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Bodily Differences?: Gender, Race, and Class in Hans Sloane’s Jamaican Medical Practice, 1687–1688

WENDY D. CHURCHILL

Abstract. Despite the multitude of seventeenth- and early eighteenth-century British medical publications regarding empire and health, Hans Sloane’s *A Voyage To the Islands [off] Madera, Barbados, Nieves, S. Christophers and Jamaica* (1707) was the first to incorporate significant numbers of female and African patients among its printed case histories. Comprising some sixty-four pages of the introduction, this unique set of records affords scholars the rare opportunity to examine how patients (of both sexes and races, various ages, and all social levels) residing in a “torrid zone” were diagnosed and treated by an English physician during the 1680s. Sloane had expected to encounter illnesses vastly different from those found in England when he arrived in Jamaica, but after practicing medicine in Jamaica for over a year, he concluded that there existed very little difference in the manifestation of illnesses in different climates. Although some ailments were sex-specific and culture-specific, for the most part Sloane transgressed categories of gender and race by diagnosing and treating all his patients according to the same medical ideology. And although it did not directly challenge accepted medical views, Sloane’s *Voyage* revealed incongruities in dealing with such categories within the context of early imperial medicine. Keywords: Hans Sloane, Jamaica, early modern, medicine, medical practice, medical cases, patients, gender, race, class.

The late seventeenth and early eighteenth centuries witnessed an explosion of British publications on the health risks of empire and appropriate treatment regimes. Substantial, book-length analyses can be traced back to the encyclopedic *The Surgeon’s Mate* of John Woodall (1536?–1643), first published in

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However, a “hot climate” medical literature began with Thomas Trapham’s study of Jamaica, published in London in 1679. Within a single generation, by the end of the first decade of the eighteenth century, there existed a substantial body of influential treatises containing both medical theory and, in the form of fragmentary patient case histories, practice. These early studies initiated a powerful trend within the medical literature of the first British Empire, one that only intensified over the course of the eighteenth century. The early emphasis upon the diseases of the British Navy (at sea and in tropical locales) eventually expanded to embrace the armed forces and the recognition of the health challenges of particular geographical locations where Britons traded, settled, or sojourned. This literature has been described as “white, elitist, masculine, and state centred.”

Prior to 1800, women occupied an extremely modest position in this corpus of published research, perspectives, and opinions. When mentioned at all, their role was identical to that of African slaves: foils by which to better understand the disease history of young British males. There is only one exception to this trend in all of this literature, provided by a unique, and odd, publication: the record of the medical services provided by the youthful Hans Sloane (1660–1753) to the inhabitants of Jamaica in the years 1687–1688. Here alone, in this center-to-periphery medical literature, women

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5. Ibid.
are shown as patients. Indeed, Sloane’s records include women of both races, various ages, and all social levels. The case histories, and Sloane’s views on imperial medicine, have hitherto never been subjected to study, despite the fact that they provide an important perspective on the literature of empire at the beginning of a professional tendency that went, for over a century, in an opposite direction: Although Sloane argued that disease manifested identically in different climates (and bodies) and thus required the same treatment, the emerging orthodoxy held that environment was an important variable in the causation, manifestation, and treatment of disease.

**HANS SLOANE, M.D., AND HIS VOYAGE**

Sloane was twenty-seven years old when he arrived in Jamaica on 19 December 1687. Born in County Down, Ireland, Sloane was the youngest son of a receiver-general of taxation. He studied medicine at Paris and Montpelier, and in 1683, at the age of twenty-three, he received his medical doctorate from the University of Orange. During the next year, it appears that Sloane further studied and practiced throughout France before returning to London, where he was introduced through Robert Boyle (1627–1691) to Dr. Thomas Sydenham (1624–1689). The eminent physician, famous for his emphasis on bedside observation rather than the canons of medical theory, quickly adopted Sloane as his protégé, introducing and even recommending him to patients. Sloane was elected a fellow of the Royal Society of London in 1685. Two years later, he was created a fellow of the College of Physicians of London and traveled to Jamaica as the personal physician to the newly appointed governor, Christopher Monck (1653–1688), the second Duke of Albemarle. In addition to his professional responsibilities to the duke’s family, Sloane treated a large number of transplanted persons, including a substantial number of British and African women, during his fifteen-month


stay on the island. Many of these medical cases were printed in 1707 in the first volume of Sloane’s famed natural history, *A Voyage To the Islands [of] Madera, Barbados, Nieves, S. Christophers and Jamaica.* The work consisted of a lengthy introduction (that included geography, climate, wildlife, history, and the health and customs of the inhabitants), a narrative of the voyage, and a detailed catalogue of the Jamaican flora. Comprising some 64 pages of the 154-page introduction to the *Voyage*, Sloane’s case records—which were left largely unaanalyzed by Sloane himself—afford scholars the rare opportunity to examine how patients residing in an imperial location were diagnosed and treated by an English physician during the late seventeenth century. Sloane himself stated that he had treated “hundreds” of patients in Jamaica. He published the medical case histories of some 128 patients, of whom seventy-eight were male and forty-three were female. These patients covered the entire social (and racial) spectrum, from slave to governor.

**PURPOSE OF THE MEDICAL CASES**

In the preface to his *Voyage*, Sloane remarked that “[t]he first Volume contains an Introduction, giving an Account of the Situation, Temperature, Diseases, &c. of the Island, which seem’d necessary to be premis’d to the History itself.” The impetus behind incorporating


9. Prior to the 1707 publication of the first volume of *Voyage*, Sloane had published in several issues of the *Philosophical Transactions of the Royal Society of London* (see the sections “Theory and Method,” “Efficacy and Mortality,” and “Conclusion” in this article). He had also published a catalogue of the plants encountered during his voyage, which was entitled *Catalogus Plantarum quae in Insula Jamaica Sponte Proveniunt, vel Vulgò Coluntur, cum Earundem Synonymis & Locis Natalibus* (London: D. Brown, 1696).


11. Among these 128 patients, at least one female patient and one male patient were treated by Sloane more than once. Ibid., pp. cxvi, cix, cxx, cxx. For seven cases (all children), the sex of the patient is undeterminable. The total figure excludes Sloane’s account of his own medical treatment for a chigoe in his toe. Ibid., p. cxxxv. A chigoe is a painful ulcer caused by the distended female flea of the *Pulux or Sarcopsylla penetrans* species that has burrowed beneath the host’s skin in order to lay and hatch her eggs. *The Oxford English Dictionary*, 2nd ed. (hereafter *OED*), s.v. “chigoe.”

12. Sloane, *Voyage*, I, “The Preface” [p. 5]. I have retained Sloane’s italization as found in *Voyage*, with the exception of quotations from the preface (wherein the italicized and non-italicized words are the reverse in the treatise). I have also silently removed repetitious words from quotations whenever they functioned merely as markers between the end of one page and the start of another.
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the medical cases within the introduction to this volume is perhaps not as incongruous as it first appears, especially given that natural history and medicine were far from mutually exclusive pursuits during this period. Indeed, Sloane’s prefatory comments reflect how closely aligned these interests were in his mind; he declared that he had been “incited . . . to do what I could to be no useless Member [of the College of Physicians and the Royal Society of London], but to cast my Mite towards the Advancement of Natural Knowledge, and the Faculty of Physic, and by that means endeavour to deserve a Place amongst so many Great and Worthy Persons. . . .” Furthermore, he stated that the medical cases had been included in his natural history for two additional reasons. First, he wished to educate the inhabitants of Jamaica about the uses of various plant species, either indigenous to the island or imported from Europe, in order that “they may have recourse to them in Cases that require them.” He noted that it was difficult to bring over “such European Simples as are proper for the Cure of all sorts of Diseases,” since they often lost some of their efficacy and virtues in a different climate. He commented that the medical cases demonstrated how this observation had “puzzl’d” him. Sloane also stated that they had been included in order to provide clinical records that might prove useful to other medical practitioners in Jamaica. He alluded to a professional responsibility to provide other practitioners with his medical observations, based on first-hand experience in diagnosing and treating


16 Ibid. Similarly, Richard Ligon had argued that indigenous plants were more effective than imported plants in treating illness on Barbados; however, he attributed this to not only differences in climate, but also race. Richard Ligon, A True & Exact History of the Island of Barbados (London: Printed for Humphrey Moseley, 1657), p. 118.

17 Sloane, Voyage, I, “The Preface” [p. 3].
patients.\textsuperscript{18} This reference to public-service expertise was extremely common in the medical literature of empire.\textsuperscript{19} Prior to the publication of Sloane’s \textit{Voyage}, the few histories and medical treatises on the British West Indies had commented upon the types of illnesses encountered but largely failed to demonstrate precisely how to treat them.\textsuperscript{20} Sloane’s work is important because it was the first in British medical science to provide actual clinical observations in order to examine the illnesses of different races in a non-indigenous climate.

Sloane presented his medical cases at least in part as evidence to support his challenge to the developing notion that illness manifested differently in different climates. In those few instances in which differences were observed, he attributed them to variations in socio-cultural practices rather than directly to differences in climates or group complexions.\textsuperscript{21} Because Sloane was challenging an increasingly accepted idea, one that became intertwined in humoral theory, he required proof to substantiate his claim that the illnesses themselves were the same regardless of climate.\textsuperscript{22} This proof was presented in the form of medical case studies that illustrated the manifestation of the patient’s symptoms, Sloane’s process of diagnosis and course of treatment, and the efficacy of treatment.

\textbf{MEDICAL ENVIRONMENTALISM}

Early modern medicine was rooted in humoralism, based on the Hippocratic notion that the four elements of nature were represented in the human body by the humors of blood, yellow bile, phlegm, and black bile. Good health was achieved by maintaining a proper balance among these humors. According to this theory, the mental constitution, the physical body, and the environment all worked in conjunction with one another.\textsuperscript{23} The late seventeenth

\textsuperscript{18} Ibid., p. xc.

\textsuperscript{19} Alsop, “Warfare and the Creation.”

\textsuperscript{20} For instance, the tracts by Ligon and Trapham referred only briefly to treatment methods and excluded clinical evidence in the form of medical cases. Ligon, \textit{True & Exact History}; Trapham, \textit{Discourse}.

\textsuperscript{21} Complexion was a holistic concept that included, but was not restricted to, skin color; it was the particular disposition of a nation’s inhabitants that resulted from “the interaction of climate [especially air temperature and sun exposure] and the bodily humors. . . .” Roxann Wheeler, \textit{The Complexion of Race: Categories of Difference in Eighteenth-Century British Culture} (Philadelphia: University of Pennsylvania Press, 2000), pp. 2, 22–28.

\textsuperscript{22} Sloane, \textit{Voyage}, I, p. xc.

century witnessed a protracted revival of the Hippocratic emphasis upon the environment. There was an intellectual shift away from the Galenic theory that disease resulted from an imbalance between the individual body and its immediate environment, which was governed by the six non-naturals of air, diet, sleep, exercise, evacuations, and emotions. Due to its emphasis on disorder within the individual constitution, this approach did not sufficiently account for manifestations of endemic and epidemic diseases among populations. Thus, physicians and physicists began focusing more upon the Hippocratic notion that illness resulted from a conflict between the body and its environment in a wider sense—an external environment that encompassed the effects of climate, meteorology, geography, and topography.24 This was originally a development in English medicine, led by Sloane’s mentor Thomas Sydenham beginning in the 1660s, and further advanced by Bernardino Ramazzini and other influential continental theorists in the decades from 1690 to 1710.25 Sydenham initiated the first phase by underlining the importance of clinical observation over a strict adherence to the humoral theory of disease. Although he implicitly accepted the Hippocratic environment-disease relationship, Sydenham was more concerned with therapies than with etiological theories.26 It was the second phase of this developing ideology—represented by the continentalists—that began to narrow the meaning of environmental pathology toward “either a medicine of places or a medicine of climates.”27 By the end of this period, the doctrines of medical environmentalism were well established. They held that environmental changes due to shifts in seasons, atmosphere, weather, or location were capable of disrupting the balance of bodily health in an individual. Environmental conditions were thought to be responsible for “group diseases,” or a common pattern of illnesses among a population of people who resided

27. Ibid., p. 31.
in a specific geographical location. Shared events such as seasonal and climatic changes were believed to cause epidemic disease patterns, and although environmental medicine continued to view illness as a highly variable process, the emphasis on the role of the individual body became in good measure superseded by that of the societal body. Increasingly, eighteenth-century medicine became focused on the external environment rather than the internal disease. Thus, altering environmental characteristics became as important as the prescribed medications in the process of curing the patient. Despite this shift, the tenets of environmental medicine found no coherent statement until 1733. Although there existed an eighteenth-century presumption that such coherency was evident in Thomas Sydenham’s writings, the earliest manifestation was, in fact, the publication of John Arbuthnot’s *An Essay Concerning the Effects of Air on Human Bodies*. Before this date, there existed numerous, competing theories of disease causation.

**THEORY AND METHOD**

This may help to explain why, in 1707, Sloane published a treatise that rejected much of Thomas Trapham’s *A Discourse on the State of Health in the Island of Jamaica* (1679), which had emphasized the differences between the illnesses found in Jamaica and England. Trapham’s *Discourse* is important because it represents the first English publication on tropical medicine. It claimed that, due to climatic reasons, there were fewer ailments in Jamaica than in England. Moreover, those illnesses that were present in Jamaica tended to

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28. Ibid., p. 51.
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exhibit more benign symptoms. According to this notion of difference, Trapham’s treatise also advocated that differences in sex and race resulted in variations of disease etiology, implicitly suggesting that different medical treatments were necessary. On the other hand, Sloane argued that disease manifested identically in different locales and thus yielded to the same medical treatment. This applied not only to the white, male body, but to all types of bodies, regardless of race or sex. Sloane believed that illnesses presented the same symptoms in different bodies and, hence, they should all receive the same types of treatments. Following in the footsteps of Sydenham, Sloane predicated his methodology largely on observation rather than theory. He conveyed this inclination to a professional colleague with whom he disagreed over a Jamaican diagnosis. Sloane “desir’d him that we should put off talking of the Theory, and come to the Practice, that perhaps we might very well agree in the Medicines he [the patient] should take, as it very often happens to Physicians, who may disagree in the Theory, and yet agree in the Practice.”

While it is difficult to obtain a full view of a practitioner’s interest (or lack of interest) in theory from his case notes, it is important to remember that theory and practice were inexorably linked. Although Sloane relied more heavily upon the direct observation of the patient’s symptoms than on preconceived “theories” regarding treatment, he readily acknowledged that “observation” was far from being an objective process. In addition to the physician’s examination of the body, observation also incorporated the patient’s self-assessment of his or her illness. Hence, the symptoms and diagnoses offered by the patients themselves (or those of family, friends, or masters or mistresses),

and their expectations of specific cures, may have impacted Sloane’s perceptions of their illnesses and subsequent treatment regimens. Nevertheless, Sloane’s medical cases appear to have adhered to his approach to natural history, which, he believed, “being Observation of Matters of Fact, is more certain than most Others, and . . . less subject to Mistakes than Reasonings, Hypotheses, and Deductions . . . so far as our Senses are not fallible.”

It is clear that Sloane began his Jamaican voyage having been versed in the same humoral training as Trapham. Sloane’s questioning of the notion that variations in climate influenced the manifestation of disease, however, began immediately upon entering the tropical climate; his observation and treatment of diseases began aboard the ship and continued on land. His puzzlement over the role that climate played on health is evident in his discussions of “seasoning.” Sloane explained that “[a] great many were of opinion . . . that every New-comer before they be accustomed to the Climate and Constitution of the Air in Jamaica, are to have an acute Disease, which is thought to be very dangerous, and that after this is over, their Bodies are made more fit to live there, with less hazard than before.”

Although Sloane rejected the notion that an outbreak of “a very Epidemic continual violent Fever” was a manifestation of seasoning because it afflicted persons other than new arrivals and presented the same symptoms as it did in Europe, he entertained the possibility that seasoning might still exist: “If there be any such thing as Seasoning, the Itch or Pustules formerly mention’d must be it, the


alteration from cold to heat being by degrees done by the way, and that Symptom appearing on increase of the heat.”

Despite grappling over the external causation, however, he noted that “my Answers to such Complaints and Remedies were the same.”

In the end, Sloane’s work would be largely ignored by a growing body of medical publications that continued to advocate the increasingly accepted truism that extreme climatic change was dangerous to the health of the European body, which was accustomed to a more temperate climate. A sudden change in climate was believed to disturb the balance of the body’s humors, which resulted in illness. The heat of the tropics was thought to be particularly unwholesome. This argument was seemingly confirmed by the observation that British settlers often became ill when they migrated to tropical locales, including the West Indies. Exposed to the developing medical notion that race and climate were determinants and influences of bodily and mental health, Sloane began his account, entitled Of the Diseases I observed in Jamaica, and the Method by which I used to Cure them, with the statement: “I was told that the Diseases of this place were all different from what they are in Europe, and to be treated in a differing Method. This made me very uneasie, lest by ignorance I should kill instead of curing, and put me on trying with the utmost caution the Remedies and Methods I had known effectual in Europe, which in a very little time, I found to have great success on the Diseases there.”

Despite his admission, the young physician was not so hesitant as to alter his modes of treatment immediately upon arriving on the island. On the contrary, Sloane informed his readers of 1707: “at first, the Inhabitants would scarce trust me in the management of the least Distemper, till their observation of the good effects the European method had in the Duke of Albemarle’s numerous Family, in the same Diseases, brought them to make trial of what I could do with some of the meaner sort, accounted in desperate Conditions.”

40. Ibid., pp. xcvi–xcviii.
41. Ibid., pp. xciv–xcv.
44. Sloane, Voyage, I, p. xc.
But after practicing medicine in Jamaica for over a year, he concluded that there existed very little difference in the manifestation of illness in different climates.\textsuperscript{45}

Sloane may have printed the 128 case studies in order to challenge the developing continental doctrine of medical environmentalism, a novel idea to him in 1687 and still an unappealing one in 1707. If so, however, then the method selected was an unsatisfactory one, and this led directly to a lack of professional success in the endeavor because medical environmentalism had largely triumphed over its opponents by 1733. Although Sloane presented longer discussions of several diseases (i.e., malaria, intestinal worms, dysentery, and whooping cough), for the most part he merely presented his notes on the individual medical cases, offering extremely limited analysis or commentary. This approach was unlike that found in contemporary medical publications, which tended to include the presentation of patient cases only in the context of extensive discussion on the illnesses and treatments. The printed works of other practitioners, including William Cockburn (1669–1739), Thomas Sydenham, and Thomas Willis (1621–1675), included substantial, well-organized, and integrated analysis; the medical cases found in their treatises were selected for inclusion as illustrative examples for their thematically organized discussions on various types of illnesses.\textsuperscript{47}

Both the method and the function of the medical portion of Sloane’s introduction to the \textit{Voyage} drew sharp criticism at the time of publication. Writing anonymously, William King (1663–1712) considered these case studies to be a worthless, jumbled compilation that revealed no system and no medical philosophy. It was, he wrote, “more like a House–Wife’s Receipt Book, or as Physick was said to be in its first Age.”\textsuperscript{48} In addition to twice satirizing Sloane’s \textit{Voyage}, King also attacked Sloane’s editorial and authorial contributions.

\begin{itemize}
\item \textsuperscript{45} Ibid., p. xc.
\item \textsuperscript{46} Ibid., pp. cxxxiv–cxxxvi, cxv, cxxii–cxxiii, civ–cv.
\item \textsuperscript{48} Anonymous [William King], \textit{The Present State of Physick in the Island of Cajamai to Members of the R.S.} (London: n.p., 1710?), p. 4 (7 pp.). The only two extant copies are housed in the British Library: 551.a.9.(6.) and 117.1.60.
\end{itemize}
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to the Philosophical Transactions of the Royal Society of London due to his apparent lack of scientific method and editorial principles. It has been argued that Sloane held a laissez-faire attitude regarding the selection and editing of the Philosophical Transactions, which reflected his reliance on observation rather than theoretical explanations.

Apparently, it was not just King who disparaged Sloane’s work. In the introduction to the second volume of his natural history, published eighteen years later, in 1725, Sloane replied to three common criticisms of the medical contents of the first volume. First, he dismissed the accusation that he had been disrespectful by naming his patients and their illnesses in the printed medical histories. He stated that he had done so only “in ordinary Cases [that is, not in culturally sensitive afflictions], and to prove that the Diseases there were the same as in England.” Sloane argued that if he had not provided the names of some of his patients, this section of diagnoses would have been attacked as “an Hypothesis without Foundation. . . .” Furthermore, he added that his presentation of medical cases adhered to “the practice of all Physicians who write Observations.”

Second, Sloane denied the charge that he had been judgmental in reporting that the inhabitants often wore clothing made of canvas. (This assertion, albeit a seemingly trivial one, likely merited a rebuttal because it criticized Sloane’s skills of observation and analysis.)


50. T. Christopher Bond, “Keeping up with the Latest Transactions: The Literary Critique of Scientific Writing in the Hans Sloane Years,” Eighteenth-Century Life, 1998, 22:2, 1–17, pp. 2–7, 13–14. Although Bond and Maarten Ultee have argued that King’s satirical attacks were based on Sloane’s lack of method and editorial principles, Kay Dian Kriz’s work suggests that there may also have been cultural (and perhaps religious) issues at hand. Ibid., pp. 1–17; Ultee, “Sir Hans Sloane, Scientist,” pp. 1–20; Kriz, “Curiosities, Commodities, and Transplanted Bodies,” p. 65.


53. Ibid., p. xv.
Third, he rejected the contention that, in comparison to those residing in Jamaica, Sloane had “spoke[n] more honorably of the Inhabitants of Barbados in respect of their Civility.” However, he never addressed the most serious accusation: the lack of intellectual vigor and a coherent medical philosophy. As will be seen, there remained contradictions within Sloane’s thought, which perhaps prevented him from composing a systematic narrative in which the case histories could have been embedded, as opposed to a series of case histories with occasional asides and disconnected observations. It should also be noted that for an eminent practitioner who was president of the Royal Society (1727–41) and royal physician to George II (from 1727), Sloane published extremely little within his own discipline. He contributed numerous short papers to the Philosophical Transactions on various subjects, which included the use of Cortex Winteranus to treat scurvy, the remedy for the bite of a rabid dog, and the case of an ovarian dropsy. Nevertheless, his only full-length medical publication was An Account of a Most Efficacious Medicine for Soreness, Weakness, and Several Other Distempers of the Eyes (London, 1745).

STRUCTURE OF THE CASES

The structure of the individual case histories followed a general pattern. Each case was ordered according to some combination of the following criteria: 1) some identifying information for the patient, such as name, title, sex, relationship to another person (i.e., family member or employer), age, race, social status, or occupation; 2) the “naming” of the ailment; 3) a description of the symptoms; 4) the prescribed course of treatment; and 5) the efficacy of the treatment. This identifying information was far from formulaic; in some cases, nearly all the categories were included, while for others only a few were provided. One result is that the gender, race, and social status were not consistently identified by Sloane. For instance, one female patient who mistakenly believed that she was pregnant was described

54. Ibid., pp. xv–xvi.
simply as “One aged about Thirty five years. . . .”\(^5^6\) Several were identified by only their last names, such as a woman who was described simply as “One Evans. . . .”\(^5^7\) Others are almost completely anonymous, containing only details regarding the illness and sex of the patient, as in the case of “One—who had a Gonorrhoea often, and a pretty while before he complain’d. . . .”\(^5^8\) And there are seven case histories, all for children ranging in age from infancy to ten years, for whom Sloane did not identify the patient’s sex. He did not provide these particular patients with gender identities. Instead, Sloane used generic terms (such as “it”) to refer to his young patients. Nearly all the children under the age of ten were presented in this manner. As Table 3 illustrates, there were only two exceptions to this: two boys aged one and a half years and seven years. Due to the inconsistent information, it is particularly difficult to obtain a ratio for the number of black and white patients. It cannot be assumed that all servants belonging to plantation owners were black, for Sloane explicitly classified two such male patients as white.\(^5^9\) Moreover, blacks were not strictly engaged in harvesting the sugar crops. Richard Dunn has demonstrated that early eighteenth-century male slaves on St. Christopher held an array of occupations, including crafts such as “cooper, potter, mason, carpenter, smith, tailor, shoemaker, basket-maker, and pewterer.” Additionally, female slaves were employed as field hands or domestics with “specialties as cooks, laundresses, and seamstresses.”\(^6^0\) It appears that this diversity of occupations also existed in late seventeenth-century Jamaica, as Sloane described several black males as plantation overseers, doctors, and footmen.\(^6^1\) He also recorded black women who were employed in their master’s household, in either domestic service or child care.\(^6^2\) Thus, while socio-economic indicators may be suggestive, they cannot be used to definitely determine the race of Sloane’s patients. Due to the fact that the meaning of abbreviated modes of address

\(^5^6\) Sloane, *Voyage*, I, p. cxl.
\(^5^7\) Ibid., p. cxl.
\(^5^8\) Ibid., p. xcii.
\(^5^9\) Ibid., pp. xcvii, cxii. In addition, he also discussed black and white servants on pp. xxxi, cxli.
\(^6^0\) Dunn, *Sugar and Slaves*, p. 319.
\(^6^1\) Sloane, *Voyage*, I, pp. xcix, cxxii, cxxi. Sloane also treated a turner and a tailor, described as “belonging to Colonel Nedham.” These two men may have been black, but white servants were also described as “belonging” to plantation owners. Ibid., pp. xcvi, cxxix.
\(^6^2\) Ibid., pp. cvii, cxiv.
such as “Mr.” and “Mrs.” were undergoing a transformation during this period, they can present problems when attempting to calculate social or marital status. Nevertheless, it does appear that Sloane chose to employ these titles to denote persons of at least some social standing. As such, it is possible to provide a loose estimate of the socio-economic status for ninety of Sloane’s patients, of whom twenty-eight were female and fifty-nine were male. As Table 2 illustrates, twenty women were from the professional or gentle social orders, while eight (of whom at least five were black) can be classified as belonging to the laboring, manual, or service sectors. It is not possible to identify the socio-economic background of the fifteen remaining women; however, the fact that Sloane did not provide titles or names (or gave only their last names) implies that many of these female patients belonged to the lower orders. By way of comparison, thirty-one male patients were from the professional or gentle social orders, while twenty-eight men belonged to the laboring, manual, or service sectors. Although it is not possible to determine the socio-economic category for nineteen males, the paucity of identifying details suggests that many of them were from the lower social orders.

Although it is not clear what criteria Sloane used to select the 128 patient cases for inclusion in his Voyage, it is certain that these particular records were chosen from a greater number of cases. As Table 4 illustrates, the published cases include thirty-one treatments that terminated in the death of the patient (twenty-two males, seven females, and two patients of undeterminable sex), as well as a small number that concluded in an indeterminate fashion. Sloane claimed that eighty-five of his patients (66.9 percent of his cases) were cured, showed marked improvement, or recovered from their illnesses (see Table 4). Several cases involved relatively minor afflictions, such as sprains, ringworm, “scabby or scall’d head,” and pubic lice. And although he included very few case histories for intestinal worms,

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63. For more on this, see n. 245 of this article.
64. For this article, I have followed Lucinda McCray Beier’s approach for determining social class among seventeenth-century patients; that is, to interpret “Mrs.” and “Mr.” as denoting patients of a higher social rank than those without such modes of address in front of their names. Lucinda McCray Beier, Sufferers and Healers: The Experience of Illness in Seventeenth-Century England (London: Routledge & Kegan Paul, 1987), pp. 9, 55, 112–13, 120, 123–24.
66. Ibid., pp. cxxv, cxcviii, cxxxiii, cliii.
scalds, bruises (both inward and outward), and sore eyes, Sloane commented that he had frequently treated patients for these ailments. There were numerous repetitions, as in the twenty-six occurrences of intermittent fevers (malaria), the nine cases of “the belly-ach,” and the eleven venereal cases. In some instances, it appears that Sloane intentionally grouped similar types of illnesses together into sections. For instance, he presented several sequential cases for epidemic continual fevers, gastro-intestinal ailments, intermitting fevers, and “dissembled” (or feigned) illnesses. However, this organization does not appear to hold together for the entire set of case histories. Although Sloane did not consistently include treatment dates, the pattern for those dates provided suggests that he generally presented the cases in chronological order. While Sloane undoubtedly treated more than the 128 patients represented here, we have no reason to believe that these published case histories do not reflect important features of Sloane’s Jamaican practice.

It is useful to compare Sloane’s case histories to the only other model for published medical case studies in the genre of British imperial medicine disseminated prior to 1707. These were the sixty-three case histories of afflications and illnesses treated by Dr. William

67. Ibid., pp. cxv, clii, cl, cxxi, cxxxii.
68. Ibid., pp. xcix, cvii, cx, cxxxvi, cxxxvii, cxli, cxxi, cxxxvi, cxxxv, cxlix, cxlv, cxxvii, cxliii, cxxxvi, cxxxvii, cxlv, cxxvii, cxxxvi, cxli.
69. Ibid., pp. xxvii, cxx. See the sections “Structure of the Cases” and “The Roles of Socio-economic Status and Age in Treatment” of this article for a detailed examination of gender, race, and class among these patients. Those patients suffering from dry bellyache were probably experiencing lead poisoning acquired from drinking rum that had been distilled with lead equipment. Dunn, Sugar and Slaves, pp. 306, 309; Kenneth F. Kiple, “Part VII: The Geography of Human Disease, Section VII. 6. Disease Ecologies of the Caribbean,” in The Cambridge World History of Human Disease, ed. Kenneth F. Kiple et al. (Cambridge: Cambridge University Press, 1993), 497–504. p. 501.
70. These venereal cases included pubic lice, yaws, gonorrhea (also referred to as “clap”), and “pox” (possibly syphilis). Sloane treated three females and eight males for venereal disease. Sloane, Voyage, I, pp. cxxx, cxxxvi, cxxxvii, cxxxviii, cxxvii, cxxxviii, cxxxvii, cxxxviii, cxxxvi, cxxvii, cxxxvii, cxxxviii, cxxxiv, cxxxv.
71. Ibid., pp. xcvi–xcvii.
72. Ibid., pp. cxxviii–cxxx.
73. Ibid., pp. cxxxiv–cxxxv.
74. Ibid., pp. cxxi–cxl. Sloane identified black—and white—male servants as well as pregnant women as persons who frequently feigned illness.
75. Sloane was in Jamaica from December 1687 until May 1689. The dated cases were January 1688 (ibid., p. xcvii), February 1688 (ibid., p. xci), ñana January and February 1688 (ibid., p. civ), February 1688 (ibid., p. cxxvii), 18 February 1688 (ibid., p. cxxxvii), 18 March 1688 (ibid., p. cxxxvii), 22 March 1688 (ibid., p. cxxxix), and 24 December 1688 (ibid., p. cxxvii).
Cockburn in the British Navy from 1695 to 1696, at the end of the Nine Years War. Like Sloane, albeit unlike most writers on overseas medicine, Cockburn was a physician, not a surgeon. The comparison is therefore an instructive one. Cockburn received his doctorate at Leyden in the early 1690s, became a Licentiate of the College of Physicians in 1694, and in the same year was appointed as one of the first physicians to the English fleet. Like Sloane, he was a Fellow of the Royal Society of London. In addition to remarking on the victuals and lodgings of seamen, Cockburn’s treatises contained substantial analysis of two main disease categories: scurvy and fever. These comprised the masculine pattern of sea diseases of the age. The range of the case histories that Cockburn published from his naval practice was far more restricted in terms of gender, race, social class, and age than those subsequently published by Sloane. Not unexpectedly, all sixty-three observations pertained to male patients. The records, however, did not accurately represent the range of patients in wartime naval medicine, as they tended to showcase socially prominent men. Cockburn’s collection of cases focused primarily upon fevers (twenty-nine cases; at least seven of these were classified as intermittent), gastro-intestinal disorders (fourteen cases), and “head” diseases (four melancholic cases and one occurrence of “apoplexy”). There were also several instances of venereal disease (three cases) and respiratory ailments (three cases); the remaining illnesses each represented only one or two patient cases. Sloane’s male patients were diagnosed with the same types of afflictions. The largest category of

76. Cockburn, Account of the Nature; idem, Continuation of the Account. There are nineteen cases included among the discourse in the 1696 treatise, while there are forty-four cases in the 1697 treatise.
79. The one instance in which Cockburn mentioned a female patient was his discussion of fevers, in which he cited a case from Dr. Thomas Willis’s work. Cockburn, Account of the Nature, p. 96.
80. Alsop, “Warfare and the Creation”; Cockburn, Account of the Nature; idem, Continuation of the Account.
81. These calculations are based on the primary illness(es) for which the patient was initially diagnosed and treated by Cockburn. (For further explanation, see n. 132 of this article.)
82. These remaining illnesses are scurvy, dropsies, “Iliac Passion” (colic), quinsies (severely sore throat), and “yellow jaundice.” Cockburn, Continuation of the Account.
complaints was fevers: nineteen cases (two mortal), of which thirteen were malarial (two mortal). Sloane also treated thirteen men for stomach illnesses: two for “Cholera Morbus” (one mortal), seven for the bellyache (two mortal), three (no mortal) for “oppression[s] at the Stomach,” and one (mortal) for “Vomiting and Looseness.” Among this group, there were at least six white men (three identified by “Mr.,” one by “Dr.,” and two by “Captain”) and one black man; it is also probable that two of the six remaining men were white. Sloane attributed seven of these thirteen gastro-intestinal cases to intemperate drinking of alcohol; of these seven, four died.

There were six women who suffered from gastro-intestinal illnesses: two were treated for Cholera Morbus, two for the bellyache, one for “a great Oppression, or Lump at her Stomach,” and one for “sickness at Stomach.” Although the race of one woman remains undeterminable, it is possible to comment on the remaining five; one woman was clearly identified as black and four others are assumed to have been white and of some social standing (one gentlewoman and three others bearing the title “Mrs.”; all four constituted the cholera and bellyache cases). None of these female patients died; three of the six cases were attributed to immoderate alcohol consumption.

83. For the malarial cases, refer to Sloane, *Voyage*, I, pp. xci, c, cxiv, cvii, cxxviii, cxxxi, cxxxvi, cxxxvii, cxdv. For other fevers (including those classified as continual, epidemic, or hectic), see ibid., pp. xciv, xcv, cvi, cxxiv, cli.
84. Ibid., pp. xc, cxliv. Because Sloane did not provide additional commentary (as he did for the bellyache), it is unclear exactly what he meant by this term. Nevertheless, he appears to have applied it to cases involving violent bouts of vomiting and diarrhea; three of the four cases were attributed to excessive alcohol consumption. Historically, there has been much confusion surrounding the use of this term; however, it is now widely acknowledged that pre-nineteenth-century references were not caused by the *Vibrio cholerae* bacterium that results in epidemic Asiatic cholera. Reinhard S. Speck, “Part VIII: Major Human Diseases Past and Present, Section VIII.27: Cholera,” in *The Cambridge World History of Human Disease*, 642–49, especially pp. 642–43; Roderick E. McGrew, “Cholera,” in Roderick E. McGrew, *Encyclopedia of Medical History* (New York: McGraw-Hill, 1985), 59–64, especially pp. 59–60; *OED*, s.v. “cholera.”
86. Ibid., pp. cxxix–cxxx.
87. Ibid., p. cxi.
88. Ibid., pp. xc, cv, cviii, cxxix–cxxx, cxxxvi.
89. Ibid., p. cxxviii.
90. Ibid., pp. cxxvi, clii.
91. Ibid., pp. cxxi, cxxv.
92. Ibid., pp. cxxvii–cxxix, cxlv.
93. Ibid., p. cxvii. The race and social status of this woman are undeterminable.
94. Ibid., p. cxxxi. This woman was identified as a black servant.
consumption. It is also interesting to note that although scurvy was seen among Cockburn’s seamen, it is wholly absent among Sloane’s Jamaican patients—both men and women. This was likely due to the fact that Sloane’s patients were able to include a wider variety of fruits, vegetables, roots, and berries in their diets; such indigenous foodstuffs would have been largely unavailable to Cockburn’s patients while they were at sea.

In addition to a necessary focus upon male patients and a smaller range of “complaints,” Cockburn’s cases were also organized differently than those of Sloane. Cockburn grouped together all patient cases that exhibited the same symptoms. The entire set of cases was itself presented as an adjunct to the more detailed discussion of the manifestation and progression of the illnesses; the cases, thus, provided supporting evidence for his earlier analysis. They reveal the individual complexities of symptoms and treatment. Overall, Cockburn was much more descriptive than Sloane in his explanation of his patients’ symptoms, including detailed observations such as pulse rate. Cockburn frequently recorded the exact number of pulsations per minute; most of these observations are located among his fever cases. By comparison, Sloane commented only briefly on pulse rate in eight cases (all of which pertained to male patients, one of whom was black). Although the majority of these instances were fevers, two involved consumptions, one was an apoplectic case, and one was related to a feigned illness. This variation in the two sets of physicians’ records likely arose from the fact that Cockburn or his assistants were close at hand aboard ship, with a clientele subject to naval discipline. This meant that, unlike Sloane, he did not rely as heavily upon the patients’ own descriptions of their symptoms; instead, Cockburn used the opportunity to make first-hand observations. Although Sloane emphasized clinical observation, he—like the majority of seventeenth-century medical practitioners—also placed much weight upon obtaining information from his patients (or their family, friends, or

95. These consist of one case of Cholera Morbus (see n. 91 of this article) and both cases of bellyache (see n. 92 of this article).
96. For instance, see ibid., “The Preface” [12 pp.], “The Introduction” (especially pp. i–lxxix, cxx, cxxviii). Although Sloane’s “Introduction” does not contain any diagnoses for scurvy, the volume includes a number of scorbutical preventatives in the main section of the book. Ibid., pp. 193, 212, 249.
masters or mistresses). In fact, the significance of this component of the patient-practitioner relationship is revealed in Sloane’s comment on the difficulty of treating infants due to their inability to verbalize their symptoms: “tampering with Physick too much with Children, where the Disease is not plain, being not safe, they not being able to inform the Physician of their Malady, but by forwardness and crying.”\(^98\) It is also supported by his remark that patients who feigned illnesses were exposed during questioning by their physicians.\(^99\) Despite the differences between the two sets of patient records, the information contained in each of Cockburn’s cases followed the same general pattern as those presented by Sloane: name, position/title, ship, age, date, constitution, symptoms, course of treatment, and efficacy of treatment. Like those contained in Sloane’s *Voyage*, these details were not consistent. Full names, occupations, and exact dates were not always provided; in this regard, both physicians followed customary seventeenth-century British practice. This comparison, therefore, establishes two separate points. First, it demonstrates that Sloane’s chosen focus upon unanalyzed case histories was atypical of his own age (thus, in good measure, warranting King’s criticism), while Cockburn’s inclusion of substantial case discussions that exemplified requisite treatments for specific illnesses represented the more conventional approach among casebooks published during this period.\(^100\) Second, it indicates the importance of a data set that extended far beyond the afflictions of the routine patient in published treatises, the British sailor. It is instructive that Cockburn became the recognized authority on early eighteenth-century imperial medicine,\(^101\) while Sloane’s views lay obscured in the pages of a lengthy prelude to a work on natural history.

\(^{98}\) Sloane, *Voyage*, I, p. cxlviii. This appears to have been a common view concerning the treatment of infants. Walter Harris expressed the same concerns in his *An Exact Enquiry into, and Cure of the Acute Diseases of Infants*, trans. William Cockburn (London: Printed for Sam. Clement, 1693), pp. 2–3.


\(^{100}\) For instance, published medical works that incorporated analyzed case studies include Richard Morton, *Phthisiologia, seu, Exercitationes de Phthisis Tribus Libris Comprehensae* (London: Samuelis Smith, 1689); Willis, *London Practice of Physick*; Martin Lister, *Sex Exercitationes Medicinales de Quibusdam Morbis Chronicis* (London: S. Smith & B. Walford, 1694); Sydenham, *Whole Works*. Also refer to the discussion in the first paragraph, the section “Theory and Method,” and n. 3, 47 of this article.

Despite the lack of completeness of the records, a number of generalizations can be made about Sloane’s medical information and the presentation of that information. Based on the ratio of seventy-eight male patients to forty-three female patients, Sloane treated a significantly larger number of men than women. This is not altogether surprising; in all the emerging West Indian colonies of the late seventeenth century, European men outnumbered women. Indeed, the prevalence of male patients among Sloane’s records is consistent with the gendered demographics among white settlers and black slaves in seventeenth-century Jamaica. At the time of Sloane’s visit, Jamaica had a plantation economy with a predominantly black population. Although he appears to have categorized the majority of his patients as being either “Europeans, Indians, [or] Negroes,” he also referred to others as “Mulatto.” Due to the inconsistent nature of the information presented in Sloane’s records, it is not possible to present precise ratios regarding the race of his patients. Nevertheless, of the 128 persons represented in the case records, the racial profile of only seventy-four can be identified (see Table 1); of these, eighteen were black (thirteen men and five women) and fifty-six were white (thirty-three men, twenty women, and three patients of undeterminable sex). In addition to treating patients of both sexes and races, we also know that Sloane treated persons of all ages. He prescribed for newborn infants, children, adolescents, adults, and the elderly; his youngest patient was a four- to five-month-old baby, and his oldest patient was a woman aged seventy. Sloane provided the approximate ages for eighty out of his 128 patients, of whom fifty were male and twenty-four were female. With the exception of children and young adults, the majority of those patients’ ages provided by Sloane were estimates, not exact figures, which he rounded


103 Dunn, Sugar and Slaves, pp. 312–14.

104 For instance, Sloane, Voyage, I, pp. lxi, xxxii, xxxvi, xlv, cxxvii, cxxvi. Sloane’s use of the term “Indians” referred to the Amerindi ans who were originally brought to Jamaica from Florida as Spanish slaves. Ibid., p. xlii; Kriz, “Curiosities, Commodities, and Transplanted Bodies,” p. 51.

105 Although few patients were explicitly labeled as “white,” it is generally assumed that those persons with titles (i.e., “Sir,” “Mr.,” “Lady,” “Mrs.”) preceding their names were white.

106 Sloane, Voyage, I, pp. cii, cxxv.
to the nearest multiple of five.\textsuperscript{107} As Table 3 illustrates, the mean age range for Sloane’s patients was forty to forty-nine years. Sloane listed the approximate ages for just over half of his female clientele; most of these patients were between thirty and fifty-nine years of age, with the largest group represented by women who were approximately thirty to thirty-nine years old.

Sloane frequently included the occupation of male patients, while he identified female patients by their relationship to either their husbands, their fathers, or less often their mothers. Only two women, a laundry maid and a household servant who attended children, were associated with a specific type of work; four others were classified simply as slaves or servants.\textsuperscript{108} Although Sloane himself did not directly attribute the illnesses of any of his female patients to occupational hazards, it is likely that the laundry maid’s case of “the itch” was related to her work: It may have been an allergic reaction to using lye soap or a contagious parasitic skin ailment—such as scabies—transmitted through contaminated laundry.\textsuperscript{109} Although Sloane commented that he treated common injuries such as bruises and burns,\textsuperscript{110} wounds resulting from accidents are noticeably absent from the female cases. On the other hand, Sloane’s male cases include a larger number of occupational illnesses and accidental injuries. Sloane treated a twelve-year-old black boy who had sprained his knee “by leaping off a high place. . .”\textsuperscript{111} Male patients with occupation-related illnesses or injuries included: Reverend Leming, who was plagued by respiratory ailments because “in preaching [he] used to strain his Lungs so much”;\textsuperscript{112} Anthony Gamble, a forty-five-year-old cook who had suffered from colic ever since he had been shot in “his right Hypochondre” during “an Engagement with some Turkish ships” several years earlier;\textsuperscript{113} a cooper whose sternum was broken, or at least depressed,

\textsuperscript{107} This vagueness may have been partially due to the fact that many patients themselves were uncertain about their own ages. Dunn, \textit{Sugar and Slaves}, pp. 330–31; Keith Thomas, “Age and Authority in Early Modern England,” \textit{Proc. Br. Acad.}, 1976, 62, 205–48.

\textsuperscript{108} Sloane, \textit{Voyage}, I, pp. cxxiv, cxiv.

\textsuperscript{109} This “Pruritus or Itch” covered her entire body in “small little whales” but were especially concentrated between her fingers. Ibid., p. cxxiv.

\textsuperscript{110} Ibid., pp. cli, cl.

\textsuperscript{111} Ibid., p. cxxv.

\textsuperscript{112} Ibid., p. cxlv.

\textsuperscript{113} Ibid., p. xci. The right hypochondre (or hypochondrium) is the abdominal area that lies on the right-hand side of the body, directly underneath the ribcage and alongside the epigastric region. \textit{OED}, s.v. “hypochondrion.”
when he was kicked by a horse;\textsuperscript{114} and a turner who had cut down a "Mansanillo" tree when its poisonous milk spurted into his eye, resulting in soreness and inflammation that lasted for three days.\textsuperscript{115} In comparison to his female patients, Sloane’s male patients also sought treatment for more accidental overdoses, poisonings, misuse of medications, or improper treatments. Although there were four such occurrences among Sloane’s male patients, there was only one such case among his female clientele.\textsuperscript{116}

Efficacy and Mortality

In almost every case, Sloane indicated—to the best of his knowledge—his perception of the efficacy of his treatment. He clearly noted those instances in which he was unable to comment on the efficacy due to having lost contact with the patient. As Table 4 illustrates, Sloane claimed that the majority of his patients—85 out of the 128 patients (66.4 percent)—were better following his treatment. These patients were cured, they recovered, or at the very least, their symptoms showed marked improvement. Sloane credited this success to the fact that “people had a belief that I could help them, and submitted to the taking Remedies in the order they were prescribed without changing the Medicines, altering the Method, or judging harshly in case the Person died.”\textsuperscript{117} Meanwhile, four patients (3.1 percent) showed either very little or no discernable improvement, one patient grew worse (0.8 percent), and thirty-one patients died (24.2 percent). The outcome for the remaining seven patients (5.5 percent) is unknown. The breadth of Sloane’s efficacy suggests that these cases are fairly representative of his practice; it does not appear likely that Sloane’s selection of cases for \textit{Voyage} was overly prejudiced toward successful treatment. It does appear, however, that efficacy statistics were gendered. Of those eighty-five patients who emerged well from treatment, forty-eight were men (56.5 percent) and thirty-two were women (37.7 percent). These figures translate into 61.5 percent of male patients and 74.4 percent of female patients within this category. Male patients, however, also appear to have comprised the largest group of those patients who died; men

\textsuperscript{114} Ibid., p. cxvii.
\textsuperscript{115} Ibid., p. cxx; Sloane, \textit{Voyage}, II, p. xii; \textit{OED}, s.v. “manchineel.”
\textsuperscript{116} Sloane, \textit{Voyage}, I, pp. xciii, cxxv, cxxi, cxxvii, cxxix.
\textsuperscript{117} Ibid., p. xc.
represent 71 percent, while women represent only 22.6 percent (see Table 5).

Of the seven deaths among Sloane’s female patients, only one was directly attributed to childbirth complications; this woman died as a result of “flooding,” or a uterine hemorrhage, during a premature delivery.118 One death was attributed to “an apoplectick Fit.”119 Three of the deaths were fever-related; two of these cases were clearly connected to malaria120 and the third case was probably the result of either puerperal sepsis or typhoid fever.121 Another patient, a seventy-year-old woman, succumbed to “Age, and weakness” following Sloane’s successful treatment of her urinary incontinence.122 There was at least one death for which Sloane was uncertain about the cause. This was an “old, very weak and Paralytic” woman whom Sloane was treating for pain, insomnia, and difficulty walking. The woman died approximately one month after mysteriously developing symptoms that closely resembled those generated by a course of salivation. Interestingly, although Sloane suggested that the salivation might have been due to mercury poisoning induced—either accidentally or intentionally—by the patient’s “Negro Woman,” he did not directly attribute her death to this suspected overdose. He stated that he did not know “of what, or how” this woman had died.123

Sloane’s medical cases indicate that dropsy was the leading cause of death among his male patients (six cases).124 In fact, all of these dropsical cases were mortal, including “a complicated Disease of the Dropsie, Consumption and Pox.”125 Sloane attributed the majority of these cases (five out of six) to the patient’s excessive drinking, venery, or keeping late hours.126 In comparison, none of his female patients were diagnosed with dropsy, although it was often cited as

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118. Sloane, Voyage, I, p. cxxxii.
119. Ibid., p. c. An apoplectic fit is a sudden attack (apoplexy or stroke) that impairs neurological functions in a patient, often resulting in loss of speech, unconsciousness, and paralysis. OED, s.v. “apoplexy.”
120. Sloane, Voyage, I, pp. cxlix–cl (this death may have been due to the bloodletting administered to treat a pleurisy that followed the malarial fever), cli.
121. Ibid., p. cxvii.
122. Ibid., p. cxxv.
123. Ibid., p. cxxi.
124. Ibid., pp. xcviii, c, ci, cxxii, cxxxiii, cxlix. In addition to these six cases, there was one male patient whom Sloane diagnosed with “an Hectic, call’d in Jamaica a Dry Dropsie.” Ibid., p. cli.
125. Ibid., p. ci.
126. Ibid., pp. xcviii, c, ci, cxii, cxxxiii, cxlix. See also ibid., p. xxxi.
an illness that was common to women. Sloane later published a paper on a case of ovarian dropsy for the Philosophical Transactions. It is difficult to determine precise mortality figures and causes for Sloane’s cases because many of patients died while simultaneously suffering from (and being treated for) more than one illness. Although statistical analysis based on a small number of records must be approached cautiously, the mortality numbers for Sloane’s patients are suggestive (see Table 5). In total, there were thirty-one deaths, which represented approximately 24.2 percent of all patients; of these, 17.1 percent were male and 5.5 percent were female. The ratio of deaths among the male patient group was significantly higher than that of the female patient group: Approximately 28.2 percent of Sloane’s male patients died, while only about 16.3 percent of female cases terminated in death. Although differences in clothing, labor, and migration patterns between males and females offer several possible explanations, the gendered morbidity and mortality rates cannot be sufficiently accounted for here. Nonetheless, the higher mortality figure for Sloane’s male patients is consistent with statistics cited elsewhere for seventeenth-century British West Indies.

THE NATURE OF FEMALE ILLNESS

The most common type of primary affliction among Sloane’s forty-three female patients was fevers (twelve cases), with malarial fevers

128. See n. 55 of this article.
129. Riley has argued that this may help to explain the high mortality figures for the seventeenth and early eighteenth centuries. He proposed that high mortality coincided with high morbidity, resulting in “a morbidity complex, a situation in which epidemics and diseases in general overlapped one another, and in which secondary infections played a large part in immediate and deferred mortality.” Riley, Eighteenth-Century Campaign, p. xiv.
130. See Dunn, Sugar and Slaves, pp. 3–4, 41, 239, 241, 263–64, 267, 281–86, 317, 326–27. For a discussion of the reasons for gendered morbidity, efficacy, and mortality rates among seventeenth-century casebooks, see Wendy D. Churchill, “Female Complaints: The Medical Diagnosis and Treatment of British Women, 1590–1740” (Ph.D. diss., McMaster University, Hamilton, Ontario, 2005). And although information regarding the race of these patients is extremely incomplete (out of the twenty-two deaths, the race of sixteen patients is unknown), the number of deaths among Sloane’s patients may have exceeded that of black patients. Out of those fifteen mortality cases in which race can be identified, there were fourteen white patients and only one black patient. This suggestion of higher mortality among whites than blacks appears to be consistent with the findings of Trevor Burnard in his “The Countrie Continues Sicklie: White Mortality in Jamaica, 1655–1780,” Soc. Hist. Med., 1999, 12, 45–72.
representing the majority (ten cases). There were also skin ailments that included erysipelas (St. Anthony’s Fire), pruritus (scabies), and chigoes and respiratory illnesses such as asthma and pleurisy. Sloane also treated his female clientele for Cholera Morbus, venereal disease, and age-related weakness. Only ten of Sloane’s printed cases involved female-specific ailments of either a gynecological or obstetrical nature (as either primary or secondary symptoms). At first glance, this seems to be a relatively small portion (approximately 23.3 percent) of the total number of female patients; nevertheless, it represents over half (approximately 55.6 percent) of those women who can be identified as being of childbearing age (see Table 3). This category included two cases in which there was a danger of miscarrying, three cases involving irregular menstrual cycles, one postmenopausal woman, two instances involving uterine hemorrhages or ruptures, one woman who unsuccessfully attempted to induce an abortion, and one case in which a woman mistakenly believed she was pregnant.

Among these gynecological disorders was the case of Mrs. Duke, a thirty-five-year-old patient who was suffering from painful and irregular menstruation. During the time of her menstruation, she experienced “intolerable pains in her Belly and Loins, with a great press downwards, so that sometimes she had a Suppression of her Menses, and at other times a Procidentia uteri.” Sloane attempted to induce menstruation by prescribing phlebotomy, purges, steel courses, and uterine stimulants of pennyroyal decoctions. When this course of treatment failed to elicit any improvement, he attempted to administer her bleeding and purging immediately prior to the time of her expected menstrual cycle. But when this too failed to alleviate

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132. In most instances, the primary afflictions are regarded as the main illness(es) diagnosed and treated by Sloane (and, generally, for which the patient first sought medical consultation) and by which he categorized the cases in the marginal notations.

133. For a definition, see n. 11 of this article.

134. This percentage is calculated by including the eighteen women who were listed in Table 3 as between ten and forty-nine years of age. Sloane often provided their ages in approximate terms: two were described as “about” twelve years (Sloane, Voyage, I, pp. cvii, cxxxiii), one “about” fourteen years (ibid., p. cxx), one “about” twenty-five years (ibid., p. cxxxvii), one thirty-five years (ibid., p. cii), eight women “about” thirty-five years (ibid., pp. cxxi, cxxiv, cxxv, cxxxii, cxxxi, cxxi, cix), and five women “about” forty years (ibid., pp. cxxi, cxxiv, cxxv, cxxxii, cxxi). If the three youngest females (who, although they may have begun to menstruate, were probably not sexually active due to seventeenth-century social customs and mores), are excluded from the calculation, then the percentage increases to approximately 66.7 percent.

135. Ibid., pp. cii, ciii, cxxiv, cxxvi, cxxvii, cxxxii, cxxi, cxi, clix. If the three youngest females (who, although they may have begun to menstruate, were probably not sexually active due to seventeenth-century social customs and mores), are excluded from the calculation, then the percentage increases to approximately 66.7 percent.
her symptoms, Sloane suspected that his patient might be pregnant and, thus, “proceeded no farther.”

Sloane’s discussion of this particular case reveals several aspects of his medical philosophy about menstruation. In this instance, he appears to have presented menstrual pain and irregularities—including suppression—as a symptom, rather than a cause, of illness. In reflecting upon Mrs. Duke’s case, he added that “[t]is very ordinary to have before, or at the beginning of the Catamentia, these Symptoms, especially when the sick Persons are out of order, have receiv’d any injury in Childbed, or are troubl’d with the Fluor albus.” Sloane dismissed the efficacy of popular methods such as “… Chalybeat and Bath Waters,” stating that he had observed no improvement in several patients who had attempted this cure. Instead, childbirth was the best remedy for this type of illness because “the Vessels about the Uterus being thereby distended, and afterwards their Pains are less.”

Although Sloane considered stoppages in menstruation to be symptomatic of illness or injury, he also believed that they could produce diseases. This dual view regarding menstruation (that it could be seen as both a cause of disease and a symptom) is consistent with seventeenth-century British medical practice. His assertion that “many Diseases in Women” were caused by the obstruction of the menses was consistent with the Hippocratic belief that the womb was responsible for innumerable female ailments. This was illustrated through the case of Dr. Rooks’s wife, whom Sloane treated for blindness due to a suppression of menstruation. In order to induce her menstrual cycle and, hence, restore the proper flow of humors, Sloane prescribed bleeding, blistering, purging, and a steel-electuary (a chalybeate medicine of iron fillings taken in powder mixed with some type of syrup) that contained “Cephalicks” (medicines to relieve disorders of the head). He also recommended ingesting up

136. Ibid., p. ciii.
to 100 live millipedes (woodlice) per day.\textsuperscript{143} This course of treatment was believed to remove the obstruction responsible for the patient’s menstrual suppression and vision loss.\textsuperscript{144}

Sloane appears to have proceeded more cautiously in prescribing medications to induce menstruation (or miscarriage) than some other Jamaican practitioners. One thirty-five-year-old woman, who thought she was pregnant even though she was afflicted by violent pains and menstrual flow, had been prescribed “... Trochisci de Myrrha, and other very forcing Medicines” by several physicians.\textsuperscript{145} Sloane, however, advised her to take bitter wine to settle her stomach, but no other medicine. Instead, she was instructed to wait “patiently to expect the event.”\textsuperscript{146} She did so and soon began to menstruate, showing that “she was better, not with Child, and pretty well.”\textsuperscript{147} Sloane also treated women throughout their pregnancies and often continued to do so following the birth of the child. He prescribed phlebotomy, bed rest, and an “easie Hypnotick” of liquid laudanum for Mrs. Fletcher when she was in danger of miscarrying during the second trimester.\textsuperscript{148}

As a disciple of Sydenham, Sloane placed more emphasis on clinical observation than on medical theories. This is particularly evident in his rejection of the “notions of some Ancient Physicians” that espoused that infants born to mothers who menstruated throughout their pregnancies were likely to be unhealthy because they had been “defrauded of its Nourishment while in the Belly.” Sloane observed that “contrary to this Opinion,” one such baby had been born “as lively and brisk as any.”\textsuperscript{149} It should be noted, however, that although Sloane rejected this particular theory based on his own first-hand observations, he continued to maintain others precisely because he encountered supporting (or, at least, not contradictory) evidence in


\textsuperscript{144} Sloane, \textit{Voyage}, I, p. civ.

\textsuperscript{145} Ibid., p. cxl.

\textsuperscript{146} Ibid., p. cxl.

\textsuperscript{147} Ibid., p. cxl.

\textsuperscript{148} Ibid., p. cii.

\textsuperscript{149} Ibid., p. cii.
his practice. In fact, Sloane had treated the baby’s mother (Mrs. Fletcher, see above) for her continued menstrual cycles because he feared that she was likely to miscarry. This treatment was consistent with the notion that menstruating women were more prone to miscarriages because they shed the blood necessary for fetal development.\textsuperscript{150}

Despite Sloane’s fears, Mrs. Fletcher carried her pregnancy to full term and bore a seemingly healthy baby. Five months later, however, the infant became “emaciated very much, did not sleep, and was always froward [sic] and crying.” Sloane initially attributed this illness to the quality of the wet nurse’s breast milk, but when the child languished (and died) despite changing its nurse, he blamed the mother’s “\textit{Plethoric, or other Constitution}.” This remark appears to reflect Sloane’s questioning of his original observation that the mother’s continued menstruation during pregnancy had not hampered the infant’s health. The excess menstrual blood was believed to nourish the unborn baby, thus accounting for the absence of regular menstrual cycles (and the onset of morning sickness) during pregnancy, as well as the appearance of lochial discharge and lactation following childbirth.\textsuperscript{151} Sloane obviously regarded this patient as unhealthy, commenting that regardless of his efforts to procure a remedy, she “had her \textit{Menses} as regularly as when well.” The inconsistency here is the result of Sloane’s reliance on observation; he did not always have an alternative theory at hand to explain the conflicting signs. It was the “variety in this case” that caused Sloane to re-examine the relationship between menstruation, pregnancy, and disease.\textsuperscript{152}

Interestingly, Sloane’s Jamaican female cases do not include chlorosis, or greensickness, which was a common medical diagnosis for young women of menstruating age.\textsuperscript{153} These patients may have been suffering from anemia or anorexia nervosa, their skin possibly exhibiting

\textsuperscript{150}. King, \textit{Hippocrates' Woman}, p. 90.
\textsuperscript{152}. Sloane, \textit{Voyage}, I, p. cii.
\textsuperscript{153}. The lack of such diagnoses in this section of \textit{Voyage} is likely due to demographics; simply put, few virgins or young widows appear among Sloane’s Jamaican cases; the majority of his female patients seemed to have been middle-aged, likely married, women (see Table 3). See also n. 102, 245 of this article.
a pale yellowish or greenish tinge.\textsuperscript{154} Greensickness, a condition that sixteenth-century (and subsequent) authors claimed dated back to ancient Greece, was believed to be caused by the uterus’s retention of the female “seed” in the menstrual blood.\textsuperscript{155} One of the suggested treatments was marriage, with its solutions of sexual intercourse and childbearing. (Such treatment courses were often prescribed to remedy uterine obstructions or disorders; see Mrs. Duke’s case above.) Thus, it followed that maids and widows—two groups of females who fell outside the circle of acceptable sexuality due to their unwed status—were believed to be most prone to this disease.\textsuperscript{156} The fact that Sloane did not include any such diagnosis among his published records for the medical observation section of his \textit{Voyage} is curious. He did, however, include a brief section in his description of the illnesses encountered on the island of Madera en route to Jamaica.\textsuperscript{157} At the request of the abbess, Sloane visited “the Nunnery of the Order of Santa Clara,” where he treated the majority of nuns for chlorosis, attributing the large number of cases to “their Single, Melancholy, and Sedentary” lifestyles.\textsuperscript{158} Rather than excessive behaviors, it was a paucity of activities—specifically, exercise and sexual intercourse—that suppressed menstruation, thereby resulting in chlorosis as well as “several [other] kinds of . . . Diseases.”\textsuperscript{159} Sloane first prescribed phlebotomy with the aim of “avoid[ing] the danger


\textsuperscript{157} Sloane, \textit{Voyage}, I, pp. 13–14. These cases lie outside the bulk of Sloane’s medical observations, which appear as a separate “Introduction” to his natural history and pertain only to Jamaica. For this reason, although I have drawn upon the Madera evidence within the text of my article, I have chosen to exclude these few cases from my statistical calculations.

\textsuperscript{158} Ibid., p. 14.

\textsuperscript{159} Ibid. See also Sydenham, “An Epistolary Discourse to the Learned Doctour William Cole, concerning some Observations of the Confluent Small-pox, and of Hysterick Diseases,” in \textit{The Whole Works}, 404–78, p. 461.
there might be from too much Blood, it generally abounding in Persons thus Diseased.” 160 He followed this by ordering a course of vomits or purgers to accompany “a Steel Course, with Exercise.” 161 Unfortunately, Sloane did not record the outcome of these treatments, since he departed after examining “most of those Sick in this place.” 162 It is not remarkable that the nuns represent the only group of women whom Sloane diagnosed with chlorosis. The demography of Sloane’s Jamaican patients was such that there would likely have been very few young, unmarried women (virgins) and widows; most were middle-aged (see Table 3). 163 Thus, the Madera nunnery likely housed the largest number of unwed female patients to whom Sloane attended on his travels through the West Indian islands of Madera, Barbados, Nieves, St. Christopher’s, and Jamaica. The inclusion of this patient group is important because it indicates that, despite its exclusion from the Jamaica cases, Sloane indeed diagnosed and treated for chlorosis, a female illness that was frequently recorded during the seventeenth century. 164 The paucity of Jamaica cases may have also been partly due to Sloane’s belief that women residing there generally experienced scantier and shorter menstrual cycles than they did in Europe, which appear to have been attributed to cultural, rather than climatic, differences. 165

The chlorosis cases in Sloane’s Voyage are of interest, in part, because Thomas Trapham examined greensickness in his Discourse. Based upon his belief that climate influenced bodily health, Trapham postulated that the female body was healthier in Jamaica because women’s cold, moist humors flowed more easily in the tropical heat than in colder locales. 166 He claimed that “the Green Sickness and accumulated evils flowing thence, the benign female moon in her direct approximation rescues that whole sex remarkably from, as well as assists and facilitates births: So that scarcely is there room left for the old cry

161. Ibid.
162. Ibid.
163. See also n. 102, 153 of this article.
165. Sloane, Voyage, I, p. cxxxii. See also further discussion in the section “Reconciling Ambiguities within the Voyage” of this article.
166. Trapham, Discourse, pp. 13, 69.
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(Lucina fer opem) Births proving as brisk as all other Produces in the Indies do.”167 According to Trapham, the womb (and thus, female illness) was eased by the climate; for the same reasons, he also believed that venereal disease was more readily cured in Jamaica than in Europe.168

THE FEMALE BREAST AND DISEASE TRANSMISSION

Sloane’s discussion of the female breast is particularly useful in exploring the intersection between gender, race, and health in his work. Sloane advised two female patients, both ill with intermitting (malarial) fevers, to wean the infants they were nursing because disease could (in his view) be communicated in this manner.169 He observed that children were often infected with “... Pustules, breakings out, &c.” by nurses who drank excessively.170 Sloane proceeded cautiously in his treatment of nursing women. This was due not only to his perception of disease transmission, but also to a concern regarding the possible effects that his prescribed treatments could have on both mother and child.171 He administered the Peruvian bark (cinchona) to one female patient who was breast-feeding only after several other treatments had not procured an abatement of her malarial symptoms.172 On the other hand, he generally prescribed the bark to his male patients and menstruating female patients as soon as a fever had established itself as malarial.173


168. Trapham, Discourse, p. 69.

169. Sloane, Voyage, I, pp. cxxxi–cxxxii, cxxxvii. He also suggested that diseases such as “Lues Venerea” could be communicated from mother to child, adhering to the contemporary theory regarding neonatal disease transmission. Aristotlian in origin, it held that disease could be transmitted to an unborn baby through the mother’s menstrual blood, which was thought to nourish the fetus and explain the absence of regular menstrual cycles. Ibid., pp. cxx–cxxi; Athenian Mercury, Tuesday, 9 June 1691, 2, 5 question 18 (fol. verso); Willis, London Practice of Physick, p. 622. See also King, Hippocrates’ Woman, pp. 34–35, 69, 90, 96, 134, 143, 218.


171. Ibid., p. cxxxii.

172. Ibid., p. cxxx.

173. Ibid., pp. xci, xcix–c, cvii, cviii, cxiv, cxxi, cxxii, cxxiv, cxxvi, cxxvii, cxxxvii, cxxviii, cxxix, cxxx.
Despite his acceptance of disease communication, Sloane nevertheless rejected the prevailing idea among planters that breast-feeding could transmit bad habits from one race to another: “Blacks are as often taken for Nurses as Whites, being much easier to be had. They are not coveted by Planters, for fear of infecting their Children with some of their ill Customs, as Thieving, &c. I never saw any such Consequences, and am sure a Blacks Milk comes much nearer the Mothers’ blood and hence the quality of their milk. It also appears that these beliefs were in alignment with the increasing number of contemporary treatises that encouraged mothers to nurse their own children.”

Although the mother’s own breast milk was best, breast milk from nurses—either white or black—appears to have represented the next best option, since the milk was produced in a human body.

In his account of the childbearing customs of black women, Sloane remarked that “[t]he Mother when she suckles her young, having no Cloths to keep her Breasts from falling down, they hang very lank ever after, like those of Goats.”

Despite this observation regarding differences in socio-cultural practices, Sloane does not appear to have treated black women different medically from white women. Sloane easily conceded that there were strong differences among the social customs of blacks and whites. Unlike their black counterparts, white

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women were expected to be fully clothed at almost all times, regardless of the climate.\textsuperscript{177} Nevertheless, in keeping with his view that neither climate nor geography impacted the manifestation of disease or its requisite treatment, Sloane also implicitly rejected the possibility that “complexion” denoted group racial differences (such as skin color), which influenced diagnosis and treatment; instead, he tended to employ the term to describe the state of individual constitutions (as reflected in their countenances).\textsuperscript{178}

Sloane’s medical support of two male patients who “suck’d” the breast milk of black women is also revealing of his attitude toward race. Prescribing breast milk as part of internal or external medical remedies was commonplace throughout the seventeenth century. Due to both its nourishing properties and the fact that it was easy to digest, breast milk was often administered to feeble adult patients—usually the very ill or aged—as a means of rejuvenating their strength and vitality.\textsuperscript{179} One of Sloane’s patients who had received this treatment was forty-year-old Captain Nowel, who was “Cholerick” and suffered from a lack of appetite, a looseness of the bowels, and persistent vomiting (diagnosed as “Cholera Morbus”). Sloane reported that the only substance that Nowel could digest was “the Milk of a Negro Woman he suck’d.”\textsuperscript{180} In another case, a fifty-five-year-old male patient had received the breast milk of two black women in order to restore both his strength and the use of his limbs after several fits of the bellyache.\textsuperscript{181} Although these men had taken the breast milk either before or after being treated by Sloane, Sloane does not appear to have considered this course of treatment as inappropriate.\textsuperscript{182} As these


\textsuperscript{178} Sloane, \textit{Voyage}, I, pp. xciii, xcv, cv, cviii, cxi, cxxvi, ccxxix, ccxxviii, ccxiv. The one exception is found on p. xviii.

\textsuperscript{179} For more on the magical and medicinal properties ascribed to breast milk, see Michael O’Dowd, \textit{The History of Medications for Women: Materia Medica Woman} (New York: Parthenon Publishing Group, 2001), p. 164.

\textsuperscript{180} Sloane, \textit{Voyage}, I, pp. xc–xci.

\textsuperscript{181} Ibid., p. clix.

\textsuperscript{182} It is interesting that Sloane’s cases do not include any instances of adult women who were administered breast milk, despite the fact that it comprised “part of the materia medica for women from ancient times until the eighteenth century.” O’Dowd, \textit{History of Medications}, p. 164.
examples demonstrate, it was the disease history of the lactating woman that was at issue, not her race. Sloane did not assign any inherent biological weakness to the black female body. Instead, he viewed it, and hence treated it, essentially the same as the white female body.

Further evidence that Sloane considered the bodies of black and white women as functioning in the same manner is found in his discussion of the Fluor Albus. This common gynecological ailment—often referred to as “the whites” (leucorrhoea)—was found in both England and Jamaica; it was typified by a white vaginal discharge and back pain and was sometimes symptomatic of venereal disease. Sloane stated that he was usually able to cure both white and black women through the same method: an infusion of Madera wine and the roots of several herbs (including angelica), a drink administered several times a day but without permitting the patient to evacuate it via urination, defecation, or vomiting. Nor is there any suggestion that he would have prescribed differing amounts of these medicinal ingredients depending upon the patient’s race. Sloane’s discussion of female-specific ailments such as the Fluor Albus suggests that race did not play a significant role in his medical practice, since he diagnosed and treated white and black women according to the same criteria.

THE ROLE OF “RACE” IN BEHAVIORS, BODIES, AND MINDS

There is little evidence to suggest that Sloane ascribed to the view that the “black body” (either male or female) of transplanted African slaves was more accustomed (through seasoning) or physiologically suited (due to their group complexions) to the tropical climate of Jamaica than the “white body” of British residents and sojourners; instead, Sloane believed that differences in health arose primarily from socio-cultural variables such as clothing, housing, and diet. For instance, he observed that the health of white European settlers, in comparison to that of “Negros and Indians,” who were “almost naked,” was disadvantaged because they failed to adapt their clothing to the tropical Jamaican climate. Similarly, he remarked that “[t]he Houses built by the English are for the most part Brick, and

185. Ibid., p. xlvii.
after the *English* manner, which are neither cool, nor able to endure the shocks of Earthquakes.” Concerning the varying degrees of health among “several sorts” of “Negros,” Sloane noted that those who came from Guinea were considered to be “the best Slaves, [while] those from the *East-Indies* or *Madagascar*, are reckoned good enough, but too choice in their Diet, being accustomed in their own Countries to Flesh Meat, &c. and do not well here [in Jamaica], but very often die.” Winthrop Jordan, Mary Floyd Wilson, and Roxann Wheeler have demonstrated that such cultural variables were as important, if not more so, as physical features in identifying and gauging racial differences during this period. This helps to explain how Sloane could simultaneously maintain that human physiology and disease etiology remained constant regardless of climate and race, while also portraying black Africans as less civilized than white Britons. In Sloane’s opinion, health was not dependent upon the suitability of innate racial characteristics to the climate, but upon the ability to adapt one’s behavior (which hinged upon socio-cultural beliefs) to the immediate environment. In the final analysis, it was the patient’s individual response and constitution, rather than group complexion, that was the determining factor in one’s bodily health.

Sloane’s explanations represented a departure from previous writers, including Edmund Hickeringill (1631–1708) and Trapham, who believed that climate and race influenced disease manifestation. Like Sloane, they believed that temperance was central to preserving the health of Britons in Jamaica; however, unlike Sloane, they subscribed to the notion of “seasoning,” which was the process...
whereby new inhabitants were acclimatized to their new environment through acute illnesses (such as dysentery or malaria).\textsuperscript{191}

In 1660, Captain Edmund Hickeringill had published a forty-four-page pamphlet titled \textit{Jamaica Viewed} that discussed the suitability of Jamaica for "[white] English Complexions."\textsuperscript{192} His notion of seasoning simultaneously provided a justification for slavery and reassurance that transplanted Britons could enjoy good health in Jamaica: "[t]he Major part of the Inhabitants being old \textit{West-Indians}, who, now \textit{Naturalized} to the Country, grow the better by their Transplantation, and flourish in Health equivalently comparable to that of their \textit{Mother-Soil}."\textsuperscript{193} Hickeringill asserted that this was due to the lack of an endemic "\textit{Country Disease}" and, moreover, declared that Jamaica did not possess "any new and unheard of Distempers that want a name."\textsuperscript{194} Although he explicitly dismissed the argument that climate and geography resulted in high mortalities among English settlers, he also observed that "the Native Indians are not sensible to such extraordinary \textit{warmth} [of the climate]."\textsuperscript{195} Regardless of his claims to the contrary, then, such comments serve to further demonstrate Hickeringill's belief that climate and group complexion influenced bodily health (and, thus, the necessity of seasoning).

Trapham also held that group disposition, due to its relationship with constitution and climate, influenced the manifestation of disease. He argued that although the "English Temperament" was "unsuitable to the torrid Zone," the negative effects of climatic change upon health could be lessened or prevented by altering customs (especially food and drink).\textsuperscript{196} And like Hickeringill, Trapham made distinctions regarding the healthiness of "new comers from the colder Europe" and "more antient inhabitants."\textsuperscript{197} He depicted Amerindians and Africans as "animal People" who were inherently more susceptible to venereal disease than white Europeans because of "the unnatural mixture of humane with brutal seed" that had resulted in "their
infirmity of Body and Mind.” 198 He further argued that “the old sower stocks of Venereal affects [were] most plentiful” among these two groups of people, who had “[brought] forth the monstrous Yaws as a proper Stock to engraft a new cion of Disease.” 199 This biological explanation lent itself to a rationalization of slavery: “the Black may well become naturally Slaves, and the vast Territories of the Indians be easily invaded and kept in subjection by inconsiderable force of the Spanish Tyranny.” 200 Although Sloane had noted the prevalence of the notion that the cure for venereal disease was more efficacious in Jamaica than Europe, he believed that both the symptoms and the requisite treatments were the same among “... Europeans, Indians and Negroes.” 201

Although social and cultural distinctions between the two groups were clearly portrayed in Sloane’s medical remarks and case studies, he did not racialize illness based on perceived physiological differences between whites and blacks. Rejecting the notion of “Seasoning,” Sloane observed that during the “Dog-days” of summer, everyone, regardless of whether they were “antient Inhabitants, or new Comers,” found it to be unbearably hot. 202 In his opinion, all bodies, regardless of sex or race, responded in the same manner to the same set of environmental conditions. For this reason, Sloane also dismissed the notion that Jamaica’s hot climate increased the sexual libido of his patients: “it is thought by some Men, that they are bewitch’d or charm’d by the Air; by others that that desire in Women by this heat is Augmented, but I believe neither, for what I could find by several People this Appetite is the same as in other places, neither are men more bewitch’d or charm’d here than in Europe.” 203 It was not the background—gendered, racial, or geographical—of the patient, but rather his or her behavior that resulted in illness. 204 Any behavior in excess had the potential to disrupt the delicate balance of the bodily humors. This meant that food, drink, sexual activity, and exercise

198. Ibid., pp. 117, 120 (see also pp. 110–22).
199. Ibid., p. 113.
200. Ibid., p. 117.
202. Ibid., p. x. Also refer to the section “Theory and Method” of this article.
203. Ibid., p. xxxi.
were all to be enjoyed in moderation.\textsuperscript{205} Although this dictum generally applied to males and females as well as to blacks and whites, there were cultural tendencies within these social behaviors. Sloane presented his white patients as more prone to alcohol-induced disease and psychological illnesses, while he considered his black patients to be more inclined toward lustful behavior.\textsuperscript{206} However, these were not mutually exclusive categories; Sloane’s case records show that he treated black patients for psychological disturbances such as madness, and white patients for illnesses such as dropsies (swellings due to fluid build-up) and eye ailments, which he attributed to excessive venery.\textsuperscript{207}

Sloane proposed that white people—both men and women—were more prone to debauchery through their indulgence in excessive alcohol consumption. He observed that “Negros, Indians, Mahumetans, and a great part of Mankind know not the use of this Wine of vinous Liquors, and yet look fresher, and are much healthier than we.”\textsuperscript{208} When treating one woman who suffered from pains in her stomach and throughout her body, as well as paralysis of her hands and feet, Sloane instructed her to abstain from drinking wine. Despite the fact that he believed that her illness was caused by “. . . Wine, Punch, and Vinous Liquors,” she refused to stop drinking and claimed that “her Stomach was cold, and needed something to warm it.”\textsuperscript{209} Sloane also cited two cases of men suffering from “Mania” brought on by excessive drinking.\textsuperscript{210} In general, white settlers were thought to be more inclined toward psychological illnesses than their non-white counterparts, due to their social customs. Sloane wrote that, in this respect, “the Indians, who are not covetous, nor trouble themselves about many things we do, have much advantage of us.”\textsuperscript{211} Sloane clearly believed that there was a strong relationship between mental state and bodily health. Sloane believed that in order to cure his patients effectively, it was important that they first settle their “Wills, Minds and

\textsuperscript{205} Sloane also noted instances in which his patients had ignored medical instructions, thereby worsening the illness or impeding the cure. For example, Sloane, \textit{Voyage}, I, p. xxvi.
\textsuperscript{206} Kriz has also noted this. Kriz, “Curiosities, Commodities, and Transplanted Bodies,” pp. 65–68. Examples from Sloane to follow in the body of this article.
\textsuperscript{207} Sloane, \textit{Voyage}, I, pp. ciii, cxxiv–cxxv, xxxi, cxxxii, cxxxiii, cxxxiv.
\textsuperscript{208} Ibid., p. xxvii.
\textsuperscript{209} Ibid., p. cxl.
\textsuperscript{210} Ibid., p. cxliv.
\textsuperscript{211} Ibid., pp. xxxi–xxxii.
Affairs.”\textsuperscript{212} It was thought that persons (presumably white) “as every where else, who had been of bad Lives, whereby their minds are disturb’d,” were more difficult to cure than those who had “sedate Minds and clear Consciences.” As such, he also ascribed the cause of several diseases to the fact that “[t]he Passions of the Mind have a very great power on Mankind here [in Jamaica], especially Hysterical Women, and Hypochondriacal Men.”\textsuperscript{213} The death of one male patient (“Isaac, belonging to the Crawle Plantation”) resulting from “an ill opinion of his Health and Melancholy” demonstrated to Sloane how “both Hope and Fear, have a very great influence on the Body.”\textsuperscript{214} Rather than emphasizing the variations in the manifestation of psychological disorders in different climates, these comments served to underscore the similarities between the English and Jamaican contexts; contemporary medical treatises depicted the “passions of the mind” as afflicting persons residing in England in much the same manner as Sloane did for those persons residing in Jamaica.\textsuperscript{215}

\textbf{THE “DISEASES OF THE HEAD, NERVES, OR SPIRITS”}

Sloane also diagnosed and treated his patients (male and female, as well as black and white) for a category of mental or emotional dis-tempers, described as “… Diseases of the Head, Nerves or Spirits.”\textsuperscript{216} This included four women, nine men, and four patients of undeterminable sex. Of the women, one female patient suffered from “a Lethargy, inclining to an apoplectick Fit,” another was prone to hysterical fits, one black woman was labeled as mad, and the fourth female experienced “giddiness in the Head.”\textsuperscript{217} The nine male cases consisted of one black man who was either “mad or uneasie,” two men diagnosed with mania, three who suffered from melancholia (one of which accompanied “a sleepy Disease”), one who complained of vertigo, and one labeled as lethargic and apoplectic.\textsuperscript{218} In addition, there was one morose and ill-natured male patient who

\textsuperscript{212} Ibid., p. xxxi.
\textsuperscript{213} Ibid., p. xxxi.
\textsuperscript{214} Ibid., pp. cxxx–cxxxii.
\textsuperscript{216} Sloane, \textit{Voyage}, I, pp. cvii, cxiv.
\textsuperscript{217} Ibid., pp. xcvi, c, cix, cxiv, cxvi.
\textsuperscript{218} Ibid., pp. ciii, cxiv, cxxx–cxxxii, cxxxviii, cxvi, cli, cxxxix–cxl.
suffered from vomiting and diarrhea, labeled by Sloane as "phrenic." Although Sloane linked only one female case to excessive alcohol consumption, he attributed four of the male cases to this behavior. Of the four patients of undeterminable sex, all of whom were children under the age of ten (see Table 3), one suffered from vertigo, two from "Convulsion Fits" (of which, one was accompanied by an intermitting fever), and one from lethargy in the form of "a sleepy Disease."220

This classification of illnesses included hysterical fits, hypochondriacal fits, and mania. Despite contemporary medical tracts—such as Thomas Willis's The London Practice of Physick—which asserted that men, as well as women, could be afflicted with hysteria, Sloane deemed it to be an exclusively female disorder.221 On the other hand, he considered hypochondriacal fits to be more particular to men, while he appears to have interpreted madness as a disease that could affect patients of either sex.222 For instance, one female patient had fallen into a series of violent "... Hysterical Fits, with a Looseness, and incoherent Fancies" and "Chimera's in her thoughts" following the death of her son.223 Sloane began her treatment by prescribing an aromatic liquid and smelling salts, in the hope that "the Sensories might be the more irritate, and the Fits taken off."224 She was also dosed with opium and administered a steel course.225 Another patient, a black woman named Rose, was treated by Sloane for madness with scarification, blistering, purges, juleps, and mercury, all methods he commonly used in treating white men and women for diseases of the head.226 Sloane further indicated that neither gender nor race influenced his treatment when he commented that Rose was "very hard, as all mad People are, to work on."227

219. Ibid., p. cxliii.
220. Ibid., pp. cxxx, cix, c.
223. Ibid., pp. xcvi, cix–cx.
224. Ibid., p. xcvi.
225. Ibid., pp. cix–cx.
226. Ibid., pp. ciii, cix–cx, cxxxi, cxliv.
227. Ibid., pp. cxxv–cxv.
Although Sloane viewed his black patients as less prone to psychological illnesses, they were frequently portrayed as lustful. Sloane appears to have applied the term “lusty” only to black persons, women as well as men. He stated that blacks were “much given to Venery, and although hard wrought, will at nights, or on Feast days Dance and Sing; their Songs are all bawdy, and leading that way.” In fact, Sloane observed that Jamaican inhabitants were “more debauch’d than in England, the Consequences may be more taken notice of; and I am apt to think that a great many Dropsies may come from this, nothing depauperating the Blood like excessive Venery.”

Although Sloane’s case records demonstrate that white men, including gentlemen, could also be guilty of excessive venery, this was usually in conjunction with drinking. The implication was that alcohol, and not their personal appetites, was the root of such behavior.

Sloane’s belief that his black patients tended to be more licentious than his white patients was reflected in his observation that "Gonorhoeas of all sorts amongst Men and Women are very common here [in Jamaica], especially in Plantations amongst Negroes." Although he attributed disease causation to behavior, he dismissed the notion that disease—once manifested in the body—could present different symptoms and progression; he continued: "[t]hey complain first of the great heat of their water, &c. and have the same Symptoms as in Europe." Thus, regardless of the perceived differences between the social bodies of his black and white patients, they were diagnosed with identical illnesses and administered the same treatments. This implies that Sloane largely dismissed the notion that there was a connection between the medical body and the social body. Although he believed that particular social behaviors could result in specific illnesses, this did not translate into different types of medical treatments. Sloane viewed the medical body of men, women, whites, and blacks as functioning in the same manner and thus required the same remedies to cure them. For instance, although he considered

228. Ibid., pp. xxxi–xxxii.
229. Ibid., p. cxxvii. There was also one “Lusty Woman” whose race is not identified. Ibid., p. cxxvii.
230. Ibid., p. xlviii.
231. Ibid., p. xxxi.
232. For instance, ibid., pp. cxxxiii, cxlix.
233. Ibid., p. cxxviii.
234. Ibid., p. cxxviii.
blacks to be more lustful in their behavior than whites, he provided the same treatments—fluxing and salivation—for venereal disease in men and women of both races. When he first arrived in Jamaica, Sloane had adhered to “the generality of the World” in his belief that “… Gonorrhoeas and the Pox, are with more ease, and sooner, cured in Jamaica and hot Countries, than in Europe.” However, once he observed that gonorrhea manifested identical symptoms among persons of different races, Sloane concluded that identical remedies and length of time were required to cure it. Furthermore, he claimed to have “never failed the Cure of any, either Man or Woman” by prescribing the same purges, vomits, and emulsions. It appears, then, that for Sloane, the treatment of disease could—and should—transcend gender as well as race.

Sloane appears to have assigned blacks and whites into one collective patient group that was diagnosed and treated in the same manner, based on the humoral theory of the body. He treated one female slave for watery ulcers on her fingers, toes, and joints, which destroyed the flesh and eventually rotted off her fingers and toes. He had been informed by slave owners that this “strange Disease” was specific to blacks. In keeping with his rejection of climatic and race-specific illness, Sloane appears to have been apprehensive about accepting this statement. But after several unsuccessful courses of treatment by salivation, Sloane himself wondered if this ailment was indeed “proper to Blacks” and resulted from “some peculiar indisposition of their black Skin.” Nevertheless, he proceeded to treat this woman in the usual manner by preparing an ointment to apply to the diseased parts. Even while grappling over whether or not this woman’s illness was related to her race, Sloane employed the same treatment he had used for other skin diseases, stating that he knew of “nothing more effectual.” Sloane’s non-racial understanding of the body is amply demonstrated by the fact that he did not always specify the race of his patients within the case histories.

235. Ibid., pp. xlviii, xciii, cxxi, cxiv, cxx–cxxi, cxxvii.
236. Ibid., p. cxxviii. This theory had been espoused by Trapham. Trapham, Discours, p. 69.
238. Ibid., p. cxxviii.
239. Ibid., pp. cvi–cvii.
240. Ibid., p. cvi.
241. For example, ibid., pp. cxx–cxxxi, cxxv, cxxiv, clxix–cl.
Although there was little emphasis on biological race in Sloane’s medical practice, social status played a more significant role. Sloane commented on several cases of patients feigning illness. He identified “. . . Servants, both Whites and Blacks” as pretending to be ill so that they could be treated by physicians. Due to the fact that the supposed disease symptoms did not respond to one another, Sloane believed that such cases were easily uncovered by physicians who conscientiously employed their skills of inquiry and observation. Sloane administered “innocent Remedies, [such] as blistering, . . . [and] bitter Medicines” so that he could be “free’d of their trouble.”

He noted that dissembling patients also included pregnant women who wished to acquire medications in order to procure abortions. These women “pretended themselves ill, coming in the name of others, sometimes bringing their own water, dissembling pains in their Heads, Sides and Obstructions.” In suspected cases of disguised pregnancy, Sloane informed these patients that nature would prove to be the best remedy or prescribed “. . . Medicines that will signifie nothing either way or other.” And although he observed the acute dangers that abortion presented to women’s health, Sloane also recognized several reasons why women sought to terminate their unwanted pregnancies, including “political considerations,” the desire to avoid scandal, and already having too many children. While regrettably he did not provide further details regarding the race or socio-economic status of these women, nevertheless, his remarks imply that such dissemblers included women from various social backgrounds. Regardless of the sex or race of the patients within this group, they all exhibited the same behavior (dissembling), and thus Sloane treated them in the same manner.

THE ROLES OF SOCIO-ECONOMIC STATUS AND AGE IN TREATMENT

There are strong indications that for Sloane, socio-economic status was more important than gender or racial categories in his treatment. Despite these consistencies in the treatment of women, the evidence suggests that Sloane may have been more concerned with
the menstruation cycles of white, particularly white upper-middle-class or aristocratic, women. In four of the six cases that dealt with menstruation, Sloane’s patients appear to have been white—possibly married—women of some social standing. But because we cannot positively identify the race, marital status, and socio-economic background of many of the women in the case records, the evidence must remain suggestive. As in England, anxiety over the reproductive capacities of elite Jamaican women was likely more acute than that of their lower-class counterparts due to the heightened social pressure for them to conceive and bear children, particularly male heirs.

In his discussion of servants who feigned illness, Sloane carefully pointed out that this included both black and white male servants (in addition to pregnant women). Once again, he categorized the black and white body into one collective patient group, choosing to make divisions along lines of social stratification rather than race or gender. Sloane himself was treated by a black woman who, he pointedly informed his readers, “had been a Queen in her own Country.” What legitimatized her role in this case was neither race nor gender, but her elevated social status. In this instance, establishing this woman’s exalted rank was essential because both race and gender might have functioned as delegitimizing forces. The importance of social class in Sloane’s Jamaican medical practice is also evident in his discussion of intestinal worms, which were “very common amongst all kinds of People here, especially the Blacks and ordinary Servants” because they were “very often obliged to eat the Country corrupt Fruits, Roots, and other Meats apt to breed many kinds of Vermin in the Guts.” It appears that due to the impact upon patients’ diets, Sloane considered social standing as the most significant factor (albeit never mutually exclusive from race or gender) leading to intestinal worms and their resultant ailments.

245. Ibid., pp. cii, ciii, civ, cxxvi, cxx, cx. Three of these women were denoted by the title “Mrs.”; the fourth was the wife of one Dr. Rooks. There is much ambiguity regarding the chronology of the evolution of “Mrs.” from an abbreviation of “mistress” to a mode of address that denoted marital status. As such, it is not possible to determine with any degree of certainty whether the three aforementioned women were married. For more on interpreting the title “Mrs.,” see n. 63 of this article; Patricia Crawford and Laura Gowing, eds., Women’s Worlds in Seventeenth-Century England (London: Routledge, 2000), p. 303; OED, s.v. “Mrs.”; ibid., s.v. “mistress.”


247. Ibid., p. cxxiv.

248. Ibid., p. cxv.
In addition to social class, the patient’s age—and, implicitly, size and strength—appears to have been a more significant factor than either sex or race in Sloane’s treatment method. When prescribing dosages for children with intestinal worms, he usually “allow[ed] [for] a Grain of Diagrildum to every year of the Childs Age, and about half the quantity of Merc. Dulc.” When these treatments proved to be unsuccessful, or when he “apprehended their Head[s] to be affected,” Sloane also administered cinnabar and recommended gentle purges. For his “aged” patients, he often altered the treatment by administering “… Pl. Coch. Min. or Extr. Rud. mixt with Calomelanos.”

Although the case histories for gastro-intestinal ailments only account for his adult patients, Sloane had observed such fluxes and bellyaches in “Men, Women and Children.” It appears, then, that Sloane thought that certain illnesses could transgress the categories of gender, race, and age. Nevertheless, he recommended that the patient’s age—not sex or race—should determine the amount of laudanum prescribed in cases of gastro-intestinal ailments such as diarrhea.

And although Sloane prescribed the same mixture (containing breast milk and liquid laudanum) to treat whooping cough in children and adults, he altered the dosage according to the patient’s age and, hence, size and strength."

RECONCILING AMBIGUITIES WITHIN THE VOYAGE

However, the question remains: why then, if Sloane was stressing similarities, did his writings reveal differences between England and Jamaica, particularly with regard to female illnesses? Despite the seemingly sound case evidence to support Sloane’s proposition that female illnesses—like other illnesses—were the same in England and Jamaica, a number of discrepancies crept into his writing. He noted that “the Menstruae Purgationes” of women residing in Jamaica were less in quantity and duration than those of women living in Europe. Upon first glance, this would imply that, like Trapham, Sloane believed that the hot climate of Jamaica somehow altered the functioning of

249. Ibid. Calomel is a milder form of mercury that had begun to be prescribed during the early decades of the seventeenth century. O’Dowd, History of Medications, p. 117.
251. Ibid., p. cxxii.
252. Ibid., pp. civ–cv.
253. Ibid., p. cxxxi.
the body (specifically, the female body)—a theory that he strove to deconstruct throughout *Voyage* through clinical observation and treatment. But upon closer examination, however, it appears that Sloane attributed such differences to specific socio-cultural practices rather than climates. For instance, Sloane also observed that many white women—and “all Indians and Negros”—in Jamaica did not keep to their beds for over one week, as was the custom in England. Instead, they resumed “their ordinary Business” soon after childbirth. This remark was consistent with his theory that bodies functioned in essentially the same manner in all climates, despite apparent cultural and behavioral differences. Sloane’s belief that altering the normal course of treatment, such as the lying-in period, could prove to be dangerous to the health of his patients is supported through his example of “a Mother of many Children, who getting up so much earlier than she used to do, fell into great pains in her Sides, after having some diminution of her Lochia.”

It appears, then, that Sloane’s assertion that Jamaican women experienced scantier and shorter menstrual cycles than European women arose from his belief that the functioning of female physiological processes were influenced by socio-cultural practices (in this case, exercise following childbirth), rather than directly by differences in climates or group complexions.

In part, Sloane’s confusion resulted from an incompatibility of two ideas. Through clinical observation, Sloane had concluded that the European body exhibited the same illnesses in Jamaica as it did in Europe. Although he asserted that these diseases should be treated in the same manner, he also determined that some afflictions (psychological disorders, venereal disease, and copious menstrual or lochial discharges) were more common in particular groups of people due to specific cultural behaviors that altered bodily constitutions. Furthermore, Sloane did not believe that all remedies worked equally as well in different climates. But did this mean that he was unable to fully reconcile his medical philosophy? If illnesses exhibited the same symptoms in these two different climate zones, then why did Sloane state that identical plants exhibited different healing properties in Europe and Jamaica? Sloane contended that all the illnesses he

254. Ibid., p. cxlvii.
255. Ibid., “The Preface” [pp. 1, 5]. Also refer to the section “Purpose of the Medical Cases” of this article.
encountered on the island were also present in England. And for those few medical cases that appeared different beyond his experience, he allowed for them by arguing that strange cases were also encountered back home. For instance, Sloane reported observing albino persons in both England and Jamaica. Sloane attempted to reassure readers that Jamaica was neither a dangerous nor an undesirable place for white English settlers. He dismissed the perception that the tropical climate was accompanied by mysterious, unknown diseases. He wrote that despite the island’s location in “the Torrid Zone,” the air was not unhealthy or poisonous to Europeans. Rather than concentrating on the differences, Sloane emphasized the similarities between England and Jamaica, drawing parallels between the climates, peoples, and diseases wherever possible. In this way, Sloane’s work demystified Jamaica for its white, British settlers. It offered reassurance that they could expect to experience the same illnesses and receive the same medical treatment as they had in England. Jamaica was depicted as a safe—not an exotic or dangerous—place for all to live: men, women, and children.

Sloane’s alternative view of overseas medicine and disease was largely ignored by an increasing body of publications that stressed differences—rather than similarities—in the healthiness of various climates and races. The insistence upon innate differences between the medical, as well as social, bodies of the British and “others” grew increasingly more important during the course of the eighteenth century. Supporting this theory of medical environmentalism became one way to explain the epidemics of disease that threatened British

256. Ibid., p. xc.
257. Ibid., p. lxi.
white settlers who continued to journey to foreign, exotic locations. It also assisted in justifying and securing their privileged social positions in a rapidly expanding empire.262 Once England firmly secured its position in the transatlantic slave trade, there was no longer room for any discussion of the similarities between the black body and the white body.263 Nevertheless, Sloane was able to forge ahead with the 1707 publication of his own medical observations largely for two reasons. First, there was not an existing body of literature on the medical diagnosis and treatment of English settlers (which included persons of both sexes and different ages and social status) in a foreign location. Second, until 1734 there were no printed medical treatises in English on the medical treatment of blacks.264 Instead, the field of early imperial medical publications focused upon the elite, white, male body.265

Unlike the authors of other publications in the developing genre of overseas British medicine, Sloane made no attempt to align his claimed medical expertise with the pressing needs of the British state. By 1707, Sloane possessed a lucrative practice in London’s West End, as well as an extensive diagnosis-by-correspondence across England.266 Sloane’s contemporaries dedicated their medical expertise to the health problems of the War of the Spanish Succession (1701–1713), as the state consciously worked to establish “universally applicable, empirical remedies” and prevention regimens for those men in service.267 The reasons why Sloane did not choose to align himself and

265. Alsop, “Warfare and the Creation.”
266. Much of this correspondence is located in the British Library manuscript collections, Sloane MSS 4036–4069 (Correspondence of Sir Hans Sloane). See Smith, “Women’s Health Care”; idem, “Reassessing the Role of the Family.”
Churchill: Bodily Differences

his expertise with this public agenda are unknown. He alone chose to publish his work as part of an introduction to an acclaimed early study of natural history, rather than as a separate medical treatise. His reasons for doing so, however, are less important than the consequences. Sloane’s *Voyage* is a crucial work in this period due to its move away from the increasing focus upon the elite, white, male body. Instead of marginalizing female patients within the case records, Sloane presented them alongside those of male patients. Rather than placing the black body in direct opposition to that of the white, it was diagnosed and treated under the same set of criteria: age, sex, social status, and affliction. The result is that this author provides a largely undigested overview of his entire practice, one in which women—black and white—were given their due space.

**CONCLUSION**

In conclusion, there was little that was exotic about the majority of illnesses that Sloane encountered in Jamaica. As in England and France, he diagnosed and prescribed for a wide range of illnesses, both physical and psychological. Sloane treated men and women for the same range of ailments that could be found in England, including various fevers, rheumatisms, skin conditions, and eye diseases. As well, Sloane often treated women for female-specific illnesses. This included prescribing for the same types of gynecological problems that he would have encountered in England, such as absent or irregular menstruation, vaginal infections, miscarriages, false conceptions, childbed fevers, and uterine ruptures. 268 Although some ailments were sex-specific and culture-specific, for the most part Sloane transgressed categories of gender and race by diagnosing and treating all his patients according to the same medical ideology. Although Sloane primarily stressed continuity between Europe and Jamaica, he nevertheless incorporated anomalous observations. 269 Thus, *A Voyage To the Islands off Madera, Barbados, Nieves, S. Christophers and Jamaica* played an important role in simultaneously transplanting and questioning aspects of early modern British medical theory. Sloane’s work


revealed important incongruities in dealing with categories such as gender and race within the context of early imperial medicine.

An examination of Sloane’s medical cases contained in his *Voyage* raises a number of important points for early modern British health care. First, in this specific set of case records women were not less healthy than men and, in some cases, enjoyed better health (see Tables 4 and 5). Second, race was not a determining factor in Sloane’s medical practice, and neither, it seems, was gender. Instead, age and social status were much stronger influences upon diagnosis and treatment. Third, while Sloane’s approach was different in its presentation of undigested medical case histories, his purpose was anything but haphazard. The method employed by Sloane in *Voyage* was consistent with his approach to natural history and his editing of the *Philosophical Transactions*; that is, he followed Sydenham’s method of regarding observation as paramount to ancient learning. This, however, presented a conflict that found fruition in the pages of his work on natural history: Although he minimized climatic influences (and, hence, group complexions) upon health, he did not dismiss social or behavioral influences. This inherently meant that those illnesses that were thought to have social causes were ascribed—albeit indirectly—racial and gendered categories.

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**Churchill: Bodily Differences**

APPENDIX: TABLE 1

Race of Sloane’s Patients

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<thead>
<tr>
<th>Sex</th>
<th>Race</th>
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<td>White</td>
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</tr>
<tr>
<td>Male</td>
<td>33</td>
<td>13</td>
</tr>
<tr>
<td>Female</td>
<td>20</td>
<td>5</td>
</tr>
<tr>
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APPENDIX: TABLE 2

Social Status of Sloane’s Patients

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<td>Professional/</td>
</tr>
<tr>
<td></td>
<td>Service</td>
<td>Gentle</td>
</tr>
<tr>
<td>Male</td>
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<td>31</td>
</tr>
<tr>
<td>Female</td>
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APPENDIX: TABLE 3

Age and Sex Distribution of Sloane’s Patients

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<th>Age range</th>
<th>Sex</th>
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<td>10–19 years</td>
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<td>3</td>
</tr>
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<tr>
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</tr>
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<td>19</td>
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<tr>
<td>Total</td>
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<td>43</td>
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APPENDIX: TABLE 4

Claimed Efficacy of Sloane’s Treatment

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<tr>
<th>Sex</th>
<th>Cured, recovered or improved</th>
<th>Little or no change</th>
<th>Worsened</th>
<th>Died</th>
<th>Outcome unknown</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
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<td>48</td>
<td>2</td>
<td>1</td>
<td>22</td>
<td>5</td>
<td>78</td>
</tr>
<tr>
<td>Female</td>
<td>32</td>
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<td>7</td>
<td>2</td>
<td>43</td>
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<td>0</td>
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</tr>
<tr>
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<td>85</td>
<td>4</td>
<td>1</td>
<td>31</td>
<td>7</td>
<td>128</td>
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APPENDIX: TABLE 5

Mortality Rates for Sloane’s Patients

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<thead>
<tr>
<th>Sex</th>
<th>Number of deaths</th>
<th>Percentage of deaths among own sex</th>
<th>Percentage of deaths among total mortality figure (31)</th>
<th>Percentage of deaths among total patient group (128)</th>
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<tr>
<td>Male</td>
<td>22</td>
<td>28.2%</td>
<td>71%</td>
<td>17.1%</td>
</tr>
<tr>
<td>Female</td>
<td>7</td>
<td>16.3%</td>
<td>22.6%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Undeterminable</td>
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<td>28.6%</td>
<td>6.5%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Total</td>
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<td>24.2%</td>
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