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Listening to Quackery: Reading John Wesley's *Primitive Physic* in an Age of Health Care Reform

Daniel Skinner[1] · **Adam Schneider**[2]

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Abstract This article uses a reading of John Wesley's *Primitive Physic, or An Easy and Natural Method of Curing Most Diseases* (1747) to resist the common rejection—often as "quackery"—of Wesley's treatments for common maladies. We engage Wesley not because he was right but because his approach offers useful moments of pause in light of contemporary medical epistemology. Wesley's recommendations were primarily oriented towards the categories of personal responsibility and capability, but he also sought to empower individuals—especially the poor—with the knowledge to safely and affordably treat maladies of their own. We leverage *Primitive Physic* to rethink contemporary medical knowledge production, especially as sanctioned by randomized clinical trials and legitimate views of experience and contemporary institutions such as the AMA. Ultimately, we suggest that the medical humanities has a key role to play in mining the discarded and dismissed for what they can tell scholars about medical knowledge.

Keywords Quackery · Epistemology · John Wesley · Foucault · Mill · Medical humanities

Can medical texts that have been dismissed on the basis of their rightness or wrongness still contain important lessons for contemporary medical professionals and scholars? If so, in what ways? This article suggests that the easy dismissal of such texts as mere historical curiosities forecloses perspectives that can be useful for thinking about contemporary problems. To illustrate our position we engage the English cleric and scholar John Wesley's *Primitive Physic*, *or An Easy and Natural Method of Curing Most Diseases* (1747) (hereafter *PP*). We do not engage Wesley because we maintain that he was right. To the contrary, we are just as

✉ Daniel Skinner
skinnerd@ohio.edu

[1] Department of Social Medicine, Heritage College of Osteopathic Medicine, Ohio University, 6775 Bobcat Way, Dublin, OH 43016, USA

[2] Master of Arts in Counseling Psychology program, The Seattle School of Theology and Psychology, Seattle, WA, USA

interested in his motivations and the way he approached medical care as whether or not his home remedies were clinically sound. Indeed, drawing upon resources from political theory, we attempt to leverage clinical unsoundness for rethinking the epistemic foundations of mainstream modern medical reasoning, beyond contemporary assumptions and blind spots. Embedded in our argument, rooted as it is in a classic text of medical literature, is not only a perspective shift in medical epistemology but an argument in support of the medical humanities.

Wesley has long been placed under a rhetorical umbrella of 'quackery.' In a 1915 speech to the Harvard Medical Historical Club, Robert Lovett, an orthopedic surgeon who consulted on Franklin Delano Roosevelt's polio, hailed Wesley as an example of an "outbreak of quackery probably unparalleled in history" (1915, 807). In the past decade, Wesley "the reformer" has often been associated with other "unqualified practitioners of medicine" that flourished in the 17th century, with A.W. Sloan broadly defining quacks as those "who practice medicine without the conventional training and examinations…" and do not meet the criteria set forth by the established medical authority (1996, 175). While validating quackery is not our aim, we maintain that it is not despite Wesley's sometimes absurd (from a contemporary perspective) remedies but because of them that *PP* has something important to offer contemporary health care debates. Contemporary debates often assume their own medical epistemological grounds. As a result, perhaps out of blindness to modern paradigms, but also possibly due to an unintentional bias for modern assumptions about medicine, they fail to interrogate them. This certainty, we suggest, is a result of presumptions about modern scientific methodologies, especially as found in randomized clinical trials and contemporary views of legitimate "experience." We briefly engage these two areas below.

Our motivation is simple. In an era of increasingly technical and complex health care, it is important to interrogate the boundaries of the "medical." At the same time, it would be hasty to dismiss *PP* as an example of a "terrible growth of home medical manuals" (Bellinghieri et al. 2004, 619) without considering the larger social forces at work that made—and could still make—such manuals useful. This requires contextualizing the role of self-help, insurgent challenges to conventional medicine from the margins, as well as general dispositional differences between kinds of physicians, and placing these considerations within a broad political and cultural context. Wesley's text provides a useful basis for undertaking these efforts.

Our focus on medical epistemology is also of *political* significance. As we write during a moment of extraordinary change in American health care, we note that many of Wesley's recommendations were oriented—as they were for his American counterparts—towards social currents such as personal responsibility. Different kinds of medical knowledge are often intended to suit different needs. Wesley is of specific interest because he sought to balance an awareness of the limits of his expertise with empowering individuals—especially the poor (Rogal 1978)—with the knowledge to safely and affordably treat maladies, when possible, on their own. We highlight the political implications of this commitment as a challenge to scholarly approaches that reject figures such as Wesley because they espoused medical ideas that do not withstand challenges made from the modern perspective. We draw upon the work of two quite different canonical political thinkers—John Stuart Mill and Michel Foucault—to help us articulate the epistemic consequences of such rejections. Finally, we suggest that the medical humanities must play a key role in mining discarded and dismissed texts for what they tell us about broader cultural contexts of medicine.

Wesley's motivation for publishing *Primitive Physic*

Wesley's most identifiable legacy lies in the Methodist tradition he shepherded. Though he sought primarily to reform the Church of England from within, the theology he preached ultimately proved too controversial and eventually, after his death, divisive for the movement to remain within Anglicanism. His life and ministry are well documented, but his interest in medicine is often limited to discourses of holistic health within Methodist contexts (Madden 2008). At the same time, these conversations have rarely contributed to debates about reforming the practice of secular medicine. In a spirit that resonates with contemporary American health care reform, Wesley wrote *PP* to fill a space created by poor access to affordable medical care. Though he was not a licensed physician, he felt that the administration of simple remedies for mild illnesses was a duty that he and his lay leaders were obligated to bear, even though doing so risked the medical establishment's opprobrium (Maddox 2007). The radicalness of Wesley's views is evidenced by *PP*'s anonymous original publication though it turned out to be what we would today call a 'best-seller.' The book wasn't published under his name until 1760.

Born in 1703, Wesley was introduced to theology at a young age. John, like his siblings, was initially taught at home by his mother but was soon recognized for his intellectual abilities and sent to a London boarding school until he entered Christ's Church, Oxford, in 1720. Most students at Oxford, regardless of their degree focus, listened to lectures on basic medical theory. According to statutes instituted by King Henry VIII in 1511, governed by the College of Physicians in 1518 until the introduction of Caroline Code in 1636, "medical scholasticism was as much a reality as scholasticism in theology or philosophy," and the faculty was restricted to lecturing from Hippocrates and Galen; "nothing [else] was either expected or permitted" (Chaplin 1920). Humoral theory was the faculty's central concern. Though Wesley read a range of medical texts from 1720-37, none focused on humors. Wesley found his own way to empiricism.

Wesley's interest in medicine was both academic and personal. Wesley's journals detail his efforts to understand his own health, especially concerning the identification of illness. For Wesley, experimentation was not only an academic discipline but also an individual commitment. He frequently tested remedies on himself before using them on others and used those results as evidence for the efficacy (or lack thereof) of those methods. Most remedies in *PP* are tagged with an empirical report, such as "tried," "this has done wonders in some cases," "this has cured many" or "tried by my Father" (Wesley 2003). This approach, as we shall see, both advanced his understanding of medicine and marked its limitations.

Wesley's life illustrates his attempt to balance his reverence for physicians with a personal knowledge of remedies. In his early fifties, Wesley developed what his physician diagnosed as consumption. After medications ceased being effective, Wesley tried his own remedy, noting, "The pain ceased in five minutes, the fever in half an hour; and from this hour I began to recover strength" (Wesley et al. 1991, Entry: November 28, 1754). We of course do not know what was actually occurring in this situation and should be skeptical of Wesley's report. But the relative simplicity of the remedy as well as the availability of the ingredients are hallmarks of Wesley's commitments.

Primitive Physic: goals and framework

Wesley's three major concerns were: (1) physicians that unnecessarily complicated the practice of medicine; (2) the access and affordability of care; and (3) the simplicity with which medically uneducated people could perform remedies for themselves and their families. To attain his primary goal of alleviating suffering, he wished to know how to identify, diagnose, and heal chronic pain and illness. He opens *PP* by noting, "It was easy to infer, 'If this will heal that creature, whose flesh is nearly of the same texture with mine, then in a parallel case it will heal me.' The trial was made: the cure was wrought: and the experience and physic grew up together" (2003). Wesley took literal pains to assure readers that his remedies were tested.

It is important to note that Wesley does not claim to be the initiator of such work. Many of these remedies, while tested by Wesley, were developed from the work of Dr. George Cheyne, whom Wesley credits in the preface, along with Drs. Sydenham and Dover (2003). Even Wesley's own interest in experience and empiricism stem from Cheyne's work. Wesley embraces both Cheyne's underlying philosophy as well as the practical remedies and incorporates Cheyne's work into his own. *PP* is therefore highly dependent on the work Wesley read, not his own discoveries. In response, Wesley showed appreciation for – and knowledge of – the history of medicine. Relevant to our argument is that this interest did not remain academic. Rather, Wesley insisted on their relevance for his society, often at odds with a medical establishment that saw not only no value but also danger in such texts. He placed himself, as we wish to do, within a heritage of medical practice that persists in questioning its progress.

PP opens with an outline of the major ingredients Wesley recommends. He hopes his readers will be "men of plain, unbiased reason" and expects them to be familiar with and capable of using "air, water, milk, whey, honey, treacle, salt, vinegar, and common English herbs, with a few foreign medicines, almost equally cheap, safe, and common" (2003, xvi). Wesley is conscious of his intended audience's level of education and socio-economic status. In future printings, he "added plain definitions of most distempers: not indeed accurate or philosophical definitions, but such as are suited to men of ordinary capacities…." (xvi). Wesley acknowledges that there may be more effective medicines or more accurate descriptions of diseases, but neither would be helpful to his readers. Wesley uses descriptions of symptoms to distinguish distempers (45). His recommendations concern not what ingredients people may need but the effective use of that which they already possess and know. As an example, Wesley frequently (for over twenty illnesses) recommends cold baths—an illustration of his belief that the more uses one remedy had, the more affordable and accessible it became. Wesley believed that this perspective, which provides insight into the economies of scale in health provision, were particularly true of remedies with few side effects.

Reception and criticism

It was only a matter of time before this popular book found itself in the crosshairs of disagreeing physicians. William Hawes, a physician and the founder of the Royal Humane Society, felt so strongly that Wesley was offering dangerous and ignorant medical advice that he published *An Examination of The Rev. Mr. John Wesley's Primitive Physic,* an often ad hominem attack on Wesley that demonstrates the extent to which physicians sought to control medical information within the faculty (Maddox 2008, 28-30). "I have not the least enmity"

for Wesley, Hawes writes, yet later declares that he has made "Quacks of all denominations my sworn enemies" (Hawes 2010, i). Hawes argues that *PP* is "founded on Ignorance of the Medical Art" while its recommendations do "essential injury" (i) to those who follow them. Though his evocation of the language of "art" differs starkly from Wesley's pragmatic view, Hawes finds no value in Wesley's text.

Since Hawes's criticism took aim at Wesley's medical advice, it is curious that Hawes sought to discredit Wesley on theological grounds, rooted in "thought…for which [he] is well known to be a very zealous advocate" (iii.). This line of attack is especially curious because Hawes—who had no training in theology—took particular issue with Wesley's lack of formal medical training. Hawes's dependence on medical scholasticism, moreover—marked by his use of phrases such as "in all probability" and "upon such principle" (10, 29)—suggest a methodological divide. Hawes chides, "What were Hippocrates and Galen,"—both of whom made their mark by insisting that medical science be empirically grounded—"compared to John Wesley!" (45).

Problematically, from a Wesleyan perspective, Hawes's critiques reinstate patient dependency upon physicians. Needing to "examine the pulse and the state of the constitution" in the case of asthma or needing to be "far acquainted with the circulation…to judge whether the discharge is arterial or venous blood" (22) in the case of bleeding requires the attention of a physician. It is not only Wesley, however, that Hawes is quick to dismiss, but proponents of more traditional occupations as well. "The state of our natural population," Hawes writes in a notably gendered tone, "is at too low an ebb, for the lives of children to be sacrificed to the ignorance of old women, or to the indolence of nurses" (29). He placed (male) physicians on a pedestal to the exclusion of other approaches. Those, such as Wesley, who did not fit the mold were feminized and dismissed.

Wesley's approach to fever is helpful for processing Hawes's criticism. Wesley classifies a variety of fevers, including a burning, nervous, rash, and slow fevers, among other ailments. Concerned that Wesley failed to distinguish between "a miliary, a spotted, or a petechial fever" (49), Hawes uses these terms to rebuke Wesley. Yet, Wesley's intent is signaled by the names he uses. As opposed to Hawes's clinical terminology, Wesley's is basic and descriptive. Hawes's concerns betray privilege while the "quack" seeks quick diagnosis and care (and refuses to bleed) for the needy. At stake appears to be the nature of poor people's medicine altogether.

Medical scholars have understood *PP* in different ways. Melanie Hughes considers Wesley an "integrated practitioner" whose medical work "can serve as a valuable resource for contemporary Christians seeking to faithfully live a life of wellbeing" (2008, 240). Deborah Madden insists the text is of "vital interest to the historian" and is clearly orthodox regarding medical knowledge at that time (2004, 365). Philip Ott concedes, "It is commonly acknowledged that many of [Wesley's remedies] were quaint, if not questionable," but goes on to argue that the text's value lies in its insistence on a "sensible regimen" for the individual, as evidenced by Christian scripture (1980, 204). Samuel Rogel goes so far as to argue, "the underlying focus of *Primitive Physick* is upon the soul of man" (1978, 81). This specifically religiously-infused support of Wesley's remedies (acknowledging some as still relevant and others as outdated) risks losing the text's broader, secular point, grounded not in its specific remedies or Christian roots, but empiricism and patient-centricity.

Problematizing Wesley's influence in 21st century medical practice is the reluctance of current Wesleyans to advocate for contemporary policy application of *PP*'s spirit. The United Methodist Church (UMC), one of the largest American Christian denominations with direct

ties to Wesley (Cracknell and White 2005) has offered the clearest support of health care reform in the U.S. A resolution approved and adopted by UMC's General Conference in 2008 "affirms in our Social Principles…health care as a basic human right and affirms the duty of government to assure health care for all" (2012). This detailed resolution mentions Wesley only once, as someone who "found ways to offer medical services at no cost to the poor in London" (2012).

The resolution goes on to detail current problems regarding access, availability, and cost of care, each of which Wesley addressed in *PP*. The limited reference to Wesley is noteworthy. Though Wesley scholars would be unlikely to characterize Wesley's thoughts on medical practice as "quackery," few if any argue that the text is relevant to current health care reform debates. In language that smacks more of American liberalism than Methodism, the UMC resolution appeals to the image of a "just society" where "all people are entitled to basic maintenance and health-care services" (2012). Where the document diverges with Wesley's approach to medicine is in its expectation for government to be ultimately responsible for care. Although it counsels "medical education for laypersons that will enable them to effectively evaluate medical care they need and are receiving," the resolution "supports" the "medical community" without tasking the Church with a responsibility for caring for the sick or poor beyond prayer and guidance. In developing nations, where governments are not equipped to provide high quality health care for all, the Church has a role to play; in the U.S., however, where the government "has the capability to provide health care for all" the Church has no concrete, political responsibility.

The resolution is concerned primarily with advocacy, which stands in stark contrast with Wesley's hands on approach. The Wesleyan perspective is not mobilized to challenge present and widespread assumptions about defining the scope of medicine and the meaning of patient-centered care, affordability and access, alternative medicine, and beyond. In the broader Methodist community, *PP* is instead valued for its holistic approach to health (body and soul) (Hughes 2008), its historical significance for medical knowledge and practice (Madden 2004), and the personal pursuit of piety (Rogel 1978). Wesley is generally thought qualified to write such a text and excused for any remedies that are now considered illegitimate.

Of course, recommending Wesley's remedies for personal use does little to advance his framework politically, something larger Methodist denominations are equipped to do. While Madden laments that Wesley is more "revered than read" (2008, 20) the greater misfortune may be that he is more read than interpreted with an eye toward policymaking. Without pursuing its political implications, *PP* becomes a tract of limited academic, historical, and theological interest. Maddox, however, argues convincingly that Wesley himself, in response to growing criticism from the expanding professional medical body, backed away from suggesting the *PP* be used for anything other than personal assistance (2998, 31). Accordingly, in light of the passing of some 250 years since its original publication, we argue that the text be reconsidered within present political contexts rather than left solely to the archives of theology and history. We now turn to some specific paths such a reconsideration might take.

Quackery in contemporary context

The policing of the epistemic boundaries of medicine has been central to the development of medical knowledge in accordance with Continental Enlightenment ideals of science (Cunningham and French 2006). But this policing also comes at a cost, as it simultaneously delimits

the boundaries of acceptable and unacceptable forms of knowledge in ways that can promote uncritical attitudes about science. In language popularized by French poststructuralist thinkers, the "epistemes"—or clusters of knowledge—of medicine that come to be associated with progress are always, even when beneficial, forms of "discipline" (Foucault 1979). To note this, of course, is not to suggest that the development of modern medical knowledge is a bad thing—far from it. Rather, as new modes of treatment and care are introduced, this perspective counsels careful attention to the role that power plays in legitimating knowledge. Science does not arise in a vacuum, nor, as Thomas Kuhn (1962) counseled some years ago, do "scientific revolutions" develop rationally out of strict adherence to new evidence and theoretical paradigms. Hence, the normalization of surgical practices (from circumcision and hip replacement to Caesarean section) and pharmaceuticals (from Adderall to Gardasil) must be read as functions of broader social forces. The medical cannot be cordoned off from the moral, political, and sexual. Implicated as well in the developmental history of medical knowledge are powerful forces of professionalization, especially—in the United States—organizations such as the American Medical Association (Starr 1982). Without dismissing the benefits of licensure and training afforded by professional associations, it is worth noting that licensure and training have a distinct impact on the constitution of medicine as an elite form of knowledge. In light of such professional distinctions it is important to remember that even "better" knowledge is normatively infused. Again, to note this is not necessarily to undermine contemporary professional medicine but to counsel a critical view of what legitimizes some medical practices and excludes others.

Counterweights to these trends are especially resonant in modern "self-help" movements. While there may be much to criticize about such movements, it is important to notice the negotiations of power that give rise to them. As a genre, modern self-help often appears to be (and often is) a cynical means of selling books, DVDs, and the like. Perhaps the most trenchant criticism of self-help in recent memory was made by Barbara Ehrenreich (2009) in *Bright-Sided: How Positive Thinking Is Undermining America*, where she criticizes American self-help campaigns for incessant optimism in the face of unrelenting odds. According to Ehrenreich, the modern self-help movement is a hypercapitalist and exploitative narrative that is threaded through the "good news" of Evangelical mega-churches, prescriptions of "positive thinking" from the medical industry, and optimism even in the face of flawed economic theories likely to lead to the destruction of working people's livelihoods. But the ethos at which Ehrenreich takes aim is different than that which Wesley embodies. Texts such as *PP* are usually constituted through a politics of a different sort, as medicine is cast as a means of resisting dominant paradigms not only because institutionalized medicine tends to eclipse folk knowledge but also because institutionalized medicine is often accompanied by an elite-driven monopoly of knowledge that makes it inaccessible to large swathes of society.

Also at issue in *PP* are the boundaries and bases of empiricism itself, a question with which philosophers have wrestled for millennia. Wesley's text is not akin to the cynical optimism of profit-seeking televangelists or the paranoia of vaccination resisters who make their cases, often in the name of individual liberty, against the grain of extensive empirical evidence. Instead, Wesley's conversation lends itself to a more productive, even scholarly effort in which critics could question the methods, orthodoxies, and regulatory systems in place in contemporary medicine with a clear focus on the benefits for and well being of the afflicted. It is here, in contemporary medicine, that we reach interesting terrain wherein medical doctors, homeopaths, naturopaths, osteopaths, and "other healers" (Gevitz 1988) jockey for position. A closer consideration of these traditions does not aim to validate them—quite the contrary. Our aim is

not to debate the merits and evidentiary bases of these traditions. Instead, we defend the value of these books for what they can offer us by way of social and political critique. We do so in the spirit of Porter, who notes, "writings for the sick – advice handbooks and self-care manuals…the agony columns of magazines, the breviaries of comfort and consolation, the keep-fit, stay-young-and-beautiful guides – all tell at least about sufferers' hopes and fears, even if we must be cautious before taking them as indices of what was done" (1985, 183). Like Porter, we emphasize the importance of listening to that which gives rise to these traditions and that which calls for a response, much as Wesley's text was written primarily out of deeply felt concern for the weak and poor.

Two perspectives

We have sought to establish a critical perspective with which to read Wesleyan quackery, creating new spaces for considering ways to use texts such as *PP*. As we have emphasized, our concern is as much to make an argument for the critical value of discarded texts as it is with valorizing any particular medical tradition. In this section we seek to deepen the stakes of this inquiry by exploring two quite different theoretical frames from the history of political thought: those of John Stuart Mill and Michel Foucault. Though they do so from quite different angles, Mill and Foucault are united by a concern with the pursuit of liberty in often extraordinarily illiberal societies that delimit and discipline rather than allowing knowledge to arise and develop freely. We maintain that contemporary medicine shares this concern and literature such as *PP* can aid in pursuit of a remedy.

Mill is well known as an advocate of the free and open exchange of ideas. Specifically, he maintained that allowing a range of ideas—even those that register as quackery—to circulate in society can advance knowledge. Mill notes:

> Were an opinion a personal possession of no value except to the owner; if to be obstructed in the enjoyment of it were simply a private injury, it would make some difference whether the injury was inflicted only on a few persons or on many. But the peculiar evil of silencing the expression of an opinion is, that it is robbing the human race; posterity as well as the existing generation; those who dissent from the opinion, still more than those who hold it. If the opinion is right, they are deprived of the opportunity of exchanging error for truth: if wrong, they lose, what is almost as great a benefit, the clearer perception and livelier impression of truth, produced by its collision with error. (2011, 16)

For Mill, rightness and wrongness are insufficient grounds for suppression. Silencing views—especially when those views are, as Wesley's are, the outcome of deliberation—can only serve to stunt the development of knowledge. As an advocate of enlightenment, Mill thought that the outcome would ultimately be truth itself, believing as he did that truth arose from these processes over time. Whether or not this is the case, however, the dismissal of certain texts as quackery while others are exalted as "truth" undermines the pursuit of knowledge itself.

One might object that this approach is dangerous when extended to medicine. It is important to reiterate that our defense is qualified, the question being how to distinguish between useful forms of knowledge, on the one hand, and dangerous nonsense, on the other. We do not take a firm position on this question but insist that not engaging these forms of

knowledge comes at a cost. To capture a related but different approach to our question, however, we turn to a critic of enlightenment: Michel Foucault.

Foucault is best known for his theorization of power, especially as it relates to discourse. In "The Order of Discourse," he argues that discourse—including medical discourse—is always conditioned by power. "Within its own limits," Foucault argues, "every discipline recognises true and false propositions, but it repulses a whole teratology of learning" (1972, 223), which is to say that learning tends to focus on that which is normal instead of noticing systemic abnormality. Ultimately, for Foucault, "Disciplines constitute a system of control in the production of discourse, fixing its limits through the action of an identity taking the form of a permanent reactivation of the rules," (1972, 224) and distinctions between disciplines are actuated by rule setting that occurs and is constantly reasserted through discourse itself. For Foucault, there is no truth external to these discursive systems with which one can anchor truth. Rather, truth becomes intrinsic to systems themselves.

Later in his career, Foucault became increasingly interested in these challengers, especially those who undertake an "insurrection" of what he calls "subjugated knowledges." Subjugated knowledges, for Foucault, are "historical contents that have been buried and disguised" (1980, 81), and "disqualified as inadequate to their task or insufficiently elaborated: naïve knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity" (1980, 82). Foucault asks:

> what type of knowledge do you want to disqualify in the very instant of your demand: 'Is it a Science?;" "Which speaking, discoursing subjects—which subjects of experience and knowledge—do you want to diminish…Which theoretical-political avant-guard do you want to enthrone in order to isolate it from all the discontinuous forms of knowledge that circulate about it? (Ibid, 85)

Where Mill believes that truth eventually arises from argument, Foucault is not so sanguine. The question regards the criterion and politics of exclusion—of marginalized medical knowledge—as well as inclusion. Here we counsel humility in the face of modern science, as certainty regarding its superiority over previous forms is rooted in confidence in its methods. We do not celebrate quacks as much as ensure that scholars of medicine and health listen to them, both in their particular claims as well as the contexts and motivations that surround them. To flesh out our position, we now turn to brief critiques of two central institutions of the contemporary medical establishment to see how Mill, Foucault and Wesley might help us think them anew.

Randomized clinical trials

Randomized clinical trials (RCTs) are studies "in which the subjects are randomly distributed into groups which are either subjected to the experimental procedure (as use of a drug) or which serve as controls" (Merriam Webster 2015). RCTs are often called the "gold standard" of biomedical research because they enable researchers to isolate and manipulate variables in controlled environments to better understand interventions' correlative effects. RCTs have enabled biomedical researchers to make tremendous strides and produce a knowledge base that has improved the lives of patients. Yet, the contemporary focus on RCTs and the medical advances they have made possible often tend to miss what is lost in these trials. The issue here is less of a flaw than a limitation, especially when those limitations have consequences for epistemological boundaries of social consequence along racial, ethnical, or sexual lines.

Following Kaptchuk, "The claim that the RCT is objective may fall short of a 'hard' correspondence with reality. Still, the blind RCT may be objective in a 'softer' or disciplinary sense: it is a standardized, explicit, replicable, and impersonal procedure that defines unambiguous and formal norms for medical researchers" (2001, 549). Ideally, an RCT's "system of rules minimizes the need for personal trust and subjective judgment and 'limit[s] the exercise of [personal] discretion'" (Kaptchuck 2001, 549, quoting Porter 1992).

Yet, RCTs are also often dependent upon funding channels that privilege high profile causes and profit-seeking interests. They are comparatively rare in cases where returns are small, as in the case of rare diseases (Gerss and Köpcke 2010) or where consent is murky, as in the case of children (van Stuijvenberg 1998). The result is that RCTs, despite their rigor, often reflect social hierarchies of various sorts—precisely the question with which Wesley was concerned. For these and other reasons, some scholars have begun to make the case for non-randomized research (Shadish et al. 2001, 2008), taking aim at what is lost in RCTs rather than merely what is gained (Kazdin 2010). These critics align themselves with Mill's concern with ensuring that marginal perspectives are given a chance to withstand critique. Concerns associated with RCTs also reflect Wesley's concern with the accessibility and democratization of medical knowledge that could serve as a counterweight of dominant epistemes that tend to subjugate and discipline competing forms of knowledge. A willingness to notice what is lost in RCTs and how they reinforce hierarchy reminds us that even celebrated institutions of contemporary medicine are subject to blind spots. Wesley's text can be read profitably toward this end.

Experience

PP is grounded not in rigorous clinical trials but a certain claim to experience. To a great extent, its legitimacy issues from a claim about what works rather than that which is grounded in the contemporary understanding of research. In *PP*'s preface, Wesley notes, "I have only consulted herein, experience, common sense, and the common interest of man-kind" (2003, iv). A key question for Wesley's contemporary readers is how his understanding of experience measures up to contemporary challenges to conventional truth and "subjugated knowledges" actively engaged in "insurrection." Wesley's question can be extended to the more recent feminist question of whose experience "counts" and whose does not (Scott 1991, 773-97). Additionally, these questions are framed in the contemporary period by the extraordinary political and social power of the American Medical Association (AMA), which has undertaken a sustained effort to not only legitimize its own perspectives on medicine but to delegitimize others (Starr 1982; Wolinsky and Brune 1994). The institutional politics of the AMA raises questions about the definitional boundaries of the "medical" underpinning the view of medicine it defends.

PP's lay empiricism can also be read as resistance to theory. As Paul Starr notes, Wesley sought "a reasoned explanation of the symptoms and causes of disease," but provided "only an inventory of what [Wesley] thought to be ancient cures" (1982, 33). In this regard, Wesley's approach aligned him with critics of scholastic and other approaches that privileged theory over observation. Yet, Wesley made his own theoretical preference known, since the problem was not theory as such, but the eclipsing of self-care traditions by "complicated theories" derived by physicians to "confuse ordinary people" (Ibid.). Wesley did not claim that physicians *intentionally* complicated medical practice, of course, but found a strategic mystification—to the advantage of elites and the disadvantage of non-elites—at work in the overcomplication of the fundamentals of health. Dr. Thomas Fuller confessed as much in 1730,

noting, "I grant indeed that in matters more speculative than practical, I have designedly written above the captus of vulgar heads" so that those who work "in trades and inferior occupations should find their proper business and not meddle" in medicine (Hill 1958, 6). Poor people were not qualified to care for their own health. Though Wesley did not disregard the growing medical profession, he was worried that "doctors' growing control over the 'secrets of healthcare' conferred too much power over a credulous public" (Holifield 1986, 141). *PP* should therefore not be read as an anti-establishment screed so much as a counter-weight and attempt to catalogue local knowledges. Wesley felt that lay experience had to matter in a world that denied regular access to elite health care.

Conclusion

In *PP* Wesley sought to disseminate what he considered to be medical knowledge for the masses and was dogged in his insistence that this knowledge should not be overcomplicated. For Wesley, the measurement of appropriate technicality is itself at issue, a theme modern scholars can appreciate given the extent to which technology drives health care costs, with an attendant impact on access (KFF 2007).

There is of course something of a paradox in the fact that Wesley saw himself uniquely qualified to write such a text. He decidedly did not advocate opening the gates of medical expertise to any layperson. His reference to his father's knowledge about consumption reminds us that this hierarchy is also gendered. Accordingly, interpreters of *PP* must remember that simply because Wesley did not believe medical knowledge *writ large* need be restricted to elites, he believed that some of it did. In their prefatory note to *PP*, addressed to members of their church, Thomas Coke and Francis Asbury remind readers that, "Simple remedies are the most safe for simple disorders, and sometimes do wonders under the blessing of God" (xix).

There is clear theological motivation in Wesley's preservation of hierarchy, but Wesley balances his different interests as follows:

> At the request of many persons, I have likewise added plain definitions of most distempers; not indeed accurate or philosophical definitions, but such as are suited to men of ordinary capacities," though "In uncommon or complicated diseases, where life is more immediately in danger, I again advise every man, without delay, to apply to a physician that fears God. (vii)

Wesley sought a hierarchy in which medical knowledge was held in differing levels of depth and use, from highly educated physicians to the everyday needs of the poor. *PP*'s success was due in part to his insistence that patients be the "final medical arbiter[s]" in decisions on treatments and their efficacy (Benjamin 1990, 178). *PP* can be read profitably as an illustration of the difficulties of negotiating medical hierarchies.

PP can also be read as a productive challenge to professional medicine or, at least, an attempt to identify its blind spots. In this regard Wesley participated in a genre engaged by other well-known authors such as the Scottish physician, William Buchan, and the American populist, John C. Gunn (both authors of books entitled *Domestic Medicine*). Buchan's book was widely read by early American medical practitioners, while Gunn's is viewed as central to the Jackson-era "popular health movement." Buchan and Gunn both counseled consultation with physicians when necessary. Wesley's advice to "without delay…apply to a physician that

fears God" is laden with social significance, bypassing the question of cost and access and asserting ultimate accountability.

A reconsideration of texts such as *PP* reminds us that not all quacks are the same. Indeed, important qualitative differences exist amongst the varieties. Thus, where Eric Boyle, in his deeply researched book tends to treat quacks as uniformly fraudulent, purposely misleading (often for gain), and dangerous, he misses the lesson that we wish to learn from Wesley. Most important of all, we must distinguish between profit-seeking charlatans operating without regard for the people they purport to be helping and those whose pursuit of less expensive and more widely available alternatives to professional medicine is rooted in genuine concern, especially for the poor. Boyle writes about the 20th century: "Critics of the antiquackery camp warned of a threefold danger in alternative medicine—wasting money on patently useless therapies, subjecting oneself to potentially dangerous unregulated and untested practices, and potentially dismissing or neglecting regular medicine in the process" (2013, 171). We note the quite different issues these three concerns raise. Critically, the third addresses a preference for a type of medicine instead of a clear problem. Boyle, moreover, does not address the problem of access that motivates Wesley's critique of "regular medicine." Instead, Boyle tends to reduce quackery to a problem of legitimacy, which he often seeks to resolve by defending the role played by institutions such as the AMA and the Food and Drug Administration. But these institutions have themselves been the subject of important criticisms, especially as concerns the question of whether they place other interests over those of patients (Berlant 1975; Poen 1979; Starr 1982; Institute of Medicine 2006; Carpenter 2010). Boyle acknowledges problems at times but never leverages them to complicate his theory of quackery itself. Texts such as *PP*, we believe, can add an important dimension to the critique and understanding of these (and other) powerful legitimizing institutions. In this regard, we believe that our appeals to Mill and Foucault—both of whom expressed concern about legitimizing trends and the role played by powerful institutions—are especially appropriate.

Wesley attempted to balance populism and professionalism. He wrote at a time in which the U.S. contained "three spheres of practice relatively equal in importance—the medicine of the domestic household, the medicine of the physicians, and the medicine of lay healers," each of which "exhibited, in a distinctive way, the continuing conflict in American life between the democratic respect for common sense and professional claims of special knowledge" (Starr 1982, 32). Contemporary American health care reform is characterized by trends that serve as testimony to the persistence of these early debates. Most prominent is the move from traditional physician-centricity to so-called patient-centricity. To grasp the radicality of this shift, consider the Institute of Medicine's definition of patient-centeredness as "care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions" (2001, 3).

Patient satisfaction is also becoming an increasingly common watchword, just as a focus on less—but better – care is becoming a key value in the pursuit of developing an efficient and effective American health care system under incentives established by the Affordable Care Act. We are learning that fewer interventions by experts can actually lead to the same and possibly even better health outcomes (Jena 2015), suggesting a need for rethinking the benefits of health services offered by "regular medicine." It is clear that more professional interventions do not necessarily yield healthier patients. This is

not to say, of course, that health care should be left to laymen. Rather, it is a call to rethink the meaning of the medical and consider alternative approaches to the persistent plight of poor people's access to routine health care.

Another important touch point for Wesley and contemporary American health care reform is their shared concern with wellness. This concern should not be surprising to those versed in early American political culture, especially as folk heroes such as Benjamin Franklin emphasized moderation and balance as core virtues of healthy and productive living. Wesley, too, understood the role that wellness and preventative care could play in making many medical interventions unnecessary. Though he never speaks about prevention in broad theoretical terms, he suggests that dependence upon unscrupulous apothecaries "may be prevented by a little care and common sense, in the use of plain, simple remedies which are here collected" (viii).

Wesley viewed *PP* as a book for the prevention of serious illness with more than forty remedies contained in it concerning themselves with prevention of the onset of illness or the prevention of its return. Wesley often counsels avoiding certain activities and foods instead of prescribing medicine or medical treatments. As two examples, Wesley advises avoiding wine and sauces in the case of nervous disorders or stagnant water in the case of worms (44, 56). Again, cold baths (largely dismissed by modern physicians) and exercise were for him the preventative measures of all preventative measures, with sedentary activities being a primary concern (vi). And although psychosomatics were many years from being seriously considered, Wesley held that "passions…actually throw people into acute diseases" and unless the "passion which caused the disease is calmed, medicine is applied in vain" (Ibid.). Wesley concerned himself with the diverse possibilities of how diseases develop (inordinately among the poor) and what could be done to address them.

The push for the deeper integration of evidence-based medicine and comparative effectiveness research, as well as payment reforms based on value (or measurable outcomes) instead of "fee-for-service" systems, is provoking discussion among health policy scholars. This push is also raising important questions about the limitations of what counts as the evidence of "evidence-based medicine" (Williams 2010), especially as scholars continue to struggle to measure the significance of medical interventions to quality of life. Rooting medical science in evidence is of course an attractive goal shared by parties as disparate as Wesley and the Institute of Medicine. Attaining this goal is far more complicated than it at first appears, as the effectiveness of some treatments is easier to demonstrate than that of others. As we have noted, professional organizations often determine whether studies are undertaken at all.

A critical reading of *PP* can yield new tools for navigating these and other questions. Rather than merely challenging contemporary medicine, such tools should pique our curiosity about what constitutes evidence, why and how certain experts are seen as legitimate while are others are discarded, and help to unearth the political dimensions of medical expertise and professionalization. Such questions can only arise out of the kind of perspective taking that the medical humanities can offer. As we have explained, contemporary systems of truth and disciplinary power secure their positions precisely by containing challenges to their epistemic orders. Returning regularly to the marginalized and discarded therefore becomes critical for scholars concerned with shoring up the bases of contemporary medical knowledge. Without broad social context and the tools of humanistic inquiry, contemporary medicine runs the risk of forgetting to question its own foundations.

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