

‘it bringeth them into dangerous perill’: Management of and recovery after miscarriage in early modern England c.1600-1750.

‘if she should continnew micarring it would be of very ill consequence to her health, I hope she is well for ye time & sh[oul]d be glad to know how she is ... - whethor, for sume tim[e]s such ill, bouts ar[e] more daingeras [sic] then a lying in’.¹

On 20 July 1717 Mary Halifax wrote to her brother Henry Davenport (in Isleworth Middlesex) full of concern over the news that her sister-in-law, his wife, had miscarried. Many women in early modern England suffered miscarriages, including losses late into the pregnancy. As Mary’s letter reveals, relatives and friends discussed miscarriages, including what we would now term still-births, in their letters as a matter of course, as an explanation for missed social engagements, or to seek and proffer medical advice. Mary’s anxious enquiries also illustrate that women’s health was understood to be significantly compromised in some miscarriages. Scholars have demonstrated the ways in which women worked through the grief and spiritual crises associated with miscarriage and still-birth, but less has been said about physicality of miscarriage and how medical practitioners and domestic healers approached the task of securing a woman’s return to health.

The ways in which women and medical practitioners understood the difficulties of miscarriage and the resultant need for medical intervention is explored here to reveal the impediments women faced in returning to good health after the loss of a pregnancy. It also reveals the gendered nature of this work. The article emphasises that printed discussions of miscarriage failed to adequately address the methods and medicines required to help a woman after a miscarriage. This is not to say that medical practitioners were not called to

attend women, as they evidently were, but that the work of helping a woman after miscarriage likely fell to midwives and those in the domestic setting who used knowledge acquired and circulating in female-centred recipe collections to support them.

The article builds upon Leah Astbury's excellent work on the return to health following childbirth. Astbury emphasizes that pregnancy and birth took significant tolls on the female body which required time to heal and regain its strength.² The month that women, with adequate wealth to support them, took to recuperate allowed their bodies to do this. However, as Astbury argued, women did not simply view the completion of this month as a return to themselves, their roles, and their community. Their own recovery might not map neatly onto the cultural script that suggested a month was all that was requisite.³ The experiences of women who miscarried are distinct from those women who gave birth to a live child, as there was no new baby to care for during recovery. Their experiences, although potentially similar, were not homogenous. An early loss may have been felt very differently to one later in gestation – although, as will be seen, medical writers did not emphasise these distinctions.

It is, therefore, important to consider their experiences in more detail. The women discussed here suffered from what would now be known as spontaneous abortion, rather than induced abortions, despite the flexible language of the era that used 'abortion' and 'abortment' to describe a miscarriage. Hannah Newton has argued that attention needs to be paid to the process of recovery in early modern health narratives more generally.⁴ She has encouraged us to think less pessimistically about medical treatment at this time by exploring more fully the road to recovery and what this experience was like for patients. Although the evidence for women's own perceptions of the experience of recovery are limited, placing these within the wider context of medical observations and texts reveals the complex nature of securing health after pregnancy loss.

The article also builds on the work of scholars such as Sara Read and Daphna Oren-Magidor who have articulated the ways in which women emotionally and spiritually rationalised their experiences and grieved for their losses. Read has argued that women used their faith to rationalize their experiences of the reproductive body and to manage their grief during pregnancy loss.⁵ Moreover, they used their losses to aid their spiritual growth.⁶ She has also shown that women used miscarriage as ‘a metaphor for broader spiritual concerns’.⁷ Oren-Magidor has similarly highlighted that women interpreted miscarriage as a reminder of sins and a call to improve piety.⁸ Women wrote poetry to work through their emotional responses to a lost pregnancy; Lady Mary Carey, Read has shown, did so to explain that her insincere worship, the dead fruit produced by her spiritual self, was rewarded with her own dead fruit.⁹ Joanne Begiato has demonstrated that in the late eighteenth century the language of grief, in this case over the death of a child, became more secular in tone, but that providence continued to provide the explanatory framework for terrible losses.¹⁰ Religious and emotional rationalisation of miscarriage therefore remained relatively stable across the period.

Men and women had to reckon with their experiences of loss. Paige Donaghy has convincingly argued that women experienced molar and false conceptions as pregnancy losses, akin to miscarriages.¹¹ In some cases, practitioners suggested to men and women that they had only lost a molar pregnancy rather than a true conception to lessen the parents’ sense of grief and loss.¹² These responses were deeply emotional and, as Karen Harvey has explained, emotions were deeply rooted in the body.¹³ Emotions were generated within the body and the body was the site in which they were experienced. Emotions caused physical effects within the body including swelling and pain.¹⁴ Harvey has examined early eighteenth-century documents relating to the case of Mary Toft which reveal in detail one woman’s need to discuss and describe the emotional and physical trauma of miscarriage.¹⁵ The emotive

terms Toft used (uneasy and desperate) to describe her ongoing pain in the monstrous birth hoax focused on her body.¹⁶

Miscarriages were also utilised to reinforce gendered expectations of behaviour, as they provided an opportunity to criticise women and men for inappropriate conduct.¹⁷ Cases were brought against men whose assaults caused women to fear they might lose a pregnancy or triggered a miscarriage underlining their failure to protect and support pregnant women.¹⁸ Responses to miscarriage were thus interwoven into the social fabric of early modern life. The desire to understand, explain, and articulate experiences of miscarriage are writ large within the sources and historians' subsequent analysis. These emotional articulations occurred, in ways that have not been fully elaborated by historians, against a backdrop of pain, discomfort, and bodily unease that likely sharpened these responses.

This article also expands our understanding of what the management of miscarriage involved. Throughout the early modern period and into the nineteenth century early pregnancy, particularly before quickening, was ambiguous and women felt uncertainty about whether gestation would terminate early.¹⁹ Michael Eshleman argued in 1975 that 'the possibility of miscarriage appeared to influence nearly every facet of prenatal care'.²⁰ Subsequently, Linda Pollock highlighted that mothers bore the weight of responsibility for following prenatal care recommendations.²¹ Dietary advice focused on the belief that adequate nourishment was necessary to avoid miscarriage or the development of a weak and sickly foetus.²² It moreover sought to correct and prevent conditions like constipation, fluxes (diarrhoea), and vomiting that could stimulate early abortion.²³ Medical literature advocated remedies intended to prevent a miscarriage from occurring. These were designed to strengthen the mother and have astringent effects that would close off the cervix.²⁴ Prayers were important alongside magical and amuletic devices that sought to ensure a conception was carried to term.²⁵ The management of miscarriage was not only the use of measures

designed to prevent it from occurring. Once a miscarriage was happening steps were also taken by physicians, midwives, and domestic healers to prevent a final loss.²⁶ More than this though, miscarriage was a significant physiological process that required careful management to best ensure a woman was able to recover her health. The physicality of miscarriage shaped understandings and experiences of pregnancy loss in ways historians are yet to consider.

Drawing on printed medical texts that addressed obstetrics alongside printed and manuscript case notes, personal correspondence, letters to physicians, and manuscript recipe collections this article focuses our attention back onto representations of the bodily experience of miscarriage. These sources are concentrated on the seventeenth century and early eighteenth century, until 1750. They include texts such as Philip Barrough's *Method of Physicke*. While this treatise was originally published in 1583, it went through seven different editions to 1652. Barrough was licensed to practice surgery by the University of Cambridge in 1559, and while his theoretic writing is conventional, the treatise included his own ideas, experiments, and observations.²⁷ Barrough's work is examined with other texts that contain discussions of theory alongside patient observations like William Salmon's *Medicina Practica* from 1692. The *Practica* presented 'the method of curing the most usual diseases', with an additional book following that discussed the philosophical works of a range of earlier authors including the thirteenth-century scholar Roger Bacon and the fifteenth-century alchemical writer George Ripley. Salmon's works typify the ways in which seventeenth century readers were presented with older ideas as worthy of 'Veneration'.²⁸ Nonetheless, Salmon proclaimed in the preface to his work that the book 'of *Practical Physick*, is (for the most part of it), my own, deduced from a large Series of Experience'.²⁹

These general works sit alongside medical texts that specifically addressed female complaints and midwifery, notably early works like the English translation of Jacques Guillemeau's *Child-birth, or, The Happy Delivery of Women* (1612), that was reprinted again

in 1635, and works produced by English writers including Nicholas Culpeper, James Wolveridge, and Jane Sharp. Culpeper's midwifery treatise went through numerous editions from 1651 onwards, while Sharp's work is recognized by some as the first midwifery treatise authored by an English female practitioner.³⁰ Midwifery treatises produced by male writers do not necessarily reflect knowledge based on extensive experience and practice, yet they reveal the theoretical understanding of the issues that shaped people's expectations and that framed medical interventions. Across the period texts were also published that considered women's health but were not explicitly labelled as midwifery guides. For instance, John Sadler's *The Sick Womans Private Looking-Glasse* (1636) and *The Ladies Physical Directory* (1727) both claimed to be written to aid ignorant women and help them seek help for secretive conditions in good time and covered a mixture of gynaecological and obstetrical topics.

The manuscripts considered cover the period c.1625 to 1752 and include private correspondence, letters to physicians, and recipe books. These items are restricted in terms of the portion of society they represent, those literate and wealthy enough to generate extensive collections of letters, engage physicians, and keep recipe collections. The letters, for example, were penned by the Earl of Halifax, Lady Meautys (the daughter of the painter Sir Nathaniel Bacon) and members of the gentry Barrington family. The letters offer a tantalising snapshot of women's embodied experiences of miscarriage, something that is largely absent from the other sources consulted, which instead reveal the practicalities of managing a woman's health from the perspective of medical practitioners and other witnesses. Many recipe books are described only as late seventeenth and eighteenth century and so exact dating is not possible. Recipe books, as has been well documented, functioned in a variety of ways.³¹ These repositories reveal imperial connections, notions of locality and space, structures for organising and testing knowledge, and gendered aspects of medical practice.³² They were

social documents that demonstrated societal connections and were familial, being refined and reworked as they moved through successive generations.³³ Remedies were experimented with, adjusted, and moulded to fit different people's needs, preferences, and experiences. Similar, but not identical, remedies were therefore shared and recorded. It is not always clear that remedies recorded in such collections were made and used. Moreover, remedies to manage the effects of miscarriage on the body were not consistently included in recipe collections. This perhaps suggests that women recognised that each miscarriage was liable to be very different and medicines needed to be tailored to individual circumstances. Moreover, it might suggest that women were attended to by midwives who brought with them their own knowledge about treating such conditions. These collections tell us very little about what ordinary working women did to manage a miscarriage. Some of the remedies described in these collections and discussed here were explicitly intended to help during a miscarriage, others were not. Examining these texts alongside letters and case notes illustrates that a range of remedies should be resituated in our understandings of the management of miscarriage and recovery from its after-effects.

Published works and domestic collections were intended for different audiences and purposes. However, reading published works alongside personal documents and recipes establishes the broader understanding that shaped the ideas presented in the brief notes about remedies and experiences. It is evident that literate men and women read and studied a range of medical works.³⁴ Elizabeth Walker (1623-1690) had copies of the works of Lazarus Riverius and other translations and works published by Nicholas Culpeper.³⁵ Where possible, case notes discussing the difficulties faced by women, the remedies they received, and their path to recovery have been drawn on. These cover physicians working in a range of locations including Lancashire, Kent, and Warwickshire between the 1630s and 1750. The letters and case notes together demonstrate the ways in which ideas discussed in medical literature were,

or were not, applied in actual cases and bring to life more vividly the complex nature of recovery in these situations, albeit largely from the perspective of practitioners.

Many seventeenth-century English medical writers did not have first-hand knowledge of attending births, conversely in France writers like Jacques Guillemeau had extensive experience working in the Hôtel-Dieu in Paris assisting with deliveries. He, like other male medical writers, outlined and categorised what constituted a miscarriage. Guillemeau explained that the ‘exclusion of the child already formed and endued with life, before the appointed time’ was considered an ‘abortment’ or miscarriage.³⁶ Over fifty years later, *The Woman’s Friend* (1666) attributed to Nicholas Sudell, likewise explained that a miscarriage was the ‘bringing forth of an imperfect or unripe child’.³⁷ Eighteenth-century audiences continued to be exposed to earlier ideas about miscarriage through editions and republications of seventeenth century works.³⁸ A 1755 edition of *A Directory for Midwives*, bearing Nicholas Culpeper’s authorial attribution nine years after his death, showed little had changed in understandings presented in medical texts. The chapter ‘*Of Abortion*’ declared that ‘IT is the exclusion of a Child not perfect nor living, before Legitimate time’.³⁹

Distinctions were made between miscarriage and still-birth, but these were not rigid or entirely clear. Guillemeau described that ‘Abortment hapneth after the fortieth day, yea, even to the end of the ninth moneth’.⁴⁰ Nicholas Culpeper’s *Directory for Midwives*, which was first published in 1651 and dominated the field of midwifery publication in the seventeenth century running into at least a dozen editions,⁴¹ likewise, described how ‘Abortion or Miscarriage’ was more likely in the ‘two first months of their Conception, because then the Ligaments are weak and soon broken, and towards the latter end of her time, because then the Womb is so full that it cannot shut close’.⁴² The later 1755 edition of

Culpeper's *Directory* also explained to readers that there were differences in what was 'cast out' in a miscarriage with some women losing something 'little and round, without distinction of Members' and some women losing a 'Child [that] is almost perfect'.⁴³ Yet both Culpeper and Nicholas Fonteyn's works included separate chapters on 'the Dead Child'. The positioning of these chapters within the works suggested that still-births were much more closely aligned with the experience of labour: Culpeper's appeared after the chapters on miscarriage and on labour with a living child, while Fonteyn's appeared after the chapter discussing women's labour and attendant complications.⁴⁴ Likewise, Richard Kay working in eighteenth-century Lancashire delivered several women of still-born children. He did not state how far into gestation these events occurred but classified them as deliveries rather than miscarriages. In one case he noted that on 24 December 1748 he attended Edward Kay's wife, of Brookbottom, and delivered her of 'two dead Boys'.⁴⁵

Laura Gowing has amply demonstrated from court records that women perceived pregnancy loss in non-specific terms until late into gestation.⁴⁶ She noted that women used terms such as 'scape', 'slip', 'gristle', thereby overlooking the detail of the flesh that was lost.⁴⁷ The unmarried women she discussed were suspected of infanticide and so were more likely to emphasize the unformed nature of their births. Nonetheless, married women also show evidence of a slippage of terms. Alice Thornton described the birth of her first daughter (who lived only half an hour) late in her pregnancy, but then explained that after 'the Miscarriage' she fell ill.⁴⁸ There was then slippage between the concepts of miscarriage and still-birth that existed for those experiencing and treating the parturient body in the early modern period.

To understand the approach to recovery that early modern society took, it is essential to comprehend the factors they considered likely to cause a miscarriage. The loss of a pregnancy could be the result of weakness in the seed contributed by the male or female

partner, or it could be caused by a lack of menstrual blood required to nourish the developing progeny. A small womb that did not provide sufficient space for the baby to grow was thought to be a particular cause of late term miscarriage, as could a weak cervix that failed to bear the weight of a baby *in utero* in the later months of gestation. Beyond these inherent problems with the reproductive body, it was explained in numerous treatises that miscarriages were caused by physical assault or accident. Medical writers were clear that ‘falls or bruises’ and ‘strokes’ (blows) caused women to miscarry.⁴⁹ Occasions like this also contributed to emotional states, ‘Anger, Fear, [and] Sorrow’, that were thought to trigger a miscarriage, by flooding the womb with hot blood (anger), or by diverting blood and vital spirits away from the womb (fear and fright).⁵⁰ Women understood the interplay between their emotional and physical states: In January 1682 Dianah Tilley claimed that her miscarriage was caused by a group of men engaging in a skimmington at her window, where she lay sleeping with her husband, because she had encouraged him to ‘putt away his Doggs & not spend his time a hunting’.⁵¹ She declared that they put her in such a state of fear that ‘she returned home & miscarried ... & was in Danger of loosing [sic] her life by that fright’.⁵²

Miscarriage could also be triggered by varied illnesses. Culpeper’s *Directory* explained that ‘Aposthumes, or Inflammations of the Womb’ stopped it from ‘perform[ing] its office’.⁵³ *The Midwives Book* (1671) added that ulcers, piles, or a bladder swollen with the stone or strangury (a urinary condition characterized by a strong desire to urinate and an irritation of the bladder), ‘Sharp diseases or Pestilential Feavers, Imposthumes in the breast, Palsies’ and falling sickness could all put the child at risk.⁵⁴ Again, the fear that disease and illness could lead to a miscarriage was widespread beyond medical practitioners. On 18 June 1700, the Earl of Halifax wrote a letter to Dr John Moore, Bishop of Norwich. He described how his wife ‘has had a feavour these ten days attended with a cough’ (coughs as well as fever were thought to be able to trigger a miscarriage).⁵⁵ The Earl described the treatments his

wife had received and her ongoing condition before stating ‘She has yet no signs of miscarrying; but in her condition, I am under all the apprehensions Imaginable for her’.⁵⁶ The potential for disease to cause miscarriage was acknowledged in a range of circumstances. Elizabeth Stafford was indicted at the Old Bailey in February 1684 for infanticide. However, she was acquitted after the witnesses all agreed that ‘she had not gone above five Months of her time at the most, that the Child was not alive, and that she having the Small Pox, did by that illness Miscarry’.⁵⁷ Women who suffered a pregnancy loss were then, in some cases, already experiencing the ravages of ill health and bodily discomfort that may have affected their recovery.

Medical treatises warned readers that miscarriage posed a distinct threat to women’s bodily wellbeing. They reflected on the dangerous nature of miscarriage and its potential effects on a woman’s future ability to conceive and carry a child to full term. They therefore outlined the potential difficulties women faced in recovering from their experience. William Salmon declared that miscarriage was more painful and dangerous than full term labour arguing that ‘It is not unlike to unripe Fruit, which is difficultly [sic] pulled off the Tree; whereas was it full ripe, it would drop of its own accord’.⁵⁸ The author of the *Ladies Physical Directory* (1727) was similarly emphatic: ‘nothing proves more dangerous to the Female Sex, than that great misfortune; for it being Unnatural, is always attended with ill Symptoms, and proves much worse than a regular Child-birth’.⁵⁹ The understanding of the dangerous nature of miscarriage, perhaps, related to ideas about the nature of birth where both the infant and womb were afforded agency and were thought to struggle together.⁶⁰ It is plausible that an underdeveloped foetus lacked the strength to aid birth thus rendering the process more difficult and dangerous. The *Ladies Physical Directory* explained that even if a woman avoided immediate danger of death, they would develop a propensity to miscarry, suffer from a ruined constitution, a weak body, and a shortened life.⁶¹

Sarah Fox has outlined the ways in which birth, in the eighteenth century, was a process; it was not one moment, or ritual, but a series of interconnected events.⁶² The experience of miscarriage can likewise be conceptualised as a process that encompassed several stages: fears that a loss might occur and the identification of concerning symptoms, the loss of the foetus, the management of the body, and eventual recovery. These stages were not necessarily entirely distinct from each other but blurred into one another. They were also different in each loss.

Newton has explained that recovery from illness in this era involved the input of three entities, God, nature, and the physician.⁶³ It was a two-stage process, the removal of disease and the restoration of strength.⁶⁴ Women who miscarried, similarly, experienced two interconnected stages (further explored below), the removal of the products of miscarriage and the recovery of strength. When Brilliana Lady Harley suffered a miscarriage in January 1639 she described to her son the ongoing process of regaining her strength explaining that a month later she was 'still weake'.⁶⁵ Yet recovery for early moderns did not always mean a return to perfect health. Medical observations often described patients as cured while noting ongoing symptoms and difficulties. This again maps onto women's miscarrying bodies. The evidence that survives and is examined here predominantly describes women whose recovery was impeded in some way by the experience of further symptoms, perhaps because it was less necessary to comment on the health of women whose recovery progressed well. For example, Samuel Pepys briefly noted in his diary for the 14 March 1662 that he had been 'to speak with my uncle Wight and found my aunt to have been ill a good while of a miscarriage'.⁶⁶ Similarly, John Evelyn noted that his wife Mary was 'extreamely ill' following a miscarriage in May 1651.⁶⁷ Managing a miscarriage thus merged with the process

of recovery, whereby disease/illness had to be removed from the body in order for a woman to regain her strength.

The management of miscarriage itself focused on ensuring that the pregnancy came away from the body. Retaining the products of miscarriage in the body resulted in infection and potentially death. Richard Wilkes was called to a Mrs Hawks of Wednesbury (then in Staffordshire) in December 1742.⁶⁸ He outlined in his journal that she started bleeding at two months pregnant (before quickening at four months it was thought to be very difficult to accurately identify a pregnancy) and presented with diarrhoea, feverish symptoms, and excessively dilated pupils that Wilkes remarked were unlike anything he had observed before.⁶⁹ Mrs Hawks only recovered once 'An Embryo abt the size of a Bee was taken from her by Mr. Altree' (likely a surgeon as they carried out physical operations rather than the attending physician).⁷⁰ Several remedies found in early modern recipe books were designed to aid those who had suffered from a miscarriage but whose offspring had not yet come away from the body. For example, in Wellcome Library MS 7721, a recipe book dated between 1675-c.1800, one author recorded two remedies designed 'To bring away a dead child'.⁷¹ Another anonymous recipe book housed in the Somerset Heritage Centre dated to the late seventeenth and early eighteenth centuries includes several remedies related to menstrual conditions and pregnancy.⁷² Listed after a method 'To Know whether a child be Male or Female' the author included a remedy 'To Expell a Dead Child'.⁷³ The author was careful to explain that the ale made with compana (possibly a bell-shaped flower) and rosin (resin) should not be given 'whilest the child is liveing by any means'.⁷⁴ A second remedy intended 'To deliver a Dead Childe' was recorded several pages later made from yellow amber and cassia fistula, again the author detailed that should only be given to a woman 'upon a greate Extremety that there is noe other waies'.⁷⁵ The author was clearly attuned to concerns that these remedies might be given in error, or deliberately, and result in the death of viable

offspring. It is plausible, as historians have often emphasized, that expulsive remedies to cleanse the womb and provoke bleeding were employed by those attempting to terminate a pregnancy.⁷⁶ Nonetheless, the threat that retained pregnancy material presented to women's bodies means that we should not overlook the need for these remedies in cases where a woman's life could hang in the balance.

Recipe book authors also described remedies intended to remove both the foetus and the afterbirth. The recipe book ascribed to Anne Brumwich and others (dated c. 1625-1700), included three recipes to preserve women from miscarriage, followed by another designed to aid postpartum women and those who suffered from a miscarriage to expel the birth and afterbirth. The author stipulated, though, that this recipe would bring away a dead foetus if 'it be in peices [sic]'.⁷⁷ The language of these recipe's titles acknowledged that not all women who suffered from a late miscarriage would experience contractions (and perhaps that both the womb and foetus lacked the agency to effect delivery), and so needed a remedy to provide the body with the impetus and stimulus to bring on labour. Remedies of this kind sometimes appeared alongside those designed to aid the delivery of living – in some cases breech or abnormal presentations – foetuses.⁷⁸ Some recipes were described as effective in both cases (a living or dead child and afterbirth). Two such recipes were included together, in two different hands, in the seventeenth-century recipe book of the Jerningham family of Costessey, near Norwich, in Norfolk.⁷⁹ Those labelled 'To procure delivery' were not specifically for either occurrence.⁸⁰ This suggests that while some people may have harboured concerns that women would misappropriate medicines of this sort to remove unwanted pregnancies, the dangers that miscarriage and still-birth posed to women's bodies were more immediate and more alarming.

Another key component of managing a miscarriage, and in so doing securing a woman's ability to recovery, was the removal of the placenta. The recipes just discussed were

clear about the intention to remove the deceased offspring, yet remedies of this sort were also regularly described as functioning to remove the afterbirth and any residue of the pregnancy from the womb. These remedies were, of course, also necessary for women who delivered at full-term and whose placentas were retained.⁸¹ William Salmon's *Medicina Practica* (1692) included a remedy explicitly for 'after Miscarriage' that was intended to remove the afterbirth and restore women who experienced a continual 'Flux of Blood' after the loss of their pregnancy.⁸² The remedy included bistort root, pennyroyal and marjoram taken in water and white wine, sweetened with syrup of mugwort and cinnamon water.⁸³ Salmon attributed the remedy to the Dutch physician Franciscus Sylvius and claimed that it had worked to remove 'a piece of the After-birth, as big as ones Fist' in a patient.⁸⁴ Salmon's only training, according to his critics, was as an apprentice to a Mountebank and while he recorded in some of his advertisements details of patients he had treated it is not evident in the *Practica* that he had ever employed this remedy himself.⁸⁵ The inclusion of the remedy does underline that this was perceived to be an important aspect of managing miscarriage to ensure women recovered. Nicholas Gaynsford who was an apprentice to Dr George Willet in Groombridge on the Sussex/Kent border in the early eighteenth century recorded in his manuscript of observations that such a remedy, made from pennyroyal, germander, and spearmint, was used to treat a woman who miscarried after falling from her horse.⁸⁶ Remedies with the same intended purpose were recorded in manuscript receipt collections. Some of these recipes, unlike those above, did not use the language of 'delivery' but portrayed the process as one of waste removal and cleansing. This reflects broader medical theory that healing necessitated the external flow of purulent matter until the body had been sufficiently cleansed.⁸⁷ The collection of remedies ascribed to Johanna Saint John includes 'A Tanzy to bring away a dead child or any thing left'.⁸⁸ This was the second such recipe recorded by the author. Another was described as 'Dr Willis for one that lyes Inn or has miscaryed when ther

cleansings smel & to bring away any thing left'.⁸⁹ The titles appended to these remedies underline the necessity of bringing away all remnants of the pregnancy to restore the woman's body to health. They also emphasise that physicians were called in to assist with this aspect of managing miscarriage. Only after these products of the body had been removed could a woman begin to recover her strength.

Salmon's text stressed how important these remedies were thought to be for women's recovery. He included an observation of a woman who miscarried at fourteen weeks and developed a fever two days later. He described how all 'due means' were used, and 'sufficient Cleansers; but the *Placenta* or After-burthen stuck so fast, that it could by no means be removed'.⁹⁰ Throughout her treatment, he related, she 'voided a filthy Cadaverous stinking Matter', at the end of the tenth day she died.⁹¹ Salmon's reference here to 'due means' is intriguing as it hints that manual removal of the child and placenta were sometimes necessary, as in the case of Mrs. Hawks above. The use of such methods is not explicitly discussed in the evidence gathered here. Salmon also took pains to caution readers to consider carefully whether a miscarriage was feared or had already occurred. Many of the remedies designed to prevent miscarriages from occurring were astringents and thus, he declared, would significantly threaten a woman's health if a miscarriage had already occurred by encouraging the body to dangerously retain the placenta.

Once the products of the pregnancy had been removed regaining strength could take significant amounts of time. As with women who gave birth at full term, evidence suggests that women who suffered a miscarriage participated in lying in. A patient described in the English translation of Louise Bourgeois's midwifery treatise suffered a still-birth in 1610. The unfortunate woman was described as having endured no illness after her experience and 'had as good and as happy a Lying in as any Woman in the world'.⁹² This emphasizes that early modern men and women understood that women required time to recover and

recuperate. In 1699 Anne Kenricke suffered a miscarriage after engaging in an affair with a tenant.⁹³ It was noted that she was lying in bed recovering when her lover discussed the affair with the other lodgers. Similarly, Mary Toft reported that when she suffered her miscarriage in 1726 women helped to support her by working in her place so that she could recover.⁹⁴

The length of time required for recovery could be extended if there were complications arising from the miscarriage. A frequently discussed complication was the potential for haemorrhages to occur. In *The Method of Physicke* (1583) which was reprinted into the seventeenth century, Philip Barrough explained that an excessive '*flowing of menstريس*' could be the result of 'grievous travaile in childbirth', in which case the symptoms would often resolve themselves.⁹⁵ He followed this by stating that 'Oftentimes after aborsion, they labour of a vehement aborsion, and fluxe of the menstريس, and sometimes it bringeth them into dangerous perill'.⁹⁶ Here Barrough was clear that the experiences of postpartum women would potentially be different to those women who miscarried. These women would be much more likely, given the symptoms would not resolve themselves and posed a significant threat to health, to need medical interventions to help them recover. This is reflected in the recipes recorded in manuscript collections. A remedy recorded in Elizabeth Okeover's collection was 'To stop ye violent overflowing of: m[enstrual]:p[urges] after miscarriage'.⁹⁷ In this remedy hot 'pigge dunge' was applied to the woman's vulva and she was given some of her own menstrual blood in a posset drink or ale. This was intended to 'burne the course of her blood by occationinge vomittinge or wretchinge' to resolve the problem.⁹⁸ Similarly, the author of an anonymous seventeenth-century recipe collection noted a medicine 'for one yt floods in a miscariage' that had come from 'Mrs Chapman the midwife'.⁹⁹ Heavy blood loss, might on occasion, also lead to further problems. *The Irish Midwives Handmaid* (1670) published by

James Wolveridge M.D., an English doctor practicing in Cork, claimed that uterine prolapse could be occasioned by sudden and immoderate fluxes of the blood ‘as is usually in Abortions’.¹⁰⁰

We should be cautious though of accepting Barrough’s argument that ‘flooding’ (excessive bleeding) affected postpartum and miscarrying women differently. The eighteenth-century midwife Sarah Stone, who practiced in Taunton and Bristol, promoted her ability to rescue women from the dangerous effects of flooding on the body. In her published case notes she included cases of women who experienced flooding during their pregnancy and who went on to full-term delivery.¹⁰¹ She noted at least one case where flooding resulted in a still-birth that left the mother weak and with her legs inclined to swelling.¹⁰² She explained that ‘I have been with many Women that have flooded prodigiously some in Miscarriages, and some at their full time; but, thank God, I never lost any Life in that case, through all my Practice’.¹⁰³ This implies that heavy bleeding was experienced similarly in a variety of different presentations.

Women might also suffer complications related to the production of breastmilk. One sign that a woman was about to suffer a miscarriage was that “the milk in her breasts doth flow and run forth in great quantity”.¹⁰⁴ Culpeper stated that “When the Breasts, which before were round and full, wax lank, and flag down, for the most part abortion follows”.¹⁰⁵ This implies that medical authors expected a woman’s body to cease producing milk as a response to the loss of the child. However, this understanding was not shared by everyone.¹⁰⁶ Alice Heatly examined Mary Lakin in 1688 to see if she had suffered a miscarriage by examining her breasts. She declared that they felt hard as women’s breasts “use to do after a miscarriage or delivery of a child”.¹⁰⁷ Heatly clearly expected to find similar physical manifestations of gestation in those who lost a pregnancy and those who carried to term. When interrogated

about her pregnancy Mary Toft, claimed that she had suffered a miscarriage in August 1726 and that in the September milk flowed from her breasts.¹⁰⁸

Some midwives also acknowledged that women who had suffered from a miscarriage might be left with breasts filled with milk, that if ignored could result in mastitis. In the case of Hester George, tried at the Old Bailey in October 1726, for the murder of her infant son, the midwife Elizabeth Powell deposed that Hester had given birth to a full-term child. Hester maintained that she had miscarried five weeks previously and had been around “4 Months gone”.¹⁰⁹ Powell examined George’s breasts and drew milk from them. However, she claimed that she “could not contradict” the claim of the defendant because “she might have had Milk, if it had been 8 or 10 Weeks after such a Miscarriage”.¹¹⁰ Powell reveals that midwives in the early eighteenth century expected women who had suffered a miscarriage to still experience the production of milk and need help to dry up a now unrequired milk supply.

It is, therefore, possible that remedies were required to dry up the milk that had begun to develop in the breasts in readiness for nourishing the child.¹¹¹ The book belonging to Frances Springatt (and others) included a recipe to “dry Away Milk” made from deer suet and bees wax.¹¹² The recipe was not overtly intended to aid those who had suffered from a miscarriage or a stillbirth, only stating that it should be applied “as sone as ye woman is delivered”.¹¹³ Presumably it was expected that those mothers who intended to use the services of a wet nurse would employ such a remedy, but it was also suitable for those women who found their breasts filling with milk who no longer had a child to nurse. Similar remedies were overtly intended to aid women whose retention of milk was beginning to cause symptoms of mastitis. One remedy was titled “For milk curdling in the breast”, a second followed “For a breast yt is curdled”.¹¹⁴ These remedies required heated wormwood, cotton, flannels, or a “very sweaty stockin” to be applied to the breasts.¹¹⁵ Further advice was included at the bottom of this page for women whose children had been born living

reminding them to suckle the child quickly after birth to avoid developing sore breasts.¹¹⁶

These remedies were primarily aimed at aiding women who had carried a child to term, but were available to a woman who had suffered a miscarriage. Case notes from male practitioners rarely mention this course of action. This might imply that it was not a complication that occurred often or, perhaps more likely, was one that medical writers understood was handled by women themselves without the intervention of male healers.

It was acknowledged in printed works that women's reproductive organs could also be irreparably damaged resulting in further reproductive difficulties. Guillemeau's treatise warned that 'Those that have been delivered once before their time, for the most part they miscarie with the rest of their children, about the same time'.¹¹⁷ Some medical writers went further questioning a woman's ability to conceive again after a miscarriage. Nicholas Culpeper's *Directory for Midwives* (1676 edition) explained that miscarriage was 'most dangerous' and the women 'commonly become barren'.¹¹⁸ *The Midwives Book* explained that future difficulties with conceiving and carrying a child to term arose because a miscarriage occurring at three, four, or five months had to be expelled by force pushing the neck of the womb (cervix) which was still shut, open, unlike at nine months when it opened itself.¹¹⁹ This meant women could no longer retain a man's seed which prevented conception from occurring.¹²⁰ These medical concerns did not always filter through to the wider populace. Oren-Magidor has found evidence that women, and men, viewed miscarriages as a sign that God would bless the womb with children in the future; it was taken as a sign that a wife was able to conceive.¹²¹ Nonetheless, those who repeatedly miscarried sought remedies designed to improve their chances of conceiving and giving birth to a live child. Robert Pierce's *Bath Memoirs* devoted an entire chapter to women who had sought his advice at the baths because of repeated miscarriages.¹²² Ann (née Ogle), wife of the Honourable Cravon Howard, a member of parliament 1695-1698, visited the baths for around five weeks after suffering nine

‘or more’ miscarriages.¹²³ This treatment, according to Pierce, resulted in the birth of a live daughter not long after.¹²⁴ For those who feared that their fertility was damaged there was the potential need for further, and potentially lengthy, medical intervention in the form of remedies designed to improve fertility and the chances of conception.¹²⁵

Barbara Duden has explained that Johannes Storch’s eighteenth-century German patients rarely attributed physical conditions to successive pregnancies and miscarriages.¹²⁶ However, people in England evidently believed that women’s health after a miscarriage could be affected in ways a variety of ways. As Salmon explained, many women suffered from illnesses, not always clearly identified, after a miscarriage. A letter from Anna, Lady Meautys, to her cousin Jane, Lady Cornwallis Bacon, from March 1641 explained that she was ‘dangerously ill’ since the loss of her daughter at three months. Lady Meautys was clear that the miscarriage had posed a grievous threat to her health and that those that ‘were about me did not think I should have escaped’. She continued that she had been left ‘so weak a creature’ but God had raised her up.¹²⁷ Lady Meautys was not alone in feeling unwell after the sudden termination of pregnancy. Mary Clarke was described as ‘vomit[ing] all she did take; and had a great paine at her stomack’ following the loss of her child in 1695.¹²⁸ Illness was not always instantaneous after miscarriage. John Hall’s case notes, largely covering his practice between 1634-5, reveal that he treated twenty-eight-year-old Mrs Broughton, a gentlewoman of Cawston, who suffered from a fever and ‘excessive uterine flux’ three days after suffering from a miscarriage at five months gestation.¹²⁹ Mrs Broughton was evidently a serious case as Hall noted she was ‘in danger of death’, unable to drink or eat and ‘overwhelmed by fainting’.¹³⁰ Each of these women suffered significant health difficulties after their miscarriages which required the attention of medical practitioners.

In some cases, the illnesses described were less obviously connected to the reproductive body. In November 1708 Sir Hans Sloane received a letter seeking his advice

for a woman who was suffering headaches having endured two miscarriages previously.¹³¹ Similarly, Anne Desoulies wrote to Sloane in October 1714 requesting his aid. She had been treated by 'Doctor Chamberlin' having been 'very ill' after 'the misfortune to miscarie of a fine boy'.¹³² She had considered herself to have recovered well, but since this time had 'a very violent sore thro[a]t and extream pain'.¹³³ William Masham reported to Lady Joan Barrington in November 1631 that his wife (her daughter) Elizabeth was doing 'very well since' suffering an early miscarriage but continued to be 'some what ill of her throate'.¹³⁴ In these cases women's prior miscarriages were not only linked to symptoms that afflicted the reproductive organs, but to the entire body highlighting that to the early modern populace miscarriage could have lasting and varied effects on a woman's health. Recovery was not assured even if haemorrhages and fevers could be brought under control; while the miscarriage itself might have been effectively managed the changes it wrought in the body caused ongoing illness that needed to be removed to allow the second stage of recovery – regaining strength – to take place.

Medical practitioners were key sources of aid when women experienced these complications. This was not simply the management of miscarriage through the expulsion of the unviable foetus from the body, but steps taken to return a woman to health. The Taunton apothecary Bernard Smith treated Mary Clarke, alongside Dr Musgrove, giving her cordials to sweeten her humours and abate her vomiting.¹³⁵ These interventions by practitioners intersected with care provided in the home. Remedies and prescriptions provided by medical practitioners were recorded in manuscript receipt books perhaps because it was acknowledged that they might be useful for others in similar circumstances. In a collection attributed to Elizabeth Okeover and others, one author wrote a detailed description of the medicines given to her sister following a 'violent flux' she suffered after a miscarriage.¹³⁶ This included a mixture of red wine, plantane water and red rose water sweetened with

purslane syrup, and dates filled with red wine and roasted in front of the fire. The patient was also thought to benefit from eating ‘calves feet’ dressed in any manner and a porringer made from new milk and egg yolks. These remedies suggest a clear need to strengthen a body made weak by the illness resulting from the miscarriage. The recommendations also included bleeding and the application of cupping glasses to the breasts.¹³⁷ The road to recovery in this case involved a complex medical regimen.

Despite the evidence above that shows women were attended to by male practitioners in certain circumstances and despite the pervasive suggestion in print that miscarriage was dangerous, medical treatises and midwifery guides did not uniformly or ubiquitously discuss these issues in a coherent way. They failed to clearly address what should be done to help women and what remedies should be offered in the specific case of miscarriage. Their chapters on abortion and miscarriage discussed causes, signs, and prognostics, but the remedies included in these chapters focused on preventing a miscarriage from occurring.¹³⁸ Guillemeau argued in his treatise that the significant danger that miscarriage posed to the female body encouraged medical practitioners and writers to focus on prevention.¹³⁹ This, of course, served the double benefit that it might protect both the mother and the forming progeny, and might protect the practitioner himself from any implication of wrongdoing or failure in the event the mother died. Moreover, it would also prevent any potential damage to the woman’s future health and fertility. Women also shared a focus on preventing miscarriage: John Campbell, Lord Glenorchy, wrote to his father-in-law Henry Grey, 12th Earl of Kent, in 1720 explaining that his wife, Lady Amabel de Grey, was pregnant.¹⁴⁰ He described that having miscarried twice before, at three months, she was determined to ‘keep her room’ and ‘see no body’ until that

time had passed for fear that the ‘fatigue of Ceremony’ would cause another miscarriage.¹⁴¹ Nonetheless, given medical writers and others’ concerns that women read medical texts against the grain to gain knowledge about contraception, it is striking the means to prevent a miscarriage from occurring (which could ostensibly be manipulated to encourage a miscarriage to occur) were included, but information about recovery that could have bolstered future fertility was not.¹⁴²

The Ladies Physical Directory (1727) included postpartum fluxes and hysteric diseases in the chapter on miscarriage, suggesting a significant overlap between the treatments for parturient women and those who suffered pregnancy loss.¹⁴³ In other texts, remedies to treat postpartum fevers, retained placenta, and other issues were included in discussions of full-term birth but not in chapters devoted to discussing miscarriage.¹⁴⁴ Likewise, midwifery guides noted in chapters on specific womb-related ailments that abortion could be a cause of the problem but did not offer a consolidated discussion about what a woman who had suffered an untimely birth might face.¹⁴⁵ The consistent absence of clear information about the body after miscarriage seen in these treatises might be the result of the pervasive copying that occurred between these texts. As Elaine Hobby has explained, midwifery manuals in this era were not the works of men who acted frequently as midwives, although some did claim to have been called to assist women in birth on occasion.¹⁴⁶ Rather midwifery manuals borrowed extensively from one another. Jane Sharp’s book does not include remedies for helping women in the chapters on miscarriage. The author of the text copied substantial sections of the book from Culpeper’s translation of Daniel Sennert and his *Directory for Midwives*.¹⁴⁷ Culpeper’s directory, as we might then expect, does not discuss remedies for those who had experienced miscarriage. Guillemeau’s 1612 work, that was then the basis for William Sermon’s *Ladies Companion*, includes miscarriage and still-birth in his discussions of difficult birth, but does not discuss women who have miscarried in his chapters

describing the care of women after birth or in the section discussing the removal of the afterbirth.¹⁴⁸ Given the prevalence of copying between midwifery texts it is unsurprising that multiple authors failed to cover this topic in any detail. It is likely that medical practitioners who were called upon to treat women at various stages of pregnancy, miscarriage, and during illnesses that occurred after untimely births would develop, with experience, the skill to know in what situations to apply the remedies designed for postpartum bodies to women who had miscarried depending on the length of gestation. For lay men and women utilizing these books they would need to search through various sections and chapters to find information that might be relevant to their circumstances. This implies that medical men included such discussions to appear authoritative on a range of obstetric matters, but in practice limited their involvement in such cases to the treatment of specific issues or symptoms.

Guillemeau's desire to focus on preventing miscarriage also suggests that the absence of post-miscarriage care existed in tension with beliefs about whether it was possible to prevent a miscarriage once symptoms had been identified. Shannon Withycombe has noted that in the later nineteenth century doctors began discussing in more detail the difference between 'threatened' and 'inevitable' miscarriages; similar advice about the inability to stop miscarriage once it has begun is still presented to woman today.¹⁴⁹ Nonetheless, beliefs about the inevitability of miscarriage were complex in the early modern period. Recipes for preventing miscarriages were widely discussed and were employed by both physicians and midwives, as Guillemeau explained.¹⁵⁰ For example, the Taunton and London midwife Sarah Stone recalled that she attended a gentlewoman who was six months pregnant and had been given 'many medicines to prevent a Miscarriage' by her physician.¹⁵¹ The widespread discussion of preventative remedies, including some in manuscript form that explicitly stated that they worked after symptoms had begun, implies a strong desire to believe that miscarriages could be prevented.¹⁵² Conceiving of miscarriage as inevitable would also not explain a lack of

attention to the post-miscarriage body, which would be expected to be affected by the physical process of miscarriage which could not be stopped. Indeed, the belief that a miscarriage could not be prevented and posed a considerable risk to health informed the advice given to readers of *The Compleat Doctress* (1656) which, contrary to other texts, did address post-miscarriage health: 'As for the Cure, the woman having already miscarried, that consists in the point of preservation, namely, to prevent the supervening of a *Fever*, or the *Whites*'.¹⁵³ The lack of explicit discussion in these texts was not, therefore, driven by a belief that nothing could be done in such cases.

The absence of useful information on recovery from miscarriage might be explained by the framing of obstetrics by authors. These texts were invested in the process of bringing a child into the world and did not, therefore, consider the post-miscarriage body to be significant in terms of 'obstetric' care. The author of the *Ladies Physical Directory* having outlined how to prevent a miscarriage using their own '*Restraining Electuary*' declared, for example, to have 'given all the necessary Directions concerning *Miscarriage*'.¹⁵⁴ The author evidently felt that a knowledge of preventing miscarriage was all that was required in cases of precarious pregnancies and that such measures would prevent women from experiencing repeated losses. Yet this would have been in contrast to measures to support the recovery of the post-partum body which were often discussed in midwifery treatises. For example, Sharp's *Midwives Book* includes a chapter on '*What must be done after the woman is delivered*' that suggests wrapping women who had a difficult labour in a sheep-skin to aid recovery.¹⁵⁵ It is more plausible that authors in contradiction to their own statements about the unique dangers of miscarriage expected post-miscarriage and post-partum bodies to be comparable in terms of treatment.

A final explanation may be that the medical writers who authored these works looked to nature as an active agent in the healing process to resolve the complications associated with miscarriage. Withycombe has shown that in the early nineteenth century doctors took a non-

invasive approach to some miscarriages allowing nature to take its course.¹⁵⁶ Early modern health practices followed similar sentiments as nature was thought to one of the primary agents of recovery.¹⁵⁷ Yet, miscarriage was configured as an event ‘contrary to nature’ in certain midwifery manuals.¹⁵⁸ Writers described what could cause the foetus to come away without explicitly framing it as a natural process. Neither Culpeper, Sharp, nor Wolveridge referred to Nature as an active agent in their discussions of miscarriage, although Sharp did elsewhere in the guide. While it is plausible that such an approach rationalised a lack of explicit engagement with women’s health in this scenario, it was not made clear to readers. It would seem that writers focus of prevention of miscarriage and their expectation of being able to use the same remedies as they relied on for post-partum women resulted in a failure to consider miscarriage in detail. This striking absence, therefore, further supports our understanding of the gendered nature of care work in this area. Despite the evidence seen here which shows that numerous women were attended by medical practitioners, the lack of explicit discussion in print suggests that women were predominantly treated by midwives or other women in the home.

Although rarely articulated in detail miscarriage involved a series of interlinked physiological stages and interventions that were required to improve a woman’s chances of recovering her health. The coming away of the foetus or, if necessary, its removal using expulsive drugs preceded the treatment of any complications and the final recovery of strength. These stages were core experiences of many women’s reproductive lives in the early modern period. The sources offer brief insights into medical responses to these complications and, albeit rarely, women’s embodied experiences of this process which reveal interesting new perspectives on early modern understandings of fertility and reproduction.

The sources begin to suggest that, in line with other areas of obstetric and gynaecological medicine there was an element of gendered practice in the care afforded to miscarrying women.¹⁵⁹ Many, who were wealthy enough, were attended by male physicians and surgeons who treated their patients for a range of conditions that resulted from the termination of their pregnancy. However, recipe books predominantly attributed to female authors and collectors also offered a range of remedies that could be applied to the body following a miscarriage. This implies that, for some at least, managing a miscarriage, removing the remains of pregnancy from the body, stemming haemorrhages, and restoring a woman's body occurred in the domestic setting overseen by female healers. This interpretation is perhaps bolstered by the striking absence of a clear discussion of the measures required to secure recovery in male authored midwifery and medical treatises.

Furthermore, the evidence here suggests that not all women failed to identify early pregnancy or discounted early losses as delayed menstruation. Duden's important work indicated that early eighteenth-century German women deemed miscarriage a 'dangerous though necessary discharge' to avoid a problematic stagnation of the menses.¹⁶⁰ For many, Duden explained, a significant loss of blood and 'clotted pieces' was viewed as a 'salutary cleansing' beneficial to the body.¹⁶¹ This was certainly true for women in many circumstances, however, in the English context explored here miscarriage could be understood as the loss of a developing foetus (sometimes molar) even early in the pregnancy, at two or three months, when the material expelled from the body might only be a foetus the size of a bee. These descriptions underline the ambiguity of early gestation before quickening allowed for more concrete identification of pregnancy and underline the flexibility that this ambiguity provided women. Although these losses could have been interpreted as the removal of an obstruction necessary to retain health, they were viewed deliberately as miscarriages which brought considerable dangers of further illness and disorder. Discussing

their physical experiences in this way allowed married women to articulate feelings about their fecundity and their potential to adhere to expected gender roles that were shaped by fertility and motherhood.

Finally, medical texts were emphatic that women who miscarried were in a uniquely precarious position. Women's descriptions of their experiences bear this out. Many miscarriages caused significant pain, discomfort, and medical issues both immediately and, in some cases, over a substantial period of time. As Duden notes, prescriptions were necessary to help cleanse the womb and purge filth to avoid dangers.¹⁶² This was the central feature of the management of a miscarriage and key to securing women's return to health. Case notes, letters, and recipes books reveal details of this careful management: the removal of the products of conception from the body, the treatment of dangerous fevers, haemorrhages, headaches, sore throats, and the recovery of strength. For many women, the struggle to comprehend, evaluate, rationalize, and reconcile their miscarriage both spiritually and emotionally occurred concurrently with this management of the body. Elizabeth Viscountess Mordaunt, for example, wrote in 1656 a reflection titled 'A thanksgiving after twice miscarrying, and a fever'.¹⁶³ The reflection spoke not explicitly about the miscarriages but about the illness and physical distress bound into it. The Viscountess's response underscores that the emotional and the bodily were bound together. If, therefore, we are to fully understand women's emotional and spiritual responses to miscarriage we must remain cognisant of their corporeal experiences.

¹ Wiltshire Record Office, 2664-3-2b-77, Letter dated 20th July 1717 from Mary Halifax to Henry Davenport.

² Leah Astbury 'Being Well, Looking Ill: Childbirth and the Return to Health in Seventeenth-century England', *Social history of Medicine*, 30,3 (2017), 500-519.

³ *Ibid.*, 504.

⁴ Hannah Newton, *Misery to Mirth: Recovery from Illness in Early Modern England* (Oxford, 2018).

⁵ Sara Read, "'Thanksgiving after Twice Miscarrying': Divine Will, Women, and Miscarriage in Early Modern England', *Women's History*, 2,5 (2016), 11-15 at p. 11. For later period see, Felicity Jensz, 'Miscarriage and Coping in the Mid-Nineteenth Century: Private Notes from Distant Places', *Gender & History*, 32.2 (2020), 270-285 at p. 280-281.

⁶ *ibid.*, p. 11.

⁷ *ibid.*

⁸ Daphna Oren-Magidor, *Infertility in Early Modern England* (London, 2017), pp. 27-8.

⁹ Read, "Thanksgiving", p. 12.

¹⁰ Joanne Bailey (Begiato), *Parenting in England 1760-1830: Emotion, Identity, and Generation* (Oxford, 2012), p. 40.

¹¹ Paige Donaghy, 'Miscarriage, False Conceptions, and Other Lumps: Women's Pregnancy Loss in Seventeenth- and Eighteenth-Century England', *Social History of Medicine* (2021), 1-23 at p. 3.

¹² Jennifer Evans and Sara Read. "Before Midnight She Had Miscarried": Women, Men, and Miscarriage in Early Modern England.' *Journal of Family History*, 40,1 (2015), 3-23 at p. 12.

¹³ Karen Harvey, 'The Body', in Susan Broomhall (ed.), *Early Modern Emotions: An Introduction* (London, 2017), 165.

¹⁴ *ibid.*, 165, 166.

¹⁵ Karen Harvey, 'What Mary Toft Felt: Women's Voices, Pain, Power and the Body', *History Workshop Journal*, 80,1, (2015), 33-51 at p. 41.

¹⁶ Harvey, 'The Body', p. 167.

¹⁷ Oren-Magidor, *Infertility*, pp. 27-8.

¹⁸ Cathy McClive, *Menstruation and Procreation in Early Modern France* (Farnham, 2015), p. 159. Jennine Hurl, "She being bigg with child is likely to miscarry": Pregnant Victims Prosecuting Assault in Westminster, 1685-1720', *The London Journal*, 24,2 (1999) 18-33; See also, Ulinka Rublack, 'Pregnancy, Childbirth and the Female Body in Early Modern Germany', *Past and Present*, 120 (1996), 84-110 at pp. 84, 103; Sara M. Butler, 'Abortion Medieval Style? Assaults on Pregnant Women in Later Medieval England', *Women's Studies*, 40 (2011), 778-799. This is also mentioned in Garthine Walker, 'Rereading Rape and Sexual Violence in Early Modern England', *Gender & History* 10,1 (1998), 1-25 at pp. 13-14; Conversely violence that threatened pregnancy was occasionally used by women as a means of asserting rights and desires. See, Sara B. T. Thiel, 'Wielding the Maternal Body: Queen Anna of Denmark Performs Blackface Pregnancy.' *Shakespeare Studies* 46 (2018), 156.

¹⁹ Joanne Begiato, "Breeding" a 'little stranger': Managing Uncertainty in Pregnancy Later Georgian England' in Jennifer Evans and Ciara Meehan (eds), *Perceptions of Pregnancy from the Seventeenth to the Twentieth Century* (Cham, Switzerland, 2016), 13-33, at pp. 27-28.

²⁰ Michael Eshleman, 'Diet During Pregnancy in the Sixteenth and Seventeenth Centuries', *Journal of the History of Medicine*, 30,1 (1975), 23-39 at p. 37.

²¹ Linda A. Pollock, 'Embarking on a rough passage: the experience of pregnancy in early modern society' in Valerie Fildes (ed.), *Women as mothers in pre-industrial England* (Abingdon, 2013), 39-67 at p. 49.

²² Eshleman, 'Diet During Pregnancy', 27.

²³ *ibid.*, 38.

²⁴ Angus McLaren, *Reproductive Rituals: The Perception of Fertility in England from the Sixteenth Century to the Nineteenth Century* (London, 1984), 46-9; Jennifer Evans, *Aphrodisiacs, Fertility and Medicine in Early Modern England*, (Woodbridge, 2014), pp. 177-189.

²⁵ McLaren, *Reproductive Rituals*, p. 48; Read, "Thanksgiving", p. 11.

²⁶ Jennifer Evans, "A Toste wett in Muskadine": Preventing Miscarriage in Early Modern English Recipe Books c.1600-1780", *Women's Writing Journal* (Forthcoming).

²⁷ ODNB, s.v. 'Philip Barrow', accessed 07.04.21, www.oxforddnb.com.

²⁸ Salmon, *Medicina Practica*, sig. A2r.

²⁹ *ibid.*

³⁰ Elaine Hobby contends that the piece demonstrates a distinctive female voice with midwifery experience: *The Midwives Book* ed. Elaine Hobby (Oxford and New York, 1999), xvi-xix; Katherine Phelps Walsh argues that the book's author was likely male: Katharine Phelps Walsh, 'Marketing Midwives in Seventeenth -Century London: A Re-examination of Jane Sharp's The Midwives Book', *Gender & History*, 26,2 (2014) 223-241.

³¹ Elaine Leong and Sara Pennell, 'Recipe Collections and the Currency of Medical Knowledge in the Early Modern "Medical Marketplace"', in Mark S. R. Jennifer and Patrick Wallis (eds), *Medicine and the Market in England and its Colonies, c. 1450-c. 1850* (London, 2007), 133-152; Elaine Leong, 'Collecting Knowledge for the Family: Recipes, Gender and Practical Knowledge in the Early Modern English Household', *Centauros*, 55 (2013), 81-103.

³² Leong, 'Collecting Knowledge'; Jack B. Bouchard and Amanda E. Herbert, 'One British Thing: A Manuscript Recipe Book, ca.1690-1730', *Journal of British Studies*, 59 (2020), 396-99; Hillary M. Nunn, 'Local Waters and Notions of Home in Early Modern Recipe Manuscripts', *Journal for Early Modern Cultural Studies*, 20 (2020), 59-82; Helen Cox, 'A Most Precious and Excellent Balm': Theory and Practice of Medicine in the Papers of Lady Grace Mildmay 1552-1620', *Midland History*, 43,1, (2018), 22-42.

³³ Leong and Pennell, 'Recipe Collections'.

- ³⁴ The commonplace book of Robert Mustow reveals that he owned numerous medical and surgical texts: Walter Bruel's *Physicians Practise*, Williams Clowe's surgical treatise, Thomas Bonham's *Chyrgians Closet*, a selection of Nicholas Culpeper's works, and a copy of the *Pharmacopoeia Londinensis*, amongst others; British Library, MS Sloane 2117, fols 1v-3v; Elaine Leong, 'Herbals she Peruseth': Reading Medicine in Early Modern England', *Renaissance Studies*, 28 (2014), 556-578.
- ³⁵ Jayne Elisabeth Archer, 'Women and Chymistry in Early Modern England: The Manuscript Receipt Book (c.1616) of Sarah Wiggess', in Kathleen P. Long (ed.) *Gender and Scientific Discourse in Early Modern Culture* (Farnham, 2010), 191-216, at p. 199.
- ³⁶ Jacques Guillemeau, *Child-Birth or, The Happy Deliverie of Women* (London, 1612), 70. Information on Guillemeau; Kathleen P. Long, *Gender and Scientific Discourse in Early Modern Culture* (Farnham, 2010), p. 248.
- ³⁷ Nicholas Sudell, *Mulierum Amicus: Or, The Womans Friend* (London, 1666), Sig. A2r, 55.
- ³⁸ For example, versions of Nicholas Culpeper's *Directory for Midwives* were published throughout the eighteenth century included 1767 and 1777; Paul Portal's *The Compleat Practice of Men and Women Midwives* was posthumously republished in 1753 and in 1763.
- ³⁹ Nicholas Culpeper, *A Directory for Midwives: Or, A Guide for Women in Their Conception, Bearing, and Suckling Their Children* (London, 1755), p. 255.
- ⁴⁰ *ibid.*, p. 70.
- ⁴¹ Suzanne W. Hull, *Women According to Men: The World of Tudor-Stuart Women* (Walnut Creek, 1996), p. 96.
- ⁴² Nicholas Culpeper, *A Directory for Midwives* (London, 1651), p. 142. See also, Sudell, *The Womans Friend*, pp. 55-56.
- ⁴³ Culpeper, *A Directory for Midwives* (London, 1755), p. 255.
- ⁴⁴ Culpeper, *A Directory for Midwives*, 161 and Nicholas Fonteyn, *The Womans Doctour* (London, 1652), p. 211.
- ⁴⁵ *The Diary of Richard Kay*, p. 134. See also pp. 131, 136.
- ⁴⁶ Laura Gowing, *Common Bodies: Women, Touch and Power in Seventeenth-Century England* (New Haven and London, 2003), p. 121.
- ⁴⁷ *ibid.* Begiato has suggested nineteenth-century women did begin to distinguish between miscarriages at different stages, but that it remained ambiguous. Begiato, 'Breeding' a 'little stranger', p. 27.
- ⁴⁸ Alice Thornton, *My First Booke of My Life* ed. Raymond A. Anselment (Lincoln and London, 2014), p. 84.
- ⁴⁹ Jane Sharp, *The Midwives Book* (London, 1671), p. 224; Culpeper, *A Directory*, p. 146.
- ⁵⁰ Culpeper, *A Directory*, p. 146. See also, Joanne Begiato, 'Pregnancy and Childbirth', in Susan Broomhall (ed.), *Early Modern Emotions: An Introduction* (London, 2017), p. 211; Barbara Duden, *The Woman Beneath the Skin: A Doctor's Patients in Eighteenth-Century Germany* (Cambridge, Massachusetts, 1991), pp. 143-144, 147.
- ⁵¹ Somerset Heritage Centre, Q/SR/152/2.
- ⁵² *ibid.* See also, Thornton, *My First Booke*, p. 133; M.J. Storey, ed., *Two East Anglian Diaries 1641-1729: Isaac Archer and William Coe* (Woodbridge, 1994), p. 153.
- ⁵³ Culpeper, *A Directory*, p. 145.
- ⁵⁴ Sharp, *The Midwives Book*, pp. 222-223.
- ⁵⁵ Cambridge Archive, K17/C/1 Baumgartner Family, Letter book of originals addressed to Dr John Moore, Bishop of Norwich. Coughs were not listed in the 1651, 1652 or 1656 editions of Culpeper's text, but do appear in the 1662 edition which is expanded from the earlier editions. Nicholas Culpeper, *Culpeper's Directory for Midwives* (London, 1662), p. 173; *The Ladies Physical Directory*, p. 66.
- ⁵⁶ Cambridge Archive, K17/C/1.
- ⁵⁷ *Old Bailey Proceedings Online* (www.oldbaileyonline.org, version 8.0, 12 July 2021), Feb.1684, trial of Elizabeth Stafford (t16840227-18).
- ⁵⁸ William Salmon, *Medicina Practica, or, Practical Physick* (London, 1692), p. 29.
- ⁵⁹ Anonymous, *The Ladies Physical Directory* (London, 1727), p. 65.
- ⁶⁰ Eve Keller, *Gendered Bodies and Gendered Selves: The Rhetoric of Reproduction in Early Modern England* (Seattle, 2007), p. 69.
- ⁶¹ Anonymous, *The Ladies Physical Directory*, p. 65.
- ⁶² Sarah Fox, *Giving Birth in Eighteenth-Century England* (London, 2022), p. 2.
- ⁶³ Newton, *Misery to Mirth*, p. 33.
- ⁶⁴ *ibid.*
- ⁶⁵ Sara Read, *Menstruation and the Female Body in Early Modern England* (Basingstoke, 2013), p. 92.
- ⁶⁶ *The Diary of Samuel Pepys. M.A. F.R.S. Clerk of the acts and Secretary to the admiralty. Transcribed from the shorthand manuscript in the Pepysian library Magdalene College Cambridge by the rev. Mynors bright m.a. Late fellow and president of the college*, ed. by Henry B. Wheatley, (London, 1893), accessed through <https://archive.org/>.

- ⁶⁷ *The Diary of John Evelyn*, ed. by E. S. De Beer (London, 2006), p. 268. See also, John Woodward, *Select Cases, and Consultations in Physick ... published By Dr. Peter Templeman* (London, 1757), p. 91.
- ⁶⁸ Wellcome Library MS 5006, pp. 156-7.
- ⁶⁹ *ibid.*, p. 157.
- ⁷⁰ *ibid.*; Mr Altree is described in the diary as performing several operations, including one alongside Richard Wilkes' brother John, who was also a surgeon. Information on John Wilkes, Irvine Loudon, *Medical Care and the General Practitioner: 1750-1850* (Oxford, 1986), p. 14.
- ⁷¹ Wellcome Library MS 7721, fol. 285^r. Recipes with the same intention also appeared in published works; Anonymous, *Every Woman Her Own Midwife* (London, 1675), p. 12.
- ⁷² Somerset Heritage Centre, DD/X/FW1 C/1751, Fol. 19r.
- ⁷³ *ibid.*
- ⁷⁴ *ibid.*; www.oed.com s.v. 'campana'.
- ⁷⁵ *ibid.*, fol. 20v.
- ⁷⁶ For example, McLaren, *Reproductive Rituals*, pp. 102-6; Angus McLaren, "'Barrenness against nature': recourse to abortion in pre-industrial England", *Journal of Sex Research* xvii/3 (1981), 224-37 at p. 231. McLaren acknowledged that some women used these to cure amenorrhea. See also, Edward Shorter, *A History of Women's Bodies*, (Harmondsworth, 1984), pp. 181-8; John Riddle, 'Oral contraceptives and early-term abortifacients during classical antiquity and the Middle Ages', *Past & Present*, 132,1 (1991), 3-32; Roy Porter, *Health for sale: Quackery in England, 1660- 1850* (Manchester, 1989), p. 148.
- ⁷⁷ Wellcome library MS 160, fol. 103r.
- ⁷⁸ For an example of a remedy designed for breech delivery and delivery of a dead child see, Wellcome library MS 3009, Elizabeth Jacob & others 1654-c.1685, 128. For examples of clearly labelled remedies see those already discussed and: Wellcome Library MS 4338, Johanna Saint John 1680, fols 42r, 211r, 215r.
- ⁷⁹ Staffordshire Record Office, D641/3/H/3/1, Jerningham Family, of Costessey, Norfolk 17th C. Recipe Book, Sig. 64v.
- ⁸⁰ Wellcome library MS 3009, 128.
- ⁸¹ Thomas Raynalde's *The Birth of Man-kinde* originally published in 1565, and reprinted into the seventeenth century explained that women might need remedies to strengthen a mother weakened by long labour, encourage the cervix and vagina to become supple if they had contracted after hard birth, or encourage an expulsive faculty. Thomas Raynalde, *The Birth of Man-Kinde* (London, 1634), pp. 116-117; Wellcome MS 7102, p. 85. This eighteenth-century recipe collection includes a broth 'most exceleent to be taken after lying or miscarage' to 'cleanse and strengthen those parts'.
- ⁸² Salmon, *Medicina Practica*, p. 33.
- ⁸³ *ibid.*
- ⁸⁴ *ibid.*
- ⁸⁵ Elizabeth Lane Furdell, *Publishing and Medicine in Early Modern England* (Rochester, 2002), p. 151.
- ⁸⁶ Wellcome Library, MS 6919, fol. 9v.
- ⁸⁷ Duden, *The Woman Beneath the Skin.*, p. 133.
- ⁸⁸ Wellcome MS 4338, fol. 215r.
- ⁸⁹ *ibid.*
- ⁹⁰ Salmon, *Medicina Practica*, p. 30.
- ⁹¹ *ibid.*
- ⁹² Thomas Chamberlayne, *The Compleat Midwives Practice* (London, 1656), p. 98.
- ⁹³ Gowing, *Common Bodies*, p. 78.
- ⁹⁴ Harvey, 'What Mary Toft Felt', p. 44. A later example shows that some women also undertook special trips to recuperate. Mary Yorke wrote to Jemima Yorke in 1793 explaining that her daughter, having suffered a miscarriage, was going to Yarmouth to strengthen her body. Bedfordshire Archives, L30/9/111/197.
- ⁹⁵ Philip Barrough, *The Methode of Physicke* (London, 1583), p. 148.
- ⁹⁶ *ibid.* This was repeated in the 1652 edition of the text. Philip Barrough, *The Method of Physick* (London, 1652), p. 187.
- ⁹⁷ Wellcome Library, MS 3712, Elizabeth Okeover & others c.1675- 1725, p. 192.
- ⁹⁸ *ibid.* This remedy was also recorded in Wellcome MS 7391, p. 126 and attributed to Mrs Nash.
- ⁹⁹ Wellcome Library MS 8097, fol. 76v.
- ¹⁰⁰ Wolveridge, *Speculum Matricis*, 163. Republished in 1671 as, *Speculum Matricis; Or, the Expert Midwives Handmaid* (London, 1671).
- ¹⁰¹ Sarah Stone, *A Complete Practice of Midwifery, Consisting of Upwards of Forty Cases or Observations in that Valuable Art* (London, 1737), pp. 55, 92.
- ¹⁰² *ibid.*, pp. 5-7.
- ¹⁰³ *ibid.*, p. 148.
- ¹⁰⁴ Guillemeau, *Child-Birth*, p. 72.

- ¹⁰⁵ Culpeper, *A Directory for Midwives*, (1651), p. 144. Although earlier than the evidence drawn on here, see also Thomas Raynalde, *The Byrth of Mankynde, otherwyse named the womans booke* (London, 1545), fol. 90r.
- ¹⁰⁶ Modern studies acknowledge that 'milk production can occur after early or later miscarriage, stillbirth, neonatal death, or infant death' and that guidance to grieving parents should include advice on the alleviation of symptoms, discomfort, engorgement, and infection, Carroll, Katherine, et al. "'The 'Lactation After Infant Death (AID) Framework': A Guide for Online Health Information Provision About Lactation After Stillbirth and Infant Death", *Journal of Human Lactation*, 36.3, (2020) 480–491 at pp. 482–483.
- ¹⁰⁷ Gowing, *Common Bodies*, p. 46.
- ¹⁰⁸ Harvey, "What Mary Toft Felt", p. 34.
- ¹⁰⁹ Old Bailey Proceedings: Accounts of Criminal Trials, 12 October 1726, T17261012-8, Harvard University Library, *London Lives, 1690-1800*, www.londonlives.org [accessed 13.02.21].
- ¹¹⁰ *Ibid.*
- ¹¹¹ Remedies of this nature were also used in nineteenth-century America. See, Shannon Withycombe, *Lost: Miscarriage in Nineteenth-Century America* (New Brunswick: Rutgers University Press, 2019), p. 105.
- ¹¹² Wellcome MS 4683, fol. 12.r.
- ¹¹³ *Ibid.*
- ¹¹⁴ Wellcome MS 7721, 176.
- ¹¹⁵ *Ibid.* See also a 'Brest curdled with milk' in Wellcome Library MS 1026, Lady Ayscough 1692, p. 228; 'For The Milk Curdled in the Breast' in Wellcome Library MS 3009, p. 57.
- ¹¹⁶ *Ibid.*
- ¹¹⁷ Guillemeau, *Child-Birth*, p. 70.
- ¹¹⁸ Nicholas Culpeper, *Culpeper's Directory for midwives: or, A guide for women* (London, 1676), p. 173.
- ¹¹⁹ Sharp, *The Midwives Book*, pp. 170-1.
- ¹²⁰ *ibid.*
- ¹²¹ Oren-Magidor, *Infertility*, pp. 26-27.
- ¹²² Robert Pierce, *Bath Memoirs: Or, Observations in Three and Forty Years Practice, at the Bath* (Bristol, 1697), p. 201. The chapter describes three women who sought treatment for repeated miscarriage at the baths. Another woman in the following chapter came for treatment for repeated miscarriage and hysterical issues, p. 208.
- ¹²³ *ibid.*, p. 203. Information on Howard, <http://www.histparl.ac.uk/volume/1690-1715/member/howard-craven-1649-1700#family-relations>, accessed 30.09.21.
- ¹²⁴ Pierce, *Bath Memoirs*, p. 204.
- ¹²⁵ See Evans, *Aphrodisiacs*, pp. 87-131; Oren-Magidor, *Infertility*, pp. 132-146.
- ¹²⁶ Duden, *The Woman Beneath the Skin.*, p. 141.
- ¹²⁷ Joanna Moody, ed., *The Private Correspondence of Jane Lady Cornwallis Bacon 1613-1644* (London and Cranbury NJ, 2003), p. 264.
- ¹²⁸ Taunton, Somerset Heritage Centre, DD/SF/2/42/11.
- ¹²⁹ Greg Wells, *John Hall Master of Physicke: A Casebook from Shakespeare's Stratford* (Manchester, 2020), p. 98. Information on dating *ibid.*, p. 54.
- ¹³⁰ *ibid.*
- ¹³¹ British Library, Sloane MS. 4041, fol. 241.
- ¹³² British Library, MS. Sloane 4043, fol. 303; Sloane also received a letter in June 1713 about Madam Baldwyn's 'hypochondiacal' issues, suspected venereal disease, following numerous miscarriages. British Library Sloane 4043, fol. 156r.
- ¹³³ *Ibid.* See also John Woodward, *Select Cases and Consultations, in Physick by the Late Eminent John Woodward MD ... published by Dr Peter Templeman* (London, 1757), pp. 10-11. In this case Mrs Stephens suffers from diarrhoea and a sore throat after a miscarriage and associated haemorrhage.
- ¹³⁴ Arthur Searle ed. *Barrington Family Letter 1628-1632* Camden Fourth Series, Volume 28 (London, 1983), p. 220.
- ¹³⁵ Taunton, Somerset Heritage Centre, DD/SF/2/42/11.
- ¹³⁶ Wellcome Library, MS 3712, pp. 208-209.
- ¹³⁷ *ibid.* This same series of remedies, again described as being prescribed for the owner's sister, appears in Wellcome Library MS 7391, p. 141 ascribed to Dr Dakins.
- ¹³⁸ Culpeper, *A Directory for Midwives*, pp. 142-153; Sharp, *The Midwives Book*, pp. 221-227; Sadler, *The Sick Womans Private Looking-Glasse*, pp. 155-164. An exception to this is Nicolaas Fonteyn, *The Womens Doctour, or, an Exact and Distinct Explanation of all such Diseases as are Peculiar to that Sex* (London, 1652), p. 197. Fonteyn states that after miscarriage women should be preserved from fevers and the whites, and that the belly should be strengthened.
- ¹³⁹ Guillemeau, *Child-Birth*, p. 72

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- ¹⁴⁰ Bedfordshire Archives, L30/8/10/6, Correspondence to Henry Grey, 12th Earl of Kent from his son-in-law, John Campbell (Lord Glenorchy).
- ¹⁴¹ *ibid.*
- ¹⁴² In *The Midwives Book* Sharp's section intended bolster women's fertility copied Nicholas Culpeper's *Directory for Midwives* chapter on preventing miscarriage. See, Evans, *Aphrodisiacs*, pp. 178-179.
- ¹⁴³ *The Ladies Physical Directory*, pp. 68-69.
- ¹⁴⁴ For Example, Culpeper, Sharp and Guillemeau.
- ¹⁴⁵ For example, Thomas Chamberlayne's *The Compleat midwives practice* explains in various chapters that abortion might result in a 'puffing up' of the womb, uterine prolapse, suppression of menstruation, and suffocation of the mother; Thomas Chamberlayne, *The Compleat Midwives Practice* (London, 1656), pp. 32, 40, 50, 64. See also James Wolveridge, *Speculum Matricis Hybernicum; Or, the Irish Midwives Handmaid* (London, 1670), p. 119. Here it was explained that overflowing lochia was often a consequence of miscarriage, but the cures that were discussed were generic for miscarrying and postpartum women.
- ¹⁴⁶ Elaine Hobby, *The Midwives Book.*, xvii-xviii.
- ¹⁴⁷ *ibid.*, xviii-xix
- ¹⁴⁸ *ibid.*, xvii; Guillemeau, *Child-Birth*, pp. 176-184, 189-209.
- ¹⁴⁹ See, Withycombe, *Lost*, p. 109; <https://www.nhs.uk/conditions/miscarriage/> [accessed 01.08.22].
- ¹⁵⁰ Evans, 'A Toste wett in Muskadine'.
- ¹⁵¹ Sarah Stone, *A Compleat Practice of Midwifery* (London, 1737), p. 62.
- ¹⁵² Wellcome MS 7102, p. 99.
- ¹⁵³ Anonymous, *The Compleat Doctress: or, A Choice Treatise of all Diseases Insident to Women* (London, 1656), p. 197.
- ¹⁵⁴ *The Ladies Physical Directory*, p. 71.
- ¹⁵⁵ Sharp, *The Midwives Book*, p. 210.
- ¹⁵⁶ Withycombe, *Lost*, pp. 99-101. From the late nineteenth century a more invasive and intrusive approach was adopted to accelerate the process of delivery.
- ¹⁵⁷ Hannah Newton, 'Nature Concocts & Expels': The Agents and Processes of Recovery from Disease in Early Modern England', *Social History of Medicine*, 28.3 (2015), 465-486.
- ¹⁵⁸ Raynalde, *The Birth of Man-kinde*, p. 137; Fonteyn, *The Womans Doctour*, p.194.
- ¹⁵⁹ Edith Snook, '"The Women Know": Children's Disease, Recipes and Women's Knowledge in Early Modern Medical Publications', *Social History of Medicine*, 30.1 (2017), 1-21; Evans, 'A Toste wett in Muskadine'.
- ¹⁶⁰ Duden, *The Woman Beneath the Skin*, 163. See also, Barbara Duden, *Disembodying Women: Perspectives on Pregnancy and the Unborn* (Cambridge, Mass., 1993), pp. 64-66.
- ¹⁶¹ *ibid.*, pp. 163-164, 170.
- ¹⁶² *ibid.*, p. 170.
- ¹⁶³ Cited in Read, 'Thanksgiving after Twice Miscarrying', p. 13.