husband, Livinus Timmerman, were still together when they moved to Antwerp in 1919.

Eugenia (1869-1941)  
Patient: 1881-1882; 9 consultations.

Elvira (b. 1872)  
Not a patient.

Virginia (1877-1946)  
Patient: 1882; 2 consultations.

The Wilmot II Family, 1888-1900, Non-Paying Patients, Pages: 160-161

Parents:

Joannus Franciscus Wilmot (1845-?)  
Flax worker  
Patient: 1889-1899; 36 consultations.

X on 11 February 1874  

Virginia Eduarda Diegenant (1849-?)  
Flax worker  
Patient: 1888-1897; 9 consultations.
CHILDREN:

Mathilda Carolina (07.09.1879-13.06.1880) Not a patient.

Maria Francisca (01.05.1881-18.08.1881) Not a patient.


Leon Franciscus (1883-1959) Patient: 1888; 12 consultations. Leon started working around age seventeen as a cement worker, but in 1903 he was registered as being needy. In 1906 he married and left his parental house.


THE VAN DRIESSCHE FAMILY 1901-1902, PAYING PATIENTS, PAGES: 161-162

PARENTS:

Alphonsus Philipus Van Driessche (1853-1919) Not a patient. Painter and shopkeeper in paint supplies

X on 28 October 1876

Joanna Christina Tency (1859-1933) Patient: 1901-1902; 3 consultations. Housekeeper

CHILDREN:

Hortensia Josephina (1877-1926) Not a patient. She left her parental house in 1898 and moved to Schaarbeek, where she married.

Joannes Augustus (1880-St. Amands 1920) Patient: 1902; 6 consultations. He earned a living as a painters' apprentice.

Maria Francisca (1882-?) Patient: 1901; 2 consultations.


Margaretha Juliana (1887= Merksem) Patient: 1902; 1 consultation.
Appendices

Eduardus Polydorus (1888-1889)  Not a patient.

Andreus Jacobus (1890-?)  Not a patient. No death certificate found.

Alphonsus (1893-?)  Not a patient. No death certificate found, but he died before 1900.

Irena Adolphina (1895-# Strasbourg)  Patient: 1901; 2 consultations.
### Appendix 6:
Complaints and Ailments of Van den Berghe's Patients, Classified by Gender 1869-1902

(Chapter 6)

<table>
<thead>
<tr>
<th>Diagnosis/complaints</th>
<th>Male</th>
<th>Female</th>
<th>Unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal and intestinal complaints</td>
<td>67</td>
<td>154</td>
<td></td>
<td>221</td>
</tr>
<tr>
<td>Abscesses, ulcers, pustules and furuncles</td>
<td>10</td>
<td>6</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Acid belches</td>
<td>2</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Albuminuria</td>
<td>2</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Anal disorder</td>
<td>3</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Anaemia</td>
<td>1</td>
<td>3</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Angina</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Arm and leg condition</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Arm condition</td>
<td>1</td>
<td>6</td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Armpit complaint</td>
<td>1</td>
<td>3</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Asthma</td>
<td>14</td>
<td>7</td>
<td></td>
<td>21</td>
</tr>
<tr>
<td>Atrophy (of muscles)</td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Back troubles and joint complaints</td>
<td>26</td>
<td>32</td>
<td></td>
<td>58</td>
</tr>
<tr>
<td>Blepharitis</td>
<td></td>
<td>3</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Blood loss</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Bulimia</td>
<td></td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>3</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
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* Based on the sample of 1,826 Ghent patients (adults and children).
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Appendix 7: Complaints of Van den Berghe’s Patients Related to their Social Class, 1869-1902

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Based on the sample of 1,826 Ghent patients (adults and children).
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## In Search of a Cure

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292
### Appendix 8:
Complaints of Van den Berghe’s Patients per Age Category, 1869-1902* (Chapter 6)

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<td>Worms</td>
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<td>192</td>
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Appendix 9:
Explanations for Illness Given by Van den Berghe’s Patients
Related to their Complaints, 1869-1902\(^7\)

(Chapter 7)

<table>
<thead>
<tr>
<th>Diagnosis/complaints</th>
<th>Behavioural explanation</th>
<th>Emotional explanation</th>
<th>Natural or medical explanation</th>
<th>Combination of explanations</th>
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<tbody>
<tr>
<td>Abdominal and intestinal complaints</td>
<td>2</td>
<td>17</td>
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</tr>
<tr>
<td>Abscesses, ulcers, pustules and furuncles</td>
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<tr>
<td>Acid belches</td>
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<tr>
<td>Anaemia</td>
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<tr>
<td>Arm and leg condition</td>
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<tr>
<td>Arm condition</td>
<td>2</td>
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<tr>
<td>Asthma</td>
<td>1</td>
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</tr>
<tr>
<td>Back troubles and joint complaints</td>
<td>2</td>
<td>7</td>
<td></td>
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<tr>
<td>Cardiac complaints</td>
<td>3</td>
<td></td>
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<tr>
<td>Chest ailment</td>
<td>2</td>
<td>5</td>
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<tr>
<td>Contusion</td>
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<tr>
<td>Convulsions</td>
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<td>Cough and/or expectoration</td>
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<td>Cyanosis</td>
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<td>Dental ailment</td>
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<td>Diarrhoea</td>
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<td>Dizzy spells</td>
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<tr>
<td>Ear, nose and throat ailments</td>
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<tr>
<td>Emaciation</td>
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<tr>
<td>Epilepsy</td>
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<tr>
<td>Eye disorder</td>
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<td>3</td>
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<tr>
<td>Fainting fits</td>
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<td>Fever</td>
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<tr>
<td>General malaise</td>
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<td>Hand condition</td>
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<tr>
<td>Headache</td>
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<tr>
<td>Hearing disability</td>
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</tbody>
</table>

\(^7\) Based on the sample of 1,826 Ghent patients.

297
### In Search of a Cure

<table>
<thead>
<tr>
<th>Diagnosis/complaints</th>
<th>Behavioural explanation</th>
<th>Emotional explanation</th>
<th>Natural or medical explanation</th>
<th>Combination of explanations</th>
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<td>Impotent</td>
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<tr>
<td>Insomnia</td>
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<tr>
<td>Leg problem</td>
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<tr>
<td>Liver condition</td>
<td>1</td>
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<tr>
<td>Lumbar pain</td>
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<td>2</td>
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<tr>
<td>Melancholy</td>
<td>1</td>
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<tr>
<td>Menstrual disorder</td>
<td>4</td>
<td>2</td>
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<td>Mental complaints</td>
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<td>Micturition problems</td>
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<tr>
<td>Migraine</td>
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<tr>
<td>Nervous disorder (crisis, fits, tics)</td>
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<tr>
<td>Nervousness</td>
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<tr>
<td>No/poor appetite</td>
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<tr>
<td>Pain complaints</td>
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<tr>
<td>Paralysis</td>
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<tr>
<td>Post-birth complaints</td>
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<td>Pregnant</td>
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<td>Respiratory complaints</td>
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<td>Sensory failure</td>
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<td>Sexual ailment</td>
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<td>Skin ailments</td>
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<td>Spermatorrhoea</td>
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<td>Tuberculosis, pulmonary consumption, phthisis</td>
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<td>Ureter disorder</td>
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<td>Urethritis</td>
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<td>Venereal ailment (gonorrhoea, syphilis, chancres, herpes)</td>
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<td>Vomiting</td>
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<td><strong>Total</strong></td>
<td><strong>34</strong></td>
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<td><strong>74</strong></td>
<td><strong>4</strong></td>
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</tbody>
</table>

(=19%) (=38%) (=43%)
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317


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322
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323
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Samenvatting


In deze studie draait het nadrukkelijk om het perspectief van de patiënt zelf en dit type onderzoek wordt dan ook wel gevat onder de noemer patiëntengeschiedenis. Naast de ontwikkeling van Van den Berghe’s clientèle als geheel in de loop der tijd (patiënt-gerelateerd onderzoek, patient-related), is er ook aandacht besteed aan de persoonlijke ziekte-ervaring van de patiënten (patiënt-specifiek onderzoek, patient-specific). Met name door deze gecombineerde benadering onderscheidt dit proefschrift zich van eerder onderzoek op het terrein van de patiëntengeschiedenis.

Het patiënt-gerelateerde onderzoek - een studie van de patiënten als groep - laat zien dat de samenstelling van Van den Berghe’s clientèle geleidelijk veranderde. Veranderingen die bevestigen dat de keuze om gebruik te maken van Van den Berghe en/of homeopathie deels voortkwam uit sociaal-economische en culturele overwegingen. Vanaf de start van de praktijk waren vrouwen in de meerderheid. Dit is niet zo verwonderlijk gezien de samenstelling van de Gentse bevolking: de textielindustrie had van oudsher een grote aantrekkingskracht op vrouwen die op zoek waren naar werk. Echter, het aandeel van vrouwen onder Van den Berghe’s patiënten nam verder toe. In 1869 was de sekseverhouding (het aantal mannen per honderd vrouwen) 80; rond de eeuwwisseling was deze verhouding 58. Vrouwelijke oververtegenwoordiging is gebruikelijk in twintigste-eeuwse homeopathische praktijken, maar was dat, voor zover bekend, niet onder negentiende-eeuwse clientèles van homeopathische artsen. Van den Berghe’s praktijk representeerde dus een overgangsperiode tussen de oudere meer door mannen bezochte en de nieuwere meer door vrouwen benutte homeopathische praktijk.

Het blijft echter moeilijk te verklaren waarom de belangstelling van vrouwen voor Van den Berghe en/of zijn therapie groeide. Vrouwen leken, meer dan mannen, geneigd de hulp in te roepen van een homeopathische geneesheer. Dit blijkt onder meer uit het soort klachten waarmee vrouwen bij Van den Berghe kwamen en de verhalen die zij vertelden over persoonlijk
lijden in het verleden. Hoewel vrouwen hem vaak consulteerden met andere klachten dan die specifiek gebonden waren aan hun sekse, verklaarden velen dat hun algehele gezondheid en welzijn aanzienlijk te lijden hadden gehad onder zwangerschap, miskramen, moeilijke bevallingen of menstruatieproblemen. Vrouwenlijke patiënten spraken over hun specifieke gestel (het biologische gegeven dat zij vrouw waren) in relatie tot hun slechte gezondheid. Zij accepteerden en gebruikten gangbare culturele opvattingen over de kwetsbaarheid van het vrouwelijk geslacht. Het werd min of meer van hen verwacht vaker ziek te zijn dan mannen. Helaas is er niets bekend over de seksesamenstelling van de clientèle van Van den Berghe’s orthodoxe, niet-homeopatische collega’s, noch over de clientèle van diens homeopatische collega’s. Gesteld dat zij meer mannen in hun praktijk ontvingen, dan zou er wellicht van een seksekloof kunnen worden gesproken bij de keuze voor een orthodoxe en een homeopatische arts, zeker tegen het eind van de negentiende eeuw. De mannen en vrouwen in Van den Berghe’s praktijk gaven evenwel in gelijke mate uiting aan hun teleurstellende ervaringen met niet-homeopatische artsen.

Ook de sociale achtergrond van nieuwe patiënten laat een grote verandering zien. Aanvankelijk behandelde Van den Berghe regelmatig aristocratische patiënten en grote industriëlen. In de loop der jaren verdwenen deze hogere klassen grotendeels uit Van den Berghe’s clientèle. Tegelijkertijd nam het aandeel van zieke arbeiders en mensen uit de lagere middenklasse aanzienlijk toe. Deze ‘popularisering’ zal ten dele het gevolg zijn geweest van Van den Berghe’s beleid om zeer arme patiënten gratis te behandelen. De adellijke patiënten verdwenen naarmate het aantal patiënten uit de midden- en lagere klassen toenam. De homeopatische praktijk werd toegankelijk voor iedereen; de hogere klassen konden zich niet langer onderscheiden door de ‘exclusiviteit’ van Hahnemann’s (de grondlegger van de homeopathie) therapie. De homeopathie zou voor hen kunnen hebben afgedaan als statussymbol. Een andere mogelijkheid is, dat met de vooruitgang van de universitaire medische wetenschap aan het eind van de negentiende eeuw, een adellijke patiënt zich uiteindelijk eerder liet behandelen door een reguliere dan een homeopatische arts.

Dat arme patiënten uitsluitend uit economische overwegingen kozén voor Van den Berghe en/of homeopathie is hiermee echter geenszins gezegd. Zij hadden allerlei andere mogelijkheden voor gratis, zij het niet-homeopatische geneeskundige hulp. Voor sommigen zal het consulteren van Van den Berghe dan ook zijn ingegeven door de aantrekkingskracht van de homeopathie zelf. De ontwikkeling van Van den Berghe’s praktijk vond bovendien plaats in een periode van economische vooruitgang in het laatste kwart van de negentiende eeuw. Gezinnen uit de lagere klassen kregen meer financiële ruimte voor medische consumptie. Hun groeiend aandeel in de
Samenvatting

clientèle viel dan ook niet samen met een aanwas van het aantal gratis behandelde patiënten.

Voorts is gebleken dat veel van de arbeidende en lagere middenklassen-patiënten niet woonden in de verder weg gelegen, speciaal ontworpen, arbeiderswijken, maar in aangrenzende wijken of zelfs daar waar Van den Berghe werkte. De nabijheid van zijn praktijk vormde dus een bepalende factor in hun kennismaking met Van den Berghe en/of homeopathie. Tenslotte, het zoeken van professionele hulp werd niet ingegeven door een veronderstelde ernst van de aandoening. Patiënten, rijk en arm, gingen gebukt onder een veelsoortigheid aan klachten, waarvan de meest nauwlijks levensbedreigend mogen worden geacht. De zieke werd vaak simpelweg in zijn dagelijkse handelen, in werk of in huishouding, gehinderd door de aandoening. Hij of zij wilde een recept of medicijn om zo snel mogelijk weer te kunnen voldoen aan de eisen van alledag.

De patiënt-specifieke benadering van Van den Berghe's clientèle geeft inzicht in (1) individuele ideeën, verwachtingen, motivatie, houding en gedrag met betrekking tot ziekte, (2) persoonlijke verklaringen voor fysieke of mentale tegenslag, (3) de toestandkoming van therapeutische keuzes en (4) de relatie tussen een patiënt en zijn arts. Ouders, bijvoorbeeld, hielden de gezondheid van hun kinderen nauwlettend in de gaten of probeerden die te verbeteren, maar dit gebeurde lang niet altijd door de hulp van een professioneel arts in te roepen. Hoe bezorgd verzorgers ook konden zijn over de ziekte of kwaal van hun zonen en dochters, vaak werd eerst in de beslotenheid van het eigen huishouden geëxperimenteerd met zelf-medicatie (home of family medicine). Volwassenen waren bereid hun kinderen aan elke beschikbare remedié te onderwerpen, inclusief purgeer- en laxeermiddelen en de pijnlijke methode van aderlaten, om hen voor verder lijden te behoeden. De uiteindelijke keuze voor Van den Berghe en/of zijn homeopathie berustte nauwelijks op een wens tot een 'zachtere' behandeling voor kinderen.

Wie binnen het gezin primair verantwoordelijk was voor medische beslissingen blijft helaas enigszins onduidelijk. Gezinsleden beïnvloedden elkaar sterk in het bezoeken van Van den Berghe's homeopathische praktijk. Was één persoon over tevredenheid behandeld, dan volgden anderen al snel. Deze eerste 'gezinspatiënt' kon een kind zijn, maar ook het hoofd van het huishouden of de moeder. Dat homeopathie of het consulteren van Van den Berghe zodoende een familieaangelegenheid werd, was nauwelijks ingegeven door seksengenoom te omstandigheden. Hoewel andere redenen ook werden gegeven, laten de familiebiografieën zien dat de keuze voor Van den Berghe en/of homeopathie in wezen vaak een keuze was voor zijn kosteloze behandeling.

Patiënten spraken met hun homeopaat, op eigen initiatief dan wel omdat er speciaal naar gevraagd werd, over ziekte in het verleden. Ook vormden
In Search of a Cure

eerdere ervaringen met uiteenlopende geneesmethoden onderdeel van het gesprek. Patiënten vertelden over zelfmedicatie, over het inroepen van professionele hulp (licensed professional medicine), over de behandeling door ongediplomeerden (unlicensed medicine), of, in mindere mate, over religie als therapie, of de behandeling door vertegenwoordigers van de Kerk (religious medicine). Uit deze ‘therapeutische geschiedenissen’ blijkt dat zoiets als ‘de enige echte’ geneesmethode in de beleving van deze negentiende-eeuwse patiënten niet bestond. Zij winkelden uitgebreid op de medische markt, probeerden alles wat beschikbaar was, en als het gewenste resultaat niet werd behaald dan veranderde men evenzo makkelijk van therapie of genezer.

Dit ‘shoppen’ werd door zowel mannen als vrouwen bedreven. Het principe van vrijheid van keuze én gebruik van de opties tot genezing bleef voor de zieke dus gehandhaafd, ondanks het monopolie van de medische beroepsgroep en de duidelijke vooruitgang van de medische wetenschap aan het einde van de eeuw. Het verbod op het illegaal beoefenen van de geneeskunst weerhield het zieke individu er niet van ongediplomeerde (irreguliere) genezers te bezoeken, evenmin als de waarschuwingen tegen zelfmedicatie het eeuwenoude gebruik van huismiddeltjes tot stoppen bracht. Van den Berghe’s patiënten waren nog steeds in de gelegenheid te kiezen uit een variëteit aan geneesmethoden. Dat bleven zij dan ook volop doen. Ondanks veelvuldig geuite klachten over de ontoereikendheid en pijnlijke consequenties van de orthodoxe geneeskunde had een meerderheid van Van den Berghe’s patiënten juist hiermee veel ervaring. Deze negatieve ervaringen weerhielden hen er echter niet van andermaal een aderlating te ondergaan of bloedzuigers te laten zetten.

Dat mensen niet strikt vasthielden aan één behandelmethode in het bijzonder blijkt niet alleen uit hun ‘medische geschiedenis’, maar ook uit hun gedrag als Van den Berghe’s patiënt. Velen gingen door met experimenteren en het overgrote deel van de clientèle (70%) verdween binnen drie maanden na het eerste consult. Sommigen waren tegen die tijd simpelweg genezen, maar anderen, wier klachten nog niet verdwenen waren, zochten elders hun heil. Het gemiddeld aantal consulten per patiënt en de behandelperiode bij Van den Berghe laten zien dat slechts een minderheid haar lot geheel en permanent verbond aan deze homeopaat. De houding van patiënten tijdens de behandeling bewijst eveneens dat er slechts zelden sprake was van volledige loyaliteit aan Van den Berghe en/of homeopathie.

De patiënten van Van den Berghe waren actief betrokken bij hun behandeling. Werd deze als niet effectief beschouwd dan stopten zij eigenmachtig met de voorgeschreven medicatie, deden zij suggesties voor andere geneesmiddelen of schortten zelfs de behandeling op. Er werd met gemak uitgeweken naar een andere arts om vervolgens, bij uitblijven van succes, gewoon weer terug te keren bij Van den Berghe. Een patiënt beschikte
vaak over de nodige dosis zelfvertrouwen en was daardoor slechts gedeeltelijk bereid de verantwoordelijkheid voor zijn gezondheid over te dragen aan de arts. Ook was het verre van ongebruikelijk door te gaan met zelfmedicatie, een verschijnsel dat Van den Berghe tevergeefs trachtte uit te roeien bij zijn patiënten. Hoe tevreden patiënten ook konden zijn over de homeopathische behandeling, een gewoonte als, bijvoorbeeld, de stoelgang op gang houden met laxeermiddelen, kon slechts moeizaam worden doorbroken. Toch was de zieke ook bereid mee te werken met en zich te voegen naar de wensen van Van den Berghe. De eerlijkheid over het voertuigende gebruik van huisgeneesmiddelen of het consulteren van andere genezers en artsen bevestigd op zijn minst dat mensen, althans sommigen, zich bewust waren dat openheid kon bijdragen aan een bespoediging van het genezingsproces. Uiteindelijk moet echter geconcludeerd worden dat patiënten bepaald geen onderdanige rol speelden in de relatie met hun homeopathische arts.

Opvallend is dat deze ‘eigengereidheid’ onder patiënten nauwelijks afhankelijk was van sociale achtergrond, leeftijd of geslacht, behalve dat niet-betalende patiënten gemiddeld iets langer onder behandeling bleven dan de anderen. Maar zowel jonge als oude mannen en vrouwen behoorden gemiddeld gedurende een even lange tijd tot de clientèle. Zij hadden in het verleden geëxperimenteerd en bleven ook onder Van den Berghe’s toezicht het nodige aan therapieën beproeven. Op andere terreinen, zoals het type klachten waarvoor zij Van den Berghe dan wel homeopathie gebruikten of de verklaring, waarneming en omgang met hun zieke lichaam, verschillen mannen en vrouwen wel degelijk.

De mannen in Van den Berghe’s praktijk kwamen relatief vaak met klachten over de ademhalingsorganen, terwijl vrouwen blijkbaar vaak te lijden hadden onder maag-darm klachten. Vrouwen consulteerden Van den Berghe voorts vaker met huidaandoeningen en mannen met seksuele en venerische klachten. Dat vrouwen betrekkelijk vaak buikklachten hadden, kan evenzo goed het resultaat zijn geweest van hun specifieke constitutie en daarmee seksgebonden zijn geweest. Typische vrouwentekens met betrekking tot de baarmoeder of het kraambed werden door vrouwelijke patiënten namelijk gecommuniceerd en uitgelegd als maag-darm aandoeningen. Het beeld dat mannen het meest te lijden hadden onder geslachtsziekten behoeft waar­schijnlijk ook enige nuancering. Bij mannen was (en is) dit soort aandoeningen nu eenmaal beter waarneembaar dan bij vrouwen. Bovendien waren vrouwen nog meer dan mannen onwillig te erkennen en te verklaren dat zij leden onder een dergelijke aandoening.

Drie algemene ziekte-theorieën waren in omloop onder Van den Berghe’s clientèle: ziekte veroorzaakt door emotionele factoren, ziekte veroorzaakt door natuurlijke of medische factoren en ziekte veroorzaakt door persoonlijk gedrag. De eerste twee theorieën verwijzen naar oorzaken waar patiënten geen invloed
op hadden. De dood van een geliefde, slechte arbeidsomstandigheden, een ongeval of een andere medische aandoening, dit soort verklaringen werd gegeven door patiënten die uiteindelijk niet verantwoordelijk waren voor hun aandoeningen. Anders lag het voor patiënten die naar hun eigen gedrag verwezen als katalysator voor het lijden. Zij hadden de ziekte over zichzelf afgeroepen, door onverantwoordelijk of onverstandig gedrag: iets drinken terwijl ze bezweet waren, alcohol misbruik en feestvieren, slapen op straat of hoerenbezoek.

Mannen en vrouwen maakten in verschillende mate gebruik van deze theorieën. Vrouwen verklaarden hun ziekte veelal vanuit emotioneel oogpunt, mannen gaven de voorkeur aan verklaringen van natuurlijke of medische aard, of beschouwden hun eigen gedrag als de oorzaak van hun kwalen. Uit de verhalen van de Gentse patiënten over de aanleiding voor ziekte en hun lichaams-perceptie blijkt bij uitstek dat persoonlijke ideeën worden beïnvloed door de sociaal-culturele omstandigheden waarin de zieke verkeert. Heersende medische, sociale en religieuze opvattingen over mannelijkheid en vrouwelijkheid schemerden door in de gedachten van Van den Berghe's patiënten. Dit blijkt met name uit de houding van mannen en vrouwen met betrekking tot seksualiteit, geschlachtsziekten en het lichaam.

Beide seksen vertelden Van den Berghe over hun seksualiteit en seksuele ervaringen, maar wel in verschillende bewoordingen. Ook vrouwen waren seksueel soms zeer ervaren, maar in hun verhalen voldeden zij vaak aan sociale criteria over hoe vrouwen zich dienden te gedragen: niet seksueel, zwak en vatbaar voor emotie en ziekte. Met name getrouwde vrouwen deden het voorkomen alsof zij eigenlijk geen seksueel verlangen kenden en slechts hun lichaam ter beschikking stelden aan de voortplanting of het genot van hun echtgenoot. Vrouwen voelden zich in zekere zin dus niet de baas over hun eigen lichaam, mannen daarentegen gaven uiting aan een grote mate van controle en namen dan ook verantwoordelijkheid voor de schade die zij eventueel aan zichzelf toebreachten. Dit gevoel van onmacht bij vrouwen, of het hiermee voldoen aan het stereotype van het zwakke geslacht, blijkt eens te meer uit de wijze waarop vrouwelijke patiënten dachten over hun masturbatiegedrag.

Mannen weten allerlei klachten aan het zich overgeven aan 'zelfbevlekking', zij ventileerden de gangbare ideeën over de schadelijke gevolgen voor de gezondheid, maar ze 'bekenden', namen verantwoordelijkheid en dat was dat. Voor vrouwen lag dit allemaal wat gevoeliger. Net zo min als een man, werd een vrouw geacht te masturberen, maar in haar geval waren de consequenties nog vele malen groter. Haar toch al zwakke gestel werd enkel nog kwetsbaarder en getrouwde vrouwen traden bovendien ook nog eens in de rechten van hun ega. Een vrouw die Van den Berghe consulteerde vanwege haar neiging tot zelfbevrediging, beweerde dan ook steevast dat zij door haar
Samenvatting

Lichaam werd gedwongen tot deze handeling. Ook hier werd de verantwoordelijkheid afgewend. Algemene opvattingen omtrent seksualiteit en sekse werden dus grotendeels omarmd door de mannen en vrouwen in Van den Berghe’s praktijk. De man had een natuurlijke seksuele drijfveer waardoor hij zich onmogelijk kon onthouden van geslachtsgemeenschap en masturbatie, de vrouw beschikte van nature geenszins over zo’n prikkel en verschoof de verantwoordelijkheid voor haar seksueel handelen dan ook naar de ander, de partner of haar lichaam.

Tenslotte: het gebruik van homeopathie was zelden een bewuste keuze beïnvloed door de behoefte aan een holistische benadering van gezondheid, ziekte en genezing. Voor de meeste van Van den Berghe’s Gentse patiënten werd het besluitvormingsproces grotendeels bepaald door andere overwegingen. Vaak werd de aanmelding als patiënt uitgelegd als gebaseerd op het advies van iemand uit de omgeving, het sociale netwerk. Anderen lieten zich in hun keuze leiden door de praktische overweging van de nabijheid van de homeopathische praktijk of de mogelijkheid van gratis behandeling. In het geval van patiënten met maatschappelijk ‘onaanvaardbare’ aandoeningen, bijvoorbeeld, een geslachtsziekte, lijken privacyoverwegingen doorslaggevend te zijn geweest. Maar veelal kwamen patiënten bij Van den Berghe uit onvrede met andere therapieën: herhaalde en vaak pijnlijke pogingen om te herstellen via orthoduxe methoden waren mislukt. Bovendien ontbrak het veel patiënten aan enige basale kennis aangaande de beginselen van de homeopathie. De verergering van de klachten of zelfs het optreden van nieuwe klachten tijdens Van den Berghe’s behandeling, betekenden in principe dat de juiste medicatie gevonden was, maar mensen ervoeren deze verergering soms als zorgelijk en zetten de behandeling stop.

Sommigen hadden al ervaring met homeopathie, voordat zij bij Van den Berghe kwamen, maar goed - over homeopathie - geïnformeerd patiënten vormden desondanks een kleine groep in Van den Berghe’s cliëntèle. Nadat Van den Berghe in 1881 de enige Nederlandstalige Belgische publicatie over homeopathie op de markt had gebracht, steeg het aantal nieuwe patiënten opzienbarend. Dit boek was echter geen zelfhulpgids en daarom weinig toegankelijk voor de gemiddelde leek. De toegenomen belangstelling voor Van den Berghe’s homeopathische praktijk moet dan ook verklaard worden, niet zo zeer door de homeopathische beloften in het boek, maar door de substantiële kritiek op de officiële geneeskunde. Bezwaren die veel patiënten aan den lijve hadden ondervonden.

Van den Berghe was echter wel een strikte volgeling van Hahnemann. Hij besteedde veel aandacht aan de persoonlijke opvattingen van patiënten over oorzaken en beleving van de kwaal. Hij bood hen de gelegenheid en de tijd om hun levensverhaal te vertellen en luisterde aandachtig naar hen. Volgens Van den Berghe kon de behandeling alleen dan optimaal plaatsvinden indien alle
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Rue de la Station, de 11h à 12h.

Petite rue de la Station, de 7h à 9h 1/2.

Kleine Statiestraat, van de Maandag met uitgerekend.

Statiestraat, van de 11 tot 11

No 43, p. 8

[Handwritten note:]

C'est la lettre qu'il fallait.