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

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Conclusions

Gustave Van den Berghe died rather unexpectedly on 18th May 1902, nine days after his sixty-fifth birthday. He had been indisposed for only a few days and neither the care and assistance of his sons nor the aid of his colleagues could protect him against apparent consumption. The practice came to a sudden standstill; Van den Berghe had seen his last new patient on the day of his death. The news of his death reached his colleagues as well as his clientele very quickly. Some of his patients seemed more disconcerted about the loss of repeat prescriptions than that of their ‘personal’ physician. Arthur Pot, for instance, felt compelled to convey his condolences to Van den Berghe’s son, Ferdinand, but was more interested actually in how to get his future prescriptions.

Renaix 22 May 1902

Monsieur,

As I arrived in Ghent this morning it was with great regret to hear that Monsieur Le Docteur, your father, has passed away and I permit myself to write to you, because they have told me that you will continue his business. [Could you] send me the medication of before last time, I think they are better than the last ones. You may send them to me cash on delivery or I will pay you at my next visit. I look forward to receiving your reply.

Sincere condolences
Arthur Pot

Pot’s interest in homoeopathy was situated in the therapy itself rather than in the person who was prescribing it. Therefore, he needed to ascertain if Ferdinand was going to take over his father’s practice and, if so, whether he would adopt his father’s custom of mailing the medication. Arthur Pot would continue with homoeopathy after Gustave Van den Berghe’s death. Other patients would not as, for them, the use of homoeopathy may have been largely

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1 After that the casebooks fall silent for two months.
2 Casebook 17 (1898-1901): p. 835. Letter from Arthur Pot to Gustave Van den Berghe, dated 22 May 1902. "Je suis venu ce matin a Gand et c'est avec regret que j'ai entendu dire que Monsieur Le Docteur, votre père est venu de mourir et je me suis permis d'écrire car on m'a dit que vous alliez continuer les affaires. Veuillez avoir [...] me renvoyer les médecines comme l'avant dernière fois je les trouve meilleurs que les dernières. Vous pouvez me les renvoyer contre remboursement ou bien je vous paierai la prochaine visite. Dans l'attente d'avoir une réponse"...
an expression of trust in this particular physician, of the need or wish for *gratis* treatment or of both.

This study has reflected upon the patients of the homoeopathic physician Gustave Van den Berghe, who practised in Ghent between 1869 and 1902. He had earlier offered homoeopathy to sufferers in his home town of Zwevegem, in West-Flanders. However, his homoeopathic career truly advanced with his move to Ghent. He treated more than 22,000 patients from home and abroad for over thirty years and for six days a week. Patients lived in Belgium, France and the Netherlands, they were young and old, male and female, rich and poor, they were suffering from a simple cold or, sometimes, were near death.

Two distinctive methodological approaches of the historical patient have been applied. Firstly, a patient-related approach, in which patients are presented as part of a larger entity, i.e. a homoeopathic physician's clientele. Secondly, a patient-specific approach, introducing patients as individuals. Analysis of the composition of Van den Berghe's clientele ascertained general transformation patterns in his practice and revealed the impact of socio-economic and culturally related circumstances on those consulting this particular homoeopathic physician. A reconstruction of patients' personal stories of suffering resulted in insights into health care-seeking behaviour and personal perceptions and experiences of illness, health and healing from the patients' perspective. Furthermore, it has shed light on the doctor-patient relationship, by examining patients' individual behaviour towards Van den Berghe during the clinical encounter.

The results are founded, to a large extent, on the interpretation of Van den Berghe's private casebooks, in which he noted, besides medical information on illness, medication, physical examination etc., the individual stories of his patients. They had the opportunity to speak from a personal point of view about the experiences and causes of their suffering. Patients' own understanding of being ill and the ways in which they dealt with bad health received his thorough-going attention. Therefore, the casebooks can be read as both a homoeopathic physician's 'medical memory' and as a patient's diary of daily life experiences with illness and (self) treatment. The casebooks can enhance knowledge and understanding of historical experiences with illness and the body from a patient-specific perspective. Casebooks symbolise more than a particular physician's medical practice. They, at the same time, represent the individuals who received the treatment and illustrate their personal approach towards illness, health, healing and their relationship with the physician.3

3 The main conclusions will follow regarding Van den Berghe’s nineteenth-century Ghent patients and their experience with homoeopathy. As the research into particular topics has yielded rather more questions or voids than results, suggestions for future research will be given as well.
Van den Berghe's clientele underwent three major changes in terms of numbers and composition of new clientele, specifically as regards gender and social background. These transformations demonstrate that the choice to consult Van den Berghe, and/or to use homoeopathy, in part consisted of social-cultural considerations.

Gustave Van den Berghe was known beyond the borders of Belgium. Although most of his patients resided in Ghent or direct vicinity, he treated also sufferers living in France and the Netherlands. This was not unique; other nineteenth-century homoeopaths were consulted also by patients from other countries. The obstacle of distance was counter-acted by the custom of written consultations. Patients wrote to the physician, as in the case of Van den Berghe, about their condition and, in return, would receive medication and advice by mail. However, writing to their physician was not restricted to those who lived at a distance. Ghent patients consulted and informed Van den Berghe by letter.4

Two per cent of Van den Berghe's patients were registered as living in another country, particularly in the department of Pas de Calais (in the north of France) and in the province of Zeeland (in the south-west of the Netherlands). Both areas directly bordered Belgium, the southern part of Zeeland even bordering East-Flanders. These 'foreign' patients were often not foreign at all; many Belgians fled their home country in times of economic and social decline or political unrest and settled temporarily in the areas where Van den Berghe's 'foreign' patients were known to live.5 Roubaix, in particular, where many 'French' patients resided, was renowned as the 'Belgian colony'. Some of the 'foreign' patients were not only probably of Belgian origin but were Ghent inhabitants; seasonal labour in France was popular amongst Ghent workers. 'Foreign' patients hardly ever consulted Van den Berghe about their children's ill health. Men predominated among the Dutch patients. Moreover, the further away people lived, the less often they requested his assistance. The distance to the practice negatively influenced the need or wish for treatment, in spite of the custom or the possibility of written consultations.

The composition of Van den Berghe's Ghent clientele confirms that his practice was open to everybody and was visited by sufferers of diverse economic and social backgrounds and age-groups. Nearly twenty per cent of his patients were children, aged sixteen or younger, the rest were adult women and men from all social strata. The clientele can be considered as a cross-section of Ghent's population, except for the higher average age of the patients. However, the clientele gradually, yet considerably, changed over time. This transformation of the clientele occurred predominantly in terms of gender and of social class of the new patients.

4 Most of these patient-letters, unfortunately, have not passed the test of time. It is, therefore, impossible to determine how often and for how long patients in general consulted Van den Berghe via letters.

5 Cf. Chapter 2.
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There was an overall transformation in Van den Berghe's clientele in a reversion of the enlistment of new patients and a growth in the request for treatment from sufferers living outside of Ghent. He had to deal with a clear waning of new clientele at the end of the century. In his first entire year of practice in Ghent (1870), he recruited 1,432 new patients, adults and children, including non-Ghent patients. Thereafter, he would never have so many new patients in one year and, in general, the new clientele gradually, but steadily, decreased. The decline in the number of new child patients, though, was far less pronounced. Thus, new adult patients registered far less often at the turn of the century, whereas care takers continued to engage professional homoeopathic help for their children. It is uncertain why the number of new children remained rather steady, but it coincides with a growing number of new female patients. However, not only mothers but also fathers took their children to Van den Berghe over the entire period.

Van den Berghe's new clientele fluctuated depending on particular events. However, it is remarkable to see that the outbreak of epidemics in Ghent did not lead automatically to more new clientele. A smallpox/typhoid epidemic in 1871, with a mortality rate of nearly thirty-eight per cent, did not yield a substantial growing new clientele, nor did an attack of influenza in 1889-1890. Ghent's population was startled by a mild outbreak of cholera between 1892 and 1894, a disease that was dreaded in the popular mind, but the number of new patients stayed virtually constant.

Other incidents did have a more distinctive impact on the growth or decline of new clientele. When he moved his practice, after buying another house in Ghent in 1871, Van den Berghe treated fewer new patients. Firstly, the change of address was not announced publicly and, secondly, the move to new premises took time from being able to practice. Van den Berghe's publication of De Homoeopathie en hare tegenstrevers in 1881, on the other hand, boosted the size of his clientele. 838 new patients consulted him, of whom fourteen per cent received treatment free of charge. Although his book was hardly meant for lay-people, the extraordinary decision to write in Dutch contributed, at least, to the accessibility of knowledge about homoeopathic principles. Perhaps, it even led to ordinary people changing their attitude towards doctors as language barriers ceased. Nevertheless, it is not unthinkable that the stagnation in growth of new clientele must have worried Van den Berghe. He may have had a more reasonable and workable arrangement for his practice days, but only a small part of his patients became steady visitors. The majority only consulted him on a few occasions which may have contributed to financial troubles.

It seems that homoeopathic practitioners lost their initial 'magical attraction', be it based on personality, homoeopathy or free treatment. At the same time as medical science began to show its first therapeutic successes the

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6 This research did not follow-up the patients after they had ended their treatment with Van den Berghe and, therefore, they may have continued to make use of homoeopathy - either personally or with another practitioner.
appeal of the 'softer alternatives' diminished. Fewer new patients found their way to his practice. Sufferers' fading interest was seen also in the decline in the number of Belgian homoeopathic physicians. No clientele, no business. Moreover, medical competition expanded. Whereas the number of homoeopathic physicians stagnated, the number of orthodox professional practitioners grew. Sufferers had more practitioners to choose from and the proximity of an orthodox practice may have diminished the number of potential patients for Van den Berghe. Yet, at a personal level, the patients who did try homoeopathy with him, still partly explained this decision out of discontent with orthodox medicine at the end of the century.

As the demand of Ghent citizens for Van den Berghe's treatment diminished, that of people living elsewhere increased. The distance and time spent did not prevent them from personally consulting him, besides writing letters. Belgium, as one of the first industrialised countries on the Continent, had invested enormously in the infrastructure and better transport opportunities reduced travelling times. Thus, for those living elsewhere, social-economic progress enlarged their options for healing. Women, in both the non-Ghent and the Ghent clientele, outnumbered the men but they consulted Van den Berghe less often than the men. It remains rather difficult to find a satisfactory explanation for the difference in consultation behaviour (i.e. the number of consultations) of non-Ghent men and women. Women were not discouraged to undertake a journey for treatment, yet hardly travelled alone. Therefore, it seems that their dependence on a fellow traveller, at times, will have been an hindrance to their need or wish to consult personally Van den Berghe.

Women predominated in Van den Berghe's clientele during all his years of practice. This female surplus continued to increase, considerably transforming the gender balance of his practice. Most of his foreign homoeopathic contemporaries had a male dominated clientele whereas, amongst Van den Berghe's patients, the female preponderance continued to expand. The sex-ratio of his Ghent clientele, the number of males per 100 females, changed from 80 in 1869 to 58 around the turn of the century. Such a female over-representation is common in twentieth-century homoeopathic practices. Therefore, Van den Berghe's practice may be considered as representing a transitional period, hovering between the 'old' male dominated and the 'new' female dominated homoeopathic practice.

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8 Cf. Chapter 2, paragraph 3, 63-73; Chapter 3, paragraph 1, 76-85.

9 Information regarding Belgian or Ghent colleagues has not been found. Cf. Chapter 2, 51-52.
The predominance of women in Van den Berghe’s practice, at first sight, is hardly surprising as Ghent’s population displayed a similar pattern. Ghent’s textile industry traditionally employed many women workers and, therefore, the city’s population consisted of more women than men in the nineteenth century. Yet, the share of women inhabitants did not increase to the same extent as that of Van den Berghe’s female patients. Thus, the over-representation of female patients only reflects partially the population structure. However, it does indicate that women were more willing than men to call in the help of a homoeopathic health professional. A possible explanation for this readiness was discovered in the ailments for which women sought treatment and their stories of the suffering they had endured in the past. Women, besides being at risk to the general health threats of being human, were confronted also with the ‘dangers’ of being females. Even when women currently consulted Van den Berghe with such ordinary, ‘human’ conditions, they seldom refrained from telling him about previous pregnancies, difficult deliveries, an occasional miscarriage and menstrual problems. Problems which had influenced their general state of health and well-being. His female Ghent patients, in general, had struggled physically or were struggling more than the males. Moreover, social, medical and religious views of women portrayed the female gender as weak, vulnerable and irritable by nature because of their specific biology, the female constitution. The reproductive organs, the uterus and the ovaries, which caused great suffering in women, ruled the female body and mind. Van den Berghe’s female patients spoke about their specific constitution in relation to their ill health; they had adopted these general ideas that, in a sense, excused women from being sickly and expected them to be ill more often than men.

Although women may have been more prepared to call in the help of Van den Berghe or of homoeopathy, this does not explain the considerable expansion in the number of female patients. Moreover, it is unknown whether the composition of Van den Berghe’s clientele deviated from that of his orthodox colleagues practising in Ghent. If orthodox practices did consist predominantly of male patients, then a gender gap did exist in choosing orthodox or unorthodox treatment in the nineteenth century. However, this has not been currently established, although, for the twentieth century, women tended to choose homoeopathy more often than men because of its perceived mildness (also for their children) and the convenience of home treatment. This research has not revealed any conclusive information as both men and women complained about the ‘cruelty’ of orthodox medicine.
The other transformation concerns the gradual shift in the patients' social background: from middle and upper class domination to a 'popularisation', an over-representation of working- and lower middle-class patients. Patients from all social strata of Ghent's society used Van den Bergh and/or homoeopathy, yet the reasons for their interest seemed culturally shaped. The absolute poor did not have the financial means to respond to instances of illness in any way they liked. They were dependent on poor relief and, thus, forced to use the public offers of therapeutic support. Yet, public medical support was strictly restricted by eligibility criteria. Some of Van den Bergh's patients, although destitute, probably did not meet these criteria; others refused to go through the demeaning procedures for applying. Although, in many cases, the *gratis* treatment was the over-riding influence in the choice to consult Van den Bergh, some destitute patients were drawn by his specific homoeopathic treatment which was not available through charity or public poor relief.

The affluent, whose share in Van den Bergh's clientele diminished considerably in the course of the century, initially may have been influenced partly by the sense of exclusiveness surrounding homoeopathy. At the same time as the number of working- and lower middle-class patients and the number of people applying for free treatment increased, noble and other upper-class patients ceased to come to the Ghent practice. For them homoeopathy may have lost its attraction as a status symbol. However, upper class patients may also have turned away from homoeopathy because of the advances of orthodox medical science at the end of the nineteenth century. None of these patients personally told Van den Bergh that they did not appreciate him treating poor patients or, at least, he never made such notes. In the case of one noble former patient it is known that the homoeopathic tradition was continued at home. The physician had lost his attraction but not the medical method. Did the affluent, with growing public accessibility to homoeopathy, withdraw from homoeopathic physicians' clienteles, yet remain loyal to the therapy at home?

The survey of the socio-economic background of the Ghent clientele relating to the conditions with which they consulted Van den Bergh did not yield any significant results. The decision to consult Van den Bergh or to try homoeopathy was barely influenced by patients' perceptions of the seriousness of their illness.

Ghent citizens lived in changing times during the second half of the nineteenth century. The population was startled regularly by social-economic turmoil, political unrest and epidemic threats. Such events were more difficult to cope with for some people than for others. The upper strata of society were barely affected by economic crises and food shortages yet, felt the threat of the

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14 This has been concluded by P.A. Nicholls regarding the interest in homoeopathy of the English upper classes. Cf. Phillip A. Nicholls, 'Class, Status and Gender: Toward a Sociology of the Homoeopathic Patient in Nineteenth-Century Britain', in: Martin Dinges (ed.), *Patients in the History of Homoeopathy* (Sheffield: EAHMH, 2002), 141-156.
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destitute working classes. Economic crises led to unemployment which, in turn, could easily spark social protest, strikes and even revolts.

Ghent had two faces. The one side reflected the splendour and grandeur of cultural prosperity; the nobility and other affluent families living in lovely, clean and green neighbourhoods. The other side demonstrated the hazards of the enormous expansion of Ghent’s textile industry; industrial workers crammed into dark, small and dirty blocks, without sewerage or running water. These districts were particularly vulnerable to outbreaks of cholera and typhoid which spread easily and caused many fatalities. These unsanitary living and unsafe working conditions of the enormous industrial work force eventually led the government to start improving the most notorious districts in the town. There was the fear of contamination of the higher classes which was countered by the education of the masses to protect bourgeois interests. Yet, maybe foremost, there was the pressure from the increasingly strong and growing labour movement. Ghent was still ranked first amongst Belgium’s twelve largest cities for poor hygiene by the end of the nineteenth century, but the average industrial worker no longer needed to apply for public poor relief.\textsuperscript{15}

This was the situation in which Van den Berghe’s Ghent patients lived. However, whether rich or poor, or in between, disease did not take account of social status. Assessment of the ailments that Van den Berghe treated did not yield any conclusive correlations between socio-economic background and susceptibility to particular ailments. It was known, for example, that textile labourers, who spent long hours in secluded badly ventilated spaces, were prone to lung and respiratory conditions. Van den Berghe had considerable numbers of textile workers in his clientele but they did not complain more than others about these types of ailments. However, his patients were only a small part of Ghent’s population.\textsuperscript{16} Another noteworthy finding is, that Van den Berghe’s lower-class patients were not condemned exclusively to living in specifically working-class districts. Instead, many of them, lived near to his practice and, therefore, seemed attracted by his proximity. Van den Berghe’s clientele becoming predominantly working class coincided with the economic progress of the last quarter of the nineteenth century. Lower-class families finally gained also more financial scope for medical consumption, as the increase in the new lower-class clientele did not coincide with an increase in the number of new patients treated for free.\textsuperscript{17}

The men, women and children in Van den Berghe’s clientele suffered from a wide variety of conditions, many of which were not grave. Patients, at times, expressed concerns about their health or contamination, for example,

\textsuperscript{15} Chapter 3, 85.

\textsuperscript{16} Therefore, generalisations about the clientele cannot be conceived as representative for Ghent’s population at large. A larger sample or different research may yet yield other insights.

\textsuperscript{17} Systematic inquiry into Ghent citizens’ health seeking behaviour will be needed, for deeper insight into the relation of social status-susceptibility-therapeutic choices.
when they had attended a seriously ill family member who eventually died. However, the use of homoeopathy or consulting Van den Berghe seems not to have been instigated by the supposed gravity of the illness. Individuals were more likely to feel uncomfortable in their daily lives. Patients were interested primarily in how the defect could be mended rather than in what they were actually suffering from; they requested a prescription for recovery to return to normality.

Parents actively monitored and promoted their children’s state of health, but seeking professional treatment yet was far from standard behaviour when a child had fallen ill. Moreover, the use of homoeopathy or consulting a homoeopathic practitioner for their children was only motivated partly by the wish for ‘soft’ treatment, yet it was inspired especially by wanting to safeguard children from suffering with whatever remedy was available.\(^\text{18}\)

Parents or care-takers were alarmed easily when a child showed the first signs of a cough or of diarrhoea. Moreover, they did not adopt a wait-and-see attitude but, instead, often undertook immediate action when they considered their child was at risk. They were aware that their offspring were extremely vulnerable as child mortality was high and most parents had lost at least one child. The conditions Van den Berghe treated in his child patients mostly were far from lethal from a medical point of view, yet considered serious enough by parents to consult this physician. One out of five children younger than eleven had typical children’s diseases such as diarrhoea, measles, scarlet fever and whooping cough.

Adults, particularly on behalf of young patients, frequently communicated the suffering of a child. Therefore, this study has yielded merely indirectly insight into the illness-experiences of the children themselves. However, it has shown that the well-being of parents and of children was closely linked. A mother or father could fall ill because of the distress caused by the suffering of a child; children’s health could be affected by the misconduct or maltreatment by or the death of an adult. Moreover, parents were concerned as much about the ailments of their daughters as of their sons. The gender of a child did not matter when that child was in danger. Van den Berghe treated an almost equal number of girls and boys, the girls being slightly in the majority. Finally, although some may have considered their off-spring as merely a provision for their old age, the mutual dependence between children and their parents, already underlined by a large number of children taken to Van den Berghe, reflects the existence of a ‘love-affair’ between a couple and their offspring.

Parents did not choose exclusively professional help in case of illness, despite the keen monitoring of their children and the care with which they were

\(^{18}\) Cf. Chapter 5, paragraph 1, 138-149.
surrounded. Home medicine was often applied first; children were administered purgatives and vermifuges on a remarkably large scale. Therefore, the suggestion that parents, especially mothers, may have preferred homoeopathy for their children because of its 'mild nature' is not confirmed by their behaviour. Some parents continued their own private medical care during Van den Berghe's treatment despite his explicit orders. Furthermore, twenty per cent of the children were treated free of charge and, hence, choosing Van den Berghe seemed based partly on financial advantages. Yet, between 1897 and 1902, the percentage of children treated for free declined from thirty-one to eleven per cent. However, that nearly one-third of the children consulted or were taken to Van den Berghe only once, proves that the trust of parents in him or in homoeopathy was often temporary. Van den Berghe's treatment was just another attempt to combat the latent threats of illness and death, as other medical methods and practitioners had been tried before.

Members of one family could easily influence each other in trying Van den Berghe or homoeopathy, but it remains largely unclear which member decided primarily on the best therapeutic course to be taken.\(^{19}\)

The review of entire families who became patients of Van den Berghe reinforces the idea that the decision in favour of Van den Berghe or of homoeopathy was really a choice in favour of his free medical support, despite the fact that even poor families eventually may have found better results from homoeopathy than from any other medical method. It is noteworthy that, notwithstanding any particular motivations, Van den Berghe developed into a true family physician for some families. He treated all the members of one household and was consulted later by offspring of the earlier patients. Children who had grown up and, sometimes, had moved out of Ghent, for example, occasionally would return to Van den Berghe with their own children. When, in particular, they were living in cities where homoeopathy was widely accessible, the return to Van den Berghe must have been inspired by the good personal relationship they had with him. More so, when they had paid always for their consultations. However, even when all family members were treated over a lengthy period of time, suggesting that they had become really dedicated to Van den Berghe and/or homoeopathy, the habit of trying homoeopathic self-treatment or other healing methods often persisted.

Nevertheless, the casebooks have shortcomings when attempting to approach illness as a family affair, who exercised authority in decisions regarding health, illness and healing? The use of other sources, e.g. advertisements (aimed at women and/or men?) or more personal testimonies in diaries, letters etc., could enlighten an understanding of the relations between the sexes, between husband and wife, on the division of responsibility regarding their children’s health. The files on Van den Berghe’s patients barely

\(^{19}\) Cf. Chapter 5, paragraph 2, 149-162.
reveal the patterns of decision-making processes within a family, if at all. It is impossible to say whether it was the head of the household, the father, or the mother, who had primary responsibility for the decision on which medical option to use in case of illness. The family histories do not give evidence for any gender-specific circumstances for making homeopathy or consulting Van den Berghe a family affair. Indeed, both mothers and fathers were the first to consult him, with their families following afterwards. The exception was child-patients who, in their adult lives, continued to consult Van den Berghe for themselves or their children; they were girls/women. However, the registration of new children in Van den Berghe’s clientele remained virtually the same, whereas new male clientele decreased considerably over the years. Thus, women increasingly, apparently, gained influence over the therapeutic choices for their children. Moreover, it is clear that individuals did not wait passively for the suffering to cease but that they took their fate into their own hands and started the search for a cure.

Gender was a decisive factor regarding (1) ailments for which treatment was requested, (2) illness and body perceptions and (3) views on the origins and nature of the suffering. The male and female patients in Van den Berghe’s clientele shared many conditions, but the genders also seemed more vulnerable to particular diseases. Socio-cultural notions engendered different illness and body perceptions in men and women. Male and female patients held different views on the origins and nature of their suffering and varied in the ways they perceived their bodies. Finally, these lay sufferers’ notions on health and illness reflected prevailing social concepts of femininity and masculinity.

The adult Ghent men and women who consulted Van den Berghe, at times, were extremely capable of depicting in detail what was wrong with their bodies or their minds. Patients made a clear distinction between what they considered the essence of their suffering and the matters of secondary importance. Nowadays, homeopathy is employed and appreciated predominantly by chronic patients. However, his late-nineteenth-century patients were far from being exclusively long-term sufferers; half of them had been afflicted for less than six months. Nevertheless, there seemed to be a limit on the time that sufferers could cope with continuous affliction. Nearly twenty-five per cent of Van den Berghe’s patients started to consult him after they had been ill for one to two years. The majority had first tried to overcome their suffering by self-treatment or by consulting other, often, orthodox practitioners. Thus, they decided to make use of yet another healing option, Van den Berghe’s homeopathy, after a period of time. Patients were not necessarily seriously ill by then, they were not burdened exclusively with dangerous incurable conditions. These sufferers did not fear for their lives, they knew that their ailment was rather innocent. However, they concluded that it was not going to

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20 Chapter 6, 168.
disappear straightforwardly and, if they wanted to end the discomfort once and for all, they should try Van den Berghe and/or homoeopathy.

Men and women did not exhibit dissimilar characters on their capability of coping with lengthy suffering. However, there are differences in the male and female susceptibility to particular diseases and the ways in which men and women in Van den Berghe’s clientele explained and perceived their physical and mental afflictions. Men and women, besides gender-specific disorders related to the reproductive organs, had to take account of the gender-related circumstances of their health complaints. A distinctive pattern has been discovered regarding the ailments for which men and women requested treatment. Many male patients were affected by respiratory disorders whereas, more women complained of gastro-intestinal suffering. Skin complaints were expressed primarily by female patients; sexual and venereal ailments were essentially a man’s business. Yet, as these women apparently suffered more often from abdominal conditions it was, in some cases, most probably gender-related. Uterine disorders or child-bearing complaints, at times, were communicated and explained by women as resulting in gastro-intestinal conditions. The picture of men’s apparent larger propensity for developing sexual ailments, at the same time, also can be distorted. These ailments were clearly visible in men, in women they were not. More importantly, although venereal suffering in both men and women was surrounded by shame and disgrace, female patients were even more reluctant to acknowledge and to explain that they had developed a condition of such nature.

Men and women, by and large, held different views on the origins of their suffering. Thus, the explanations for the symptoms were marked by the gender of the bearer. Three different illness theories were distinguished: (1) illness caused by emotional factors, (2) illness resulting from natural or medical factors (other conditions or erroneous treatment) and (3) suffering originating from personal conduct. Patients who spoke about the first two explanations indicated that the ailment had developed outside their own control. If they referred to their own behaviour as a cause of the suffering, they were acknowledging, in a sense, that they had brought it on themselves. There does not seem to have existed a positive correlation between the illness theories and certain conditions, a correlation that was found in the case of gender. Men and women displayed differing perceptions on the origins of their ailments. Women generally tended to explain their suffering from an emotional point of view, with anger, fear, anxiety, grief and sorrow causing all types of ailments. Women used such explanations twice as often as men. The male patients most frequently offered explanations of a behavioural or natural/medical nature. These natural/medical explanations for men often meant that they had worked

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21 Cf. Chapter 6, paragraph 2, 169-178.
22 Cf. Chapter 7, paragraph 1, 203-209.
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too hard, too long or in an unhealthy environment. Women, in this case, complained about gender-specific circumstances such as pregnancy, delivery etc.

The stories of the Ghent patients on the origin of ailments and their body perceptions infallibly reflect the impact of the social-cultural context on sufferers’ personal ideas, knowledge and comprehension. Prevailing medical, social and religious notions of femininity and masculinity, ideas on proper behaviour in men and women, fostered by the perceived functioning of one’s biological constitution, filtered through to the minds of lay-people, as communicated and reflected upon by Van den Berghe’s patients. This has been elaborated by the example of male and female attitudes about sexuality, venereal disease and the body.23

Although men and women were involved equally in sexual activities, the language used for their behaviour diverged. Women, at times, met the social criteria of what it meant to be a woman, a-sexual, susceptible and weak. Some women freely expressed that they had sexual urges but married women, especially, made it appear that sexual intercourse was merely putting their bodies at procreation’s disposal. Their bodies were not their own but served to bear, deliver and nurse children or to satisfy their husband’s needs. Women, in a sense, felt that they had no control over their bodies. Men, in contrast, felt in charge of their bodies and, hence, took responsibility for whatever harm they might do to it. If a man was afflicted with venereal disease he pointed out that his own conduct was the cause, women usually blamed their husbands. Women, apparently, could not choose to deny sex to a visibly venereally affected husband, although their spouses will have infected them.

Accounts of masturbation reflect also the impact of social-cultural gender views of the consequences of this act. Although the propensity to masturbate was considered harmful in both men and women, as it was considered to result in a range of ailments, the deed of gratification was clarified in substantially different ways. It was a clear sexual act for men yet, never amplified. They were aroused, masturbated, developed certain conditions of which they wanted to be freed, and that was all. Women, on the other hand, never explained their masturbating behaviour in sexual terms but, instead, claimed that they were forced to the act by their bodies. A physical sensation had forced them to touch themselves. Men and women, thus, largely accepted the general concepts of sexuality and gender; men declaring that they were behaving according to the standard of natural male passion and inability to abstain; women who acted ‘abnormally’, as they were perceived to have no sexual needs, denied responsibility for their behaviour and blamed their husband or their bodies.

However, the women in Van den Berghe’s practice were far from complaining constantly about the burdens of the female body. They attributed their suffering to more than their biological constitution. Nonetheless, it

23 Chapter 7, paragraph 2, 209-222.
remains largely unclear whether a patient's social class influenced the perception and experience of and explanations for their suffering, as there is little information about patients' backgrounds. The social background could be assessed of only a few women who consulted him with gender-related ailments. Yet, it has been convincingly argued that working-class women, in contrast with women from the upper strata, could hardly afford in time or money to allow emotional events or the 'monthly malady' to interfere with their daily affairs. Reflections on Van den Berghe's female patients' who suffered women's illnesses correlated with their social background should provide more insight. The same type of questions should also be asked of male sufferers. Does a correlation exist between social background and illness experience? Nevertheless, it is known, at least, that men and women perceived their bodies and experienced their illnesses quite differently.

It has been argued that, although interest in the historical body has yielded a wealth of publications in the last decade, daily dealings with the body and corporality of the historical individual have remained some what neglected. This research has resulted in important findings because systematic attention has been paid to the patients' personal perspectives on their bodies and because both sexes have been examined simultaneously. The interpretation of Van den Berghe's casebooks made it possible to compare and to distinguish male and female attitudes towards health, illness, healing and the body.

Ghent sufferers, at random and haphazardly, experimented with whatever healing options available in the medical marketplace. There did not exist for most of them a 'single, unequivocal best buy' for restoring their health.

The results of this research challenge the pre-supposition in Anglo-Saxon studies that the principle of free choice and free use of options for healing was lost when the medical profession gained control over healthcare services and medical science had achieved clear progress at the end of the nineteenth century. It is highly debatable whether these developments changed distinguishably the experiences, perceptions and behaviour of sufferers. A declining new clientele confronted Van den Berghe but, in terms of therapeutic

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25 See Chapter 7.
behaviour, the patients continued to use freely unorthodox medicine, healers or self-treatment. Sufferers continued to test all options for healing that they had at their disposal, despite therapeutic improvements, for example with the discovery of the tubercle bacillus in the 1880s, and restrictions on the unbridled practice of medicine by lay-people. Van den Berghe’s patients still could and would select from a variety of healing methods, home medicines and unlicensed practitioners. However, the behaviour of his clientele is not necessarily typical of the entire Ghent population. Unfortunately, the extent of other Ghent citizens’ experimentation in the medical marketplace remains unknown.

The therapeutic past of many of Van den Berghe’s patients demonstrate that they had ‘shopped around’ in the medical market, instead of clinging rigorously to one particular healing option. There did not exist one single ‘best buy’ for them. Van den Bergh recorded numerous stories of the earlier use of home medicine, consulting licensed practitioners, or applying for treatment by unlicensed or unorthodox healers. Occasionally, a patient let it be known that an appeal to God or the saints to be released from the suffering had been made. Yet, Ghent society displayed already strong signs of secularisation. Sufferers apparently had more faith in medical personnel, professional or otherwise, or self treatment, than in the Creator to combat disease despite some unique instances of renewed devotion, for example, with the outbreak of serious epidemics. It is also possible that patients deliberately never told Van den Berghe about their attempts with religious medicine. It is of significance that, notwithstanding the general perception and experience of orthodox medical treatment as being harsh and largely inadequate, the majority of Van den Berghe’s patients had made an appeal previously to practitioners in the field of professional licensed medicine. Many patients had allowed themselves to be bled or leechd on a large scale, even at the end of the nineteenth century.

Patients were active agents in their own healing process: the relationship between patient and doctor was largely patient-dominated and independent of the social status/class of the sufferer.

If a sufferer wanted to be treated by Van den Berghe, he could apply during the office hours that the homoeopathic physician had established. The consultation hours depended on social background; new well-to-do patients were welcome in a two hour period in the afternoon, new poor patients had one hour in the morning. Another indication of a differing patient-approach based on social class was found in the fees charged, in addition to the specific division in his office hours and the creation of two separate entrances. Patients were expected to contribute according to their income.

Nonetheless, the relationship that developed between patient and doctor was barely influenced by social background, except that gratis treated and, therefore, social-economic patients of lower status displayed a little more perseverance in their consultation behaviour. Experimentation with all types of
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treatment hardly changed after contact with Van den Berghe. Seventy per cent of the new patients would disappear from the practice within three months of the first consultation, more than twenty five per cent consulted his practice only once. The number of consultations and the period of treatment indicate that only a few truly or permanently committed themselves to this homoeopathic physician. Moreover, commitment to Van den Berghe or to homoeopathy is not evident from the attitude that the patients adopted during the clinical encounter.

Several studies on the doctor-patient relationship in the nineteenth century have argued that the balance of power between doctor and patient had changed by the end of the nineteenth century, as the doctor became 'the authority' and the patient turned into 'the admirer'. This research contests that assumption. Van den Berghe's patients were active agents during the clinical encounter. They exhibited a dominant attitude; if the treatment was considered insufficient or inadequate they would postpone or disappear from his practice. Van den Berghe dealt with self-confident patients who were only willing partially to turn over responsibility for their health. Patients did try to follow his orders on diet, or the way of taking the medication. However, if they felt that their health was not improving, suggestions were made easily for other treatments. Patients, at times, not only bluntly ignored Van den Berghe's prescriptions but also continued the use of other remedies or healers. He did not, or would ever, hold sole authority over them, and such self-willed ways of acting put them in command. This 'patient-domination' is clear from the patients' therapeutic histories, revealing the lack of trust in one type of treatment or healer and the custom of dealing with illness on a personal level, based on the advice of families and friends. Van den Berghe could not overcome this, nor could his orthodox colleagues who, at the end of the nineteenth century, still struggled to be the one and only medical authority. Sufferers were not yet impressed by the progress of orthodox medical science, they even complained about the treatment they had received previously and, thus, often continued to search for healing options outside of mainstream medicine.

Patients' choice in favour of homoeopathy or of Van den Berghe was seldom supported by a perceived 'likelihood of cure'. Van den Berghe, on the contrary, at times, was told directly that a patient doubted the efficacy of his treatment or disbelieved generally that recovery would ever be obtained. Yet, such sceptical honesty about his skills or admitting the continuing use of other remedies reflects, at the same time, a willingness to co-operate or an understanding of the necessity to co-operate or comply. The bulk of Van den Berghe's patients, in terms of number and period of consultations and behaviour whilst being in his care, cannot be portrayed as dedicated users of

28 Cf. Chapter 6, paragraph 4, 181-198.
homoeopathy and/or faithful patients of Van den Berghe. However, the group of patients that belonged to his clientele for over ten years were, if not wholly convinced adherents of homoeopathy, at least, highly committed to Van den Berghe.

The use of homoeopathy was seldom a deliberate choice, inspired by the wish for a holistic (more humane, softer, milder) approach to health, illness and healing. Other considerations predominantly influenced the decision-making process.

Nowadays, homoeopathic medicine is praised often by patients for being holistic, for the deep attention given to the patient in relation to their suffering. The sick person is not merely a defect machine, of which the symptoms are the sole sign. The patient consists of body and mind, one influencing the other, and, hence, a personal approach to the patient is employed to unravel the causes of the illness. Users of homoeopathy today often refer to this holism as the appeal of homoeopathy. The personal relationship with the homoeopathic physician or healer, who pays lengthy attention to psychological and individual circumstances, and also the relative mildness of homoeopathic medication compared with the supposed side-effects of biomedicine, persuades sufferers to try homoeopathy.

Van den Berghe’s casebooks offer a detailed insight into illness-experiences and body perceptions as well as into therapeutic careers. Yet, the particular and unequivocal motivations for seeking the help of homoeopathy and/or Van den Berghe are only occasionally seen. The extensive reasoning of the paths to homoeopathy and to Van den Berghe or the preference for this healing method necessarily had to be deduced from ‘circumstantial evidence’, probability, possibility and likelihood.

The nineteenth-century Ghent patients of the homoeopathic physician Van den Berghe, barely seem to have cared for the holistic aspects of homoeopathy. Patients, more women than men, regarded body and mind as one, as borne out by the accounts of patients explaining that emotional events had triggered off their physical suffering. Humoral pathology, thus, had not yet left the lay mind at the end of the nineteenth century. Illness occurred when the four body fluids (humores), blood, phlegm, yellow and black bile, corresponding with a sanguine, phlegmatic, choleric or melancholic temperament, became disturbed after, for instance, emotional upheaval. Health would be restored after the fluids had been re-balanced. Therefore, sufferers continued to endure the orthodox practice of bleeding and leeching. Van den Berghe’s patients had not sought systematically for practitioners who could attend to their psychologically/emotionally related bodily signs of illness, nor was this what they particularly looked for in Van den Berghe. The patients'
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'routes' to Van den Berghe were rather contingent; the decision-making process being influenced largely by other than holistic considerations.  

Patients' social networks, the advice of family, friends and neighbours, were raised often as the reasons for consulting Van den Berghe. This decision had been based, in some cases, on sheer coincidence. Moreover, the proximity of Van den Berghe's practice to where sufferers lived played a role. Geographic analysis revealed that his proximity influenced the decision to consult him, even within the city limits. Financial considerations for others, at times, lay at the basis of the decision, as Van den Berghe exempted the poor from payments and treated them pro bono.

Occasionally, a story was found of sufferers wishing to conceal their health problems and, therefore, consulted this homeopathic physician who practised outside the official medical circles. Patients, especially those having socially 'unacceptable' ailments, venereal disease or sex-related conditions (masturbation), at times, appear to have preferred some privacy.

Discontent with orthodox medicine was another reason for sufferers to consult Van den Berghe. Patients criticised orthodox medicine, allopathy as labelled by homoeopaths, and only had started to consult him after repeated, unsuccessful and often painful attempts with orthodox medicine. Nevertheless, being Van den Berghe's patient did not tend to change the attitude of 'I'll try whatever needed'. The 'shopping around' continued and many persisted in using self-medication or other therapies and healers. Occasionally, a patient turned into a true adherent.

Finally, patients had no deep knowledge of the medical concepts of the therapy being tried. As an example, an initial aggravation of the condition, meaning that the medicines are 'doing their job' in homoeopathy and that the homoeopath had prescribed the correct medication, was often responded to by the patient by postponing the treatment (not taking the drugs anymore) or by taking other 'allopathic drugs'. Although some had tried homoeopathy prior to consulting Van den Berghe, knowledgeable patients were the exception in his clientele. However, it was said that many working-class patients had read his book on homoeopathy, the only Belgian homoeopathic publication written in Dutch. The remarkable increase in the number of new patients after the book had been published in 1881 suggests that this induced sufferers to try homoeopathy. They were probably not impressed so much by the promises made for homoeopathy but rather by the criticisms of orthodox medicine, objections that many of them had experienced in person.

30 Cf. Sociologists Frank and Stollberg have come to the same conclusions in their studies on the motivations of German present-day users of Asian medicine (Ayurveda and acupuncture). Robert Frank and Gunnar Stollberg, 'Ayurvedic Patients in Germany', Anthropology and Medicine 9 (2002), 223-244; Robert Frank and Gunnar Stollberg, 'Medical Acupuncture in Germany - Patterns of Consumerism among Physicians and Patients', Sociology of Health and Illness 26 (2004), in print.

31 The research did not reveal the number of purchases by members of the working-class.
Yet, Van den Berghe as a true follower of Hahnemann strictly followed the rules for homoeopathic case-taking and, indeed, took into account the personal perceptions of the causes of and reasons for the affliction. He offered patients the opportunity and time to tell their life story and he listened attentively to them. Van den Berghe, in his opinion, could only obtain recovery in his patients, when all relevant details of bodily symptoms, psychological causes or results, personal situation and medical history were reviewed. Patients may not have labelled this approach as holistic, but they must have enjoyed or appreciated the time, compassion and interest Van den Berghe took in their entire being.

32 Except in the different number of office hours during which new affluent and poor patients could apply for treatment, Van den Berghe does not seem to have made other 'social' distinctions. The length of the files strongly suggests that time reserved per patient depended on the pressure of work and not on a patient's social status.