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

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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 breathe 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 Berghe 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 Berghe, 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 Berghe. 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 Berghe 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.

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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.
In Search of a Cure

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.3

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: Dendermondssteenweg 273, district 7 and Straatnamenregister 1891-1900: Dendermondssteenweg 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.\(^4\) 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 psora (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.\(^5\)

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 Berghe 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 Berghe 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 Berghe 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 Berghe 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 Berghe could often do nothing but offer understanding and mental assistance for them.

One long-term sufferer was Pier Cnudde (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 Berghe 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 Berghe 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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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.\textsuperscript{13} 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 single 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).\textsuperscript{14}

\begin{table}
\centering
\begin{tabular}{lccc}
\hline
\textbf{Disorder} & \textbf{Men} & \textbf{Women} & \textbf{Total} \\
\hline
Asthma & 14 & 7 & 21 \\
Bronchitis & 3 & 1 & 4 \\
Cough and/or expectoration & 136 & 145 & 281 \\
Lung emphysema & 1 & 1 & 2 \\
Pleurisy & 1 & & 1 \\
Pneumonia & 1 & & 1 \\
Respiratory complaints & 25 & 25 & 50 \\
Tuberculosis etc. & 25 & 17 & 42 \\
\hline
\textbf{Total} & \textbf{206} & \textbf{196} & \textbf{402} \\
\multicolumn{3}{r}{(27\%)} & \multicolumn{1}{c}{(18.5\%)} & \multicolumn{1}{c}{(22\%)} \\
\end{tabular}
\caption{Disorders of the Respiratory Organs in Men and Women (based on the sample of 1,826 Ghent patients)\textsuperscript{15}}
\end{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-

\textsuperscript{13} Cf. the Introduction.

\textsuperscript{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.

\textsuperscript{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 Berghe. 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.16

A female patient concluded that her asthma was the result of having caught cold some fourteen years previously.17 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.18

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.19 Standaert consulted Van den Berghe 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

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. 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.

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. 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. 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-

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economic circumstances, by promoting a hygienic life-style, by offering free X-ray examination and by separating consumptives in sanatoria.\textsuperscript{24}

Forty-two people within the sampled clientele were specifically diagnosed by Van den Berghe to have suffered tuberculosis.\textsuperscript{25} 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.\textsuperscript{26} 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.\textsuperscript{27} 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).\textsuperscript{28}


\textsuperscript{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.


\textsuperscript{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 Berghe. 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 Bergh 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.

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>
</thead>
<tbody>
<tr>
<td>General abdominal and intestinal complaints</td>
<td>67</td>
<td>154</td>
<td>221</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>14</td>
<td></td>
</tr>
<tr>
<td>Anaemia</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Nausea</td>
<td>3</td>
<td></td>
<td>3</td>
<td></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>4</td>
<td></td>
</tr>
<tr>
<td>Other liver conditions</td>
<td>2</td>
<td>2</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>117</td>
<td>220</td>
<td>3</td>
<td>340</td>
</tr>
<tr>
<td><strong>(15%)</strong></td>
<td></td>
<td><strong>(21%)</strong></td>
<td></td>
<td><strong>(19%)</strong></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 gastrointestinal 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 Berghes 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. 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. 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.

Ear, nose, throat and eye disorders were another large part of conditions that Van den Bergh 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. 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 Berghes (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 Berghe with a wet and slimy throat and
dying 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
Berghe, 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 Berghe’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,
chancres 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.
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.42 Van den Berghe had noted both complaints and age of 1,428 adults in the sample (Appendix 8).43 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.44 However, from this sample, it is largely impossible to make firm statements about the age at which guard should be taken against which diseases. Nevertheless, young patients were more likely to catch one disease than another.45

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.46 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

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 homeopath 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>Total</td>
<td>1,826</td>
<td>100%</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 Hilde 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


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.

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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

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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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

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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{center}
\textbf{RUE DE LA STATION, 22, CAND:}

\textbf{Le Docteur VANDENBERGHE}

Reçoit tous les jours, le Lundi excepté.

Petite rue de la Station de 7 à 9 1/2 h.

Rue de la Station, de 11 1/2 à 1 h.

Outrengt alle dagen, den Maandag uitgezonderd.

Kleine Statiestraat, van 7 tot 9 1/2 uur

Statiestraat, van 11 1/2 tot 1 uur.

\begin{tabular}{c}
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\textit{Figure 1. ‘Appointment Card’, 1882. Private Archive Gustave Van den Berghe}
\end{center}

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,  

\footnote{\textsuperscript{69} Digby, \textit{The Evolution of British General Practice}, 136-137.}
\footnote{\textsuperscript{70} Ibidem, 139-140; Digby, \textquote{‘A human face to medicine’}, 95.}
\footnote{\textsuperscript{71} Cf. Chapter 2, 48-49.}
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 to 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.72

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.73 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.74 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

72 Cf. Chapter 4.
73 E.g. Digby, The Evolution of British General Practice, 146.
74 E.g. Casebook 4 (1871-1873): p. 125. 'en visit ne fait constater ...' (on visit at home, could not establish ...)

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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, âgé, 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
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.
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.\textsuperscript{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.\textsuperscript{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.\textsuperscript{82} Confirmation has been found in one case that Van den Bergh did not trivialise a deterioration of a patient’s financial situation but, instead, adjusted his fees. When the Meirsmans entered Van den Bergh’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 Bergh free of charge.\textsuperscript{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 Bergh was not firm in insisting on payments and it was far from easy


\textsuperscript{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.

\textsuperscript{82} Casebook 4 (1871-1873): p. 71 (Louis DeSadeleeer (age 18), a student); Casebook 17 (1898-1901): p. 629 (Louis Andelhof b. 1849, d. 1904); Casebook 8 (1881-1882): p. 225 (Hippolytus Magerman, b. 1854, d. 1882).

\textsuperscript{83} Casebook 17 (1898-1901): p. 53. Emilius Gustavus Meirsman (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. 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).

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. 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.

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. Patient and doctor exchanging and sharing views, trust and understanding undeniably benefit the healing process. The extent of

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91 Ibidem: p. 563.
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. 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. 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.

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’?

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

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95 Cf. footnote 4.


97 Matthews, ‘Illness Classification and Treatment Choice’, 188.

himself, more or less, to the Father of homoeopathy 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.

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while 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

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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 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.
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straight at the following consultation and assured Van den Berghe that her illness was not caused by being disappointed in love.111

It has been suggested that patient-doctor encounters differed according to the status of the patients and the nature of the practice.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.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.114 An eighteen-year-old man stopped his treatment because ‘he was convinced that there was no remedy for his aching’.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 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: ‘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.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 life style issues such as

115 Casebook 14 (1891-1894): p. 971. ‘decouragé il avait cessé son traitement, convaindu qu’il n’avait aucun remède pour son mal.’
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
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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 homeopathy. 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 homeopathy. The question presents itself if non-homeopathic 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.