

# COMMUNICATING MEDICINE

British Medical Discourse in Eighteenth-Century Reference Works

Elisabetta Lonati









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in Eighteenth-Century Reference Works**

**Elisabetta Lonati**

**di/segni**

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## O.

### SOCIO-CULTURAL BACKGROUND AND GENERAL AIMS OF THE STUDY

The core of the present study is an investigation on eighteenth-century medical writing, particularly concerning the elaboration and the communication of medicine in reference works such as universal dictionaries of arts and sciences, medical dictionaries, and handbooks. Most of the vernacular texts under scrutiny here were issued in the second half of the century, a period in which the advancements in medical research, medical education and medical practice<sup>1</sup>, as well as a growing awareness of health issues (Pirohakul-Wallis 2014: 3-4), favoured the circulation of an expanding medical vocabulary and stimulated medical writing as a whole.

A vast amount of books – especially instruction books for a vast and uneven readership – was produced for experts and non-experts alike (case studies, accounts, observations, records, short treatises, handbooks, compendia or *practica*<sup>2</sup>, medical dictionaries, etc.), and medical topics were common in social settings, in genteel conversation, in personal and communal letters, in specialised journals, in pamphlets and in magazines. In the second half

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<sup>1</sup> Changes in medical education and in the practice of medicine are complex processes which cover long periods of time. Interesting works on the topic are Loudon (1986 and 1995), French-Wear (1989), Wear (1989: 294-320), Cunningham-French (1990), Wilson (1990: 4-39), French-Wear (1991), Lawrence (1991: 45-73), Nutton-Porter (1995), Brown (2011).

<sup>2</sup> *Practica* were the outcome of an ancient tradition. Wear (2000: 116-117) explains that «the coherent medical textbook exposition of the nature of diseases took place in the context of a genre of writing called the *practica* or compendia on the practice of medicine. These dated from the Middle Ages [...] the *practica* went beyond naming a disease and giving treatments for it. They also gave its signs and causes. [...] they identified or constructed diseases by selecting salient signs from the huge variety that would be reported by patients or observed upon their bodies.» The format of *practica* (signs, causes, regimen and treatments) continued to be used later on, and in the eighteenth century plays a key role in organising medical writing and its practical issues, as well as in defining – and delimiting – the roles of practitioner vs. patient. On the one hand, there is the practitioner-observer recording his experience, on the other hand, the patient-observed being informed by a professional on diseases, cures, and remedies.

of the century, reference works began to circulate extensively (Lane 2001: 23), encouraged by a lively and expanding book market (Fissel 2007). These works often included the classification of diseases, their denominations – either in Latin, or in English, or both – and definitions, along with the descriptions of symptoms, the development of the disease in time, the available cures or practical remedies. On the one hand, medicine was on its way to specialisation and professionalisation: the approach to medical events was becoming ‘scientific’, strictly based on observation, data collection, and experimentation by an emerging disciplinary and restricted community. On the other hand, medicine pervaded civil society and human interests, as general knowledge and shared experience. It was, in a sense, common ground for everybody, within and outside emerging and developing professional circles. Another key factor was an increasing interest in public health and healthy strategies to improve the average living standards. Towns were crowded with people, hygienic conditions were poor, and the danger of endemic diseases or epidemic outbreaks was elevated. Preventative medicine and environmental approaches thus became a priority, with a view to avoid contagion and infections. Specific plans to maintain or improve hygiene in hospitals – but also in jails, in the army, and aboard the ships – and (over) crowded public places, as well as to spread cleanliness in private dwellings, were frequently issued as practical advice (cfr. Borthwick 1784).

If the production of books cannot just be considered as a direct consequence of the advancements in medicine on the one hand, or of social changes on the other, all this unprecedented and remarkable activity contributes to the vernacularisation, the popularisation, and the dissemination of medicine in different kinds of works and different text types: «never before had the medical profession so saturated the market with writings, from sixpenny pamphlets to weighty tomes, directed specifically at a health-conscious lay readership» (Porter 1992: 106). These works are generally addressed to a multifarious audience: the lay community shared general notions concerning everyday health and medicine, and was interested in novelties, remedies and cures. The emerging community of practitioners instead was interested in communicating and sharing professional experience with fellow colleagues: recording and framing medical experience, recommending techniques and remedies, updating procedures and cures were the key issues of medical writers. In other words, record, advise, instruct, and inform can be considered the general aims. At least three groups of medical men as regular practitioners were involved in this writing and communication process: university-educated physicians «whose job was to diagnose, and provide attendance and advice» (Porter 1992: 92); trained professionals, such as surgeons whose «job [...] was to treat external complaints (boils, wounds, etc.), to set bones and perform simple operations» (Porter 1992: 93); and apothecaries who «dispensed» what the «physician

prescribed» (*Ibidem*). A new professional role – and function – emerged:

The early eighteenth century saw the gradual disappearance of the barber-surgeon [...] and the emergence of the surgeon-apothecary, separate from the apothecary, who continued to sell and dispense drugs as he had always done. Physicians, without exceptions, were university men and not apprenticed, although a minority had begun their medical careers as surgeon-apothecaries before seeking the physician's status. [...] The surgeon-apothecary is one of the eighteenth century's most interesting examples of personal and professional upward social mobility and of steadily enhanced status. (Lane 1985: 57, 58)

In the late eighteenth century, British Medical Reform was a key factor in expanding regular medicine and in establishing clear boundaries and roles in the practice of medicine, notably concerning the distinction between university-educated physicians and trained practitioners (surgeons and apothecaries) from a multitude of quacks<sup>3</sup>. Loudon (1992: 219) defines this period as one of «uninterrupted progress», producing radical changes in medical institutions, in medical legislation, in medical men, and in the general social context<sup>4</sup>. Orthodox practitioners needed a formal qualification: a university degree for physicians, private apprenticeship or hospital training for surgeons (for example, army and naval appointments or walking the wards) and apothecaries (for example, visiting the sick with the master or, later, by themselves). Usually, a basic theoretical instruction including anatomy, physiology, medicine, pharmacy, etc. was followed by an intense practical activity.

The challenge to expel quackery from the medical community at large, not only implied a regulated and institutionalised expansion of medical instruction among medical men, but also the expansion of medical information among the (educated) members of the civil society:

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3 Lane (2001: 9, 12) maintains that «The line between charlatan and orthodox was not always clear, for a number of qualified practitioners [...] also made lucrative livings as quacks [...]. In addition, some distinguished qualified men, such as Robert James, [...] also promoted remedies bearing their names, usually in the more expensive range of preparations. [...] Early eighteenth-century England saw medicine struggle to be more orthodox and indeed a recognisable medical profession had emerged by the early 1800s. [...] Physicians remained at the apex of the medical pyramid, few in number, practising only in the largest towns and cities, [...] generally never performed manual tasks or dispensed medications. Surgeons and apothecaries, although originally separated occupations, increasingly joined their skills into the title of surgeon-apothecary, the equivalent of the modern general practitioner». On the new professional role of the surgeon-apothecary and the importance of apprenticeship, see also Lane (1985: 57-103), Bynum (1985: 105-128), and Lawrence (1991: 45-73), whereas the relationship between orthodox medicine and medical fringe is treated extensively in Bynum-Porter (1985).

4 Loudon also discusses the structure and the role of medical education, as well as the reform of medical profession, in an interesting paper published in Nutton-Porter (1995: 229-249), and in Loudon (1986).

Indeed, the most effectual way to destroy quackery in any art or science, is to diffuse the knowledge of it among mankind. Did physicians write their prescriptions in the common language of the country, and explain their intentions to the patient, as far as he could understand them; it would enable him to know when the medicine had the intended effect; would inspire him with absolute confidence in the physician; and would make him dread and detest every man who pretended to cram a secret medicine down his throat. [...] For this reason the prescriptions of physicians, instead of being couched in mystical characters and a foreign language, ought, in my humble opinion, to be conceived in the most plain and obvious terms imaginable. (Buchan <sup>2</sup>1772: xxv-xxvi)<sup>5</sup>

Attention to accuracy and simplicity in language were emphasised, whereas literary rhetoric, figurative language and obscure formulations were gradually abandoned in favour of more comprehensible expressions.

The texts examined in the study are representative of their authors' effort to expand medical knowledge and to define medicine as an independent science based on observation, as well as to establish intelligibility<sup>6</sup> within and outside the disciplinary discourse community, both at a metalinguistic level (general principles regulating writing for a purpose) and at a practical level (rhetorical strategies and linguistic choices to make contents accessible to the readership).

#### O.I. INTRODUCING AND CONTEXTUALISING SOURCE MATERIAL

The following sections introduce the two groups of source materials selected for the analysis. The first group includes two dictionaries of arts and sciences, *The Encyclopaedia Britannica* (1768-1771), and Abraham Rees's *Cyclopaedia* (1778-1788), as well as two medical dictionaries, Robert James's *A medicinal dictionary* (1743-1745), and George Motherby's *A new medical dictionary* (1775). The second group is constituted by a set of handbooks and compendia (*practica*) on the practice of medicine, some of them are especially focussed on infectious and contagious diseases. Among them, the most relevant are Buchan's *Domestic medicine: or, a treatise on the preven-*

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5 For the present analysis the second edition of Buchan's *Domestic medicine* (London 1772) was used; the first edition was published in Edinburgh (1769) with the title *Domestic medicine; or, the family physician: being an attempt to render the medical art more generally useful, by shewing people what is in their own power both with respect to the prevention and cure of diseases. Chiefly calculated to recommend a proper attention to regimen and simple medicines.*

6 Intelligibility becomes the general aim of medical writing at any level: here, it refers to the effort to be effective in textualising and communicating medical knowledge to a composite audience, including both the professional and the general educated reader.

tion and cure of diseases by regimen and simple medicines (<sup>c</sup>1772), Borthwick's *The method of preventing and removing the causes of infectious diseases* (1784), Fisher's *The practice of medicine made easy* (1785), Black's *Comparative view of the mortality of the human species* (1788), Clark's *Observations on fevers, especially those of the continued type; and the scarlet fever* (1780), Grant's *An enquiry into the nature, rise, and progress of the fevers most common in London* (1771), Grant's *An essay on the pestilential fever of Sydenham, commonly called the gaol, hospital, ship, and camp-fever* (1775), Millar's *Observations on the prevailing diseases in Great Britain* (1770), Sims's *Observations on epidemical disorders, with remarks on nervous and malignant fevers* (1776), and Wallis's *The art of preventing diseases and restoring health, founded on rational principles, and adapted to persons of every capacity* (1793). The two sections put forward the general features of the texts included in the two groups, contextualising them in the socio-cultural background of the period.

#### 0.1.1. UNIVERSAL DICTIONARIES OF ARTS AND SCIENCES AND SPECIALISED MEDICAL DICTIONARIES

The eighteenth century is characterised by the compilation and the publication of many dictionaries of arts and sciences or, in other words, encyclopaedic dictionaries including the terms of multifarious branches of knowledge and emerging disciplines. The encyclopaedic principle, that is to say the expansion of the lexical meaning of a term to include further details and contents belonging to the extra-linguistic world, is first introduced in universal (or general) dictionaries of the English language since the very beginning of the century. However, the encyclopaedic inclusion goes back to the seventeenth-century hard-word dictionary tradition and later stimulates the production of a new type of reference works completely based on it. These reference works constitute a new emerging genre which develops throughout the century as a repository of many branches of knowledge: in this case, they are issued as *universal dictionaries of arts and sciences*; when they focus on a single discipline, they are known as *specialised dictionaries*, such as, for example, *medical, medicinal or physical dictionaries*.

Usually organised in alphabetical order for a quick reference, the universal dictionaries of arts and sciences aim at systematising contents in the tree of knowledge. In connecting topics and sub-topics, this kind of organisation establishes and emphasises hierarchical relationships among them instead of circular ones as the encyclopaedic perspective – and the word encyclopaedia itself – would suggest. Of this kind are Chambers's *Cyclopaedia* (1728 and following editions), and Rees's *Cyclopaedia* (1778-88). In addition, the use of cross-references across entries helps establish, and further enhance, connections among topics and sub-topics.

Quite the opposite, the *Encyclopaedia Britannica* (1768-1771) is conceived on a new principle<sup>7</sup>. Relationships and connections across single entries (and the multifarious disciplines) are reduced to a minimum with the introduction of long, inclusive, monothematic treatises systematising each single discipline separately. In general, the various strategies adopted by compilers at different times are used to avoid the structural dispersion and parcelling out of information across entries, and to suggest the idea of a comprehensive and coherent whole:

The alphabet thus gave scientific dictionaries the flexibility to absorb the new findings of the Scientific Revolution without having to assess the implications for traditional doctrines in long treatises. But eighteenth-century encyclopaedists rarely linked the choice of alphabetical order with an attack on systematic organisation. One reason for this was that the alphabet had not been seen as necessarily incompatible with classification. (Yeo 2001: 25)

Unlike encyclopaedias, specialised dictionaries, medical dictionaries among them, focus on single, independent disciplines and their emerging or well-known sub-disciplines, as well as on medical history, medical events (diseases and health issues, etc.), and medical vocabulary. Their terminology and key concepts are organised in alphabetical order. In this case, neither tree of knowledge, nor long all-inclusive treatises are used to systematise contents. Once again, the semasiological approach and cross-references are the two organising principles. However, some entries are particularly long and expanded, combining sections and sub-sections on single, detailed aspects of the subject treated (ex. the entries Abortus, Abscessus, Cephalalgia, Fever, Paralysis, etc. are many pages long).

Encyclopaedic reference works, whether universal or specialised, are traditionally addressed to a vast educated readership, neither necessarily an expert one nor university educated. Within this conventional frame, the target always depends on the specific aims of individual compilers, or medical writers in the case of medical dictionaries. Universal dictionaries of arts and sciences often refer to the 'curious reader', interested in discoveries, experimentation, research and new perspectives in investigating everyday human experience, but also interested in a more general outlook on present and past knowledge and learning. The emerging disciplines, for their innovative contribution and appeal, often become the topic of conversation in genteel society. Thus, on the one hand, reference works answer the needs

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<sup>7</sup> Interesting introductions to the *Encyclopaedia Britannica* (1768-1771) may be found in the following studies: Kafker (1994a: 145-182 and 1994b: 389-399), Abbattista (1996: 397-434), Castagneto (1996: 435-476).

of the society in which they are produced and, on the other hand, their publication stimulates these needs and, as a result, their consumers and «the commercialization of knowledge» (Yeo 2001: 46)<sup>8</sup>. Useful universal knowledge and specialised medical knowledge are not only a social and cultural opportunity for many educated readers, but also a disciplinary opportunity: the need to select and organise contents implies their definition and distinction between topics and sub-topics. According to Yeo (1991: 25-26), this phenomenon «rather than being a force against specialization» highlights how «encyclopedias have reflected and facilitated the crystallization of natural knowledge into disciplines from the late eighteenth to the mid-nineteenth century».

Dictionaries of arts and sciences were originally conceived and compiled as kinds of «inventor[ies] of facts [...] storehouse[s] of knowledge» (Werner 1994: 189-190), particularly those which included a vast amount of topics. These universal encyclopaedic dictionaries become a fundamental and interesting cultural, social, disciplinary and linguistic commodity:

In the case of scientific dictionaries, apparently quite suitable for quick consultation [...] there was an emphasis on the need to read closely and methodically. [...] alphabetical order was not regarded as an invitation to superficial reading. [...] Knowledge presented in condensed and summarised form was not necessarily regarded as light or inferior. For this reason, a scientific dictionary could be said to have a lasting value for those readers who either used its cross-references to study a single science or to appreciate the connections among various subjects chartered in the map of knowledge. (Yeo 2001: 76)

Throughout the century, universal dictionaries and encyclopaedias expanded their subjects and their treatment, updating their contents; whereas specialised ones added disciplinary details according to new methodological perspectives and well-established practices. The spread of ideas through encyclopaedic dictionaries also helped establish the vernacular as a form of communication among scholars, besides being the medium of popularisation. However, it would be a very simplistic and partial perspective to consider dictionaries of arts and sciences only as a vehicle of popularisation. They actually helped focus and distinguish the many different subjects selected and included, and their peculiar features (Yeo 1991: 26).

It is from this shared social and cultural experience «adapted to a very

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<sup>8</sup> R. Yeo (2001: 47): «The scientific dictionaries that came to be known as encyclopaedias were more expensive and weighty products, but they are a stunning example of how the trade in knowledge was judged to be worth large capital investment. They also exemplify the assumption that knowledge should circulate freely, that it should be accessible to anyone, irrespective of social rank, who could buy or borrow a copy of such a work».

numerous class of readers» (Rees 1778-1788, Preface 1786, vol. I, B, AS) that gradually a far more restricted and specialised attitude emerges in the last quarter of the century. The fact that encyclopaedias were addressed to a vast heterogeneous audience does not preclude their role in making the single subjects develop and define themselves as emerging disciplinary fields, or sciences, since «encyclopedias have recorded and reinforced the divisions within knowledge, especially science, as much as they have evinced connections and interactions» (Yeo 1991: 25).

Abraham Rees, in the preface to his new and modernised edition of Chambers's *Cyclopaedia*, is well aware of the innovative function of a «SCIENTIFIC DICTIONARY» OR, «A DICTIONARY OF SCIENCE», as he calls it (Rees 1778-1788, Preface 1786, vol. I, B, AS), in a changed context:

we must not forget to mention, that it records and transmits to future ages many inventions and improvements, which might otherwise sink into oblivion; that it forms a compendious history of science; that it furnishes the outlines of its gradual progress and advancement; and that, by preserving a summary of what has been already done and discovered, it lays a foundation for further discoveries and improvements. In this latter view of its importance and use, it may not be improperly compared to a map of science, in which the line that terminates the *terra cognita* is distinctly marked out for the direction of those, whose ingenuity and industry are employed in extending the boundaries of knowledge, and in exploring those regions that are still unknown. (Rees 1778-1788, Preface 1786, vol. I, B, AS)

The *EB*, alongside Rees's revised *Cyclopaedia*, «highlighted, and possibly reinforced, the transition from eighteenth-century natural philosophy to the specialised scientific disciplines of the nineteenth century. [...] the predominant alphabetical arrangement [...] contributed to this consolidation of disciplines» (Yeo 1991: 26).

Dictionaries are moving on, they are not just a *static* repository, a mere systematisation and codification of what is known: they become a *dynamic* space, a basis for establishing future perspectives and discoveries in any field. Thus, they help display a more and more scientific outlook in comparison with preceding philosophical approaches to the ordering and connecting of subjects as elements of universal learning. Omni-comprehensive views are perceived as too vague in a scientific perspective, though fundamental in their original scope and function.

At the same time, disciplinary-bound reference works are compiled by medical men – physicians, surgeons and apothecaries – thus emphasising the new trend which will lead to a clear differentiation among laymen and

experts, as well as to the «consolidation of disciplines» (Yeo 1991: 26).

Except for James's *A medicinal dictionary* (1743-45), the other reference works analysed belong to the second half of the century. There is more than one reason for this: first, it is in this period that medical education undergoes dramatic changes, particularly concerning the epistemological approach to medical events and medical practice (ex. clinical observation and training); second, it is a period in which the reading habits change, both stimulating the production, the circulation and the commercialisation of multifarious works and affecting their nature, structure and contents.

The definition of a disciplinary area in which medical men (independent of their education and/or training, or practice) can identify themselves as professionals, different from a more general context in which medicine continues to be merely empirical and non-professional, runs parallel to the elaboration of distinct but complementary medical discourses, for experts on the one hand, and for non-experts on the other.

Universal and specialised dictionaries are compiled within the tradition of eighteenth-century British encyclopaedism, and so based on shared principles: from the lexicographic practice of organising non-linguistic contents under linguistic or, rather, lexical items in alphabetical order, to the aim of spreading universal or specialised useful knowledge among educated people in vernacular. However, each of them is also representative of gradual epistemological changes: particularly, from an all-inclusive idea of knowledge as scholarship and erudition to a more defined and specialised, (de)limited idea of disciplinary field. This means the progressive shift from learning to science, which involves a specialised and technical approach to reality (entities and events). This also implies the ongoing separation between an emerging restricted community of experts and a broader community of (educated) laymen. As a result, even though these works originate from the same principles, they operate different – and differentiating – choices in including, arranging and encoding medical contents and terminology (for example the length and the complexity of their entries for the same subject-headword, such as *Abortus*, *Abscessus*, *Cephalalgia*, *Fever*, *Paralysis*, etc.).

#### 0.1.2. HANDBOOKS AND COMPENDIA: THE EXPANSION OF REFERENCE WORKS

Since the mid-century the role and number of practitioners performing medicine had been changing. This tendency was influenced both by a growing population interested in medical service, and by the spread of new drugs, updated techniques to cure diseases (Lane 2001: 22; this is the case, for example, of inoculation against small-pox), or innovative surgical skills based on improved anatomical research.

The approach to medical events was more and more practical in nature, and strictly based on clinical observation of phenomena:

Modern medicine has fixed its own date of birth as being in the last years of the eighteenth century. Reflecting on its situation, it identifies the origin of its positivity with a return – over and above all theory – to the modest but effecting level of the perceived. [...] it meant that the relation between the visible and the invisible – which is necessary to all concrete knowledge – changed its structure, revealing through gaze and language what had previously been below and beyond their domain. A new alliance was forged between words and things, enabling one *to see* and *to say*. (Foucault 2003: xii)

The collection of data, the observation of recursive symptoms and signs of diseases, the experimentation of cures and remedies all promoted the recording and the communication of case studies to colleagues. Thus, many practitioners at any level became productive authors on medical topics: both university-educated physicians (with a well-established reputation and élite patients in higher society) and unknown practitioners (particularly surgeons, but also apothecaries) published their accounts, case studies, treatments, collections of diseases (Lane 2001: 23), and lectures (ex. Cullen 1789). It was a way to inform and instruct students, colleagues, and a selected lay audience (particularly among the middle classes), and it was also a means to be recognised by potential new ‘customers’, and make a living by the medical profession:

in the consumerist eighteenth century, medicine expanded fastest of all the superior occupations to become [...] a recognised and respected profession, with registration, professional journals and a career structure in both private practice and institutional appointments. [...] By the 1750s, [...] patients increasingly came to spend money on more scientific successful medical attention as part of a higher standard of living, greater disposable income and increased life expectancy. Medicine became [...] an occupation which gentry or ambitious parents could choose as a career for their sons. (Lane 2001: 11)

Another interesting stimulus to the production of reference works was the consolidation of medical education and training. British medical reform, and especially the need for regular training, promoted the expansion of private medical teaching with a strong practical focus, mostly outside the universities. Private schools of medicine offering training courses with a

basic theoretical approach were widespread, and particularly developed, in London:

private or commercial teaching and medical education outside universities had come to dominate medical training. Students frequented a number of private schools or ‘walked the wards’ of the city’s hospitals with attending physicians and surgeons. The great city of London, of course, had no university at the time so it was not possible to link university teaching with metropolitan hospitals or with any of the new voluntary (charitable) hospitals established in the eighteenth century. (Lindemann 2010: 148-149)

This professionalising attitude was the effect of middle class values and commercial interests applied to a traditional domain of knowledge: this also implied further change as regards the doctor-patient relationship (Cunningham-French 1990: 3). The doctor extends his experience coming out of his closet and changing the attitude towards his patients: the one-to-one relationship is gradually substituted by a one-to-many relationship which focusses on the disease itself (its symptoms, signs, typical observable manifestations, etc.) and not on the personal account of the individual patient. The cures and remedies are thus based on facts and on the professional experience and outlook of the physicians or practitioners, and not negotiated with patients. The individual professional experience expands to become the shared experience within an emerging disciplinary community of colleagues who exchange information, experimentation, ideas and perspectives. This also allows preventative medicine to emerge and make «rational social planning to eliminate diseases» possible (Cunningham-French 1990: 3), particularly after the mid-century:

advances in medicine [...] like most other aspects of improvement, were most marked after the mid-century; the early decades of the eighteenth century represented the more or less stagnant ground-level against which the post-1750 take off could be favourably compared. (Wilson 1990: 9)

The hospitals (but also infirmaries and dispensaries) that were established in London and elsewhere became the institutional places of clinical observation. Hospitals already existed but new ones were built and, more importantly, they were medicalised (Fissel 1991: 93, 99-100). They became a medical workplace: the context in which medicine was systematically practised by professionals. Hence, the role of the hospitals changed and, with it, the role of the practitioner as an expert of scientific experimental medicine. Obviously enough, this also changed the epistemological foundations of medicine:

The voluntary hospitals [...] constructed a new political space for the practice of medicine; and as a result they produced and fostered many new medical initiatives in the eighteenth century and afterwards. [...] they were certainly the site of an independent London medical revolution [...]. It was certainly a large-scale development: by 1750 there were seventeen of them in England, when in the 1718 had been none. (Wilson 1990: 10-11)

Hospitals were also the places in which preventative medicine was made effective, since crowding stimulated the establishment of clear norms to avoid the spreading of infections and contagious diseases. Hygienic rules governed daily and weekly cleaning practices to improve sanitation and asepsis, thus favouring inpatient recovery. Instruction books on these topics were frequently issued and most of them were the outcome of the army – or the navy – surgeons: that is, those practitioners who were constantly performing medicine in overcrowded spaces and contexts of poor hygiene conditions (cfr. Borthwick 1784). According to Riley (1987: x), «It is the origin of a medicine of avoidance and prevention, a medicine that sought to show mankind which diseases-conductive circumstances to evade, and to determine what aspects of the environment might be modified to weaken or eliminate their capacity to cause disease».

It is in this context that public health reforms were planned and aimed at cleansing the environment «to reduce its pathogenic properties and its capacity to promote epidemics» (Riley 1987: 151), so dangerous and scary at the time: many medical writers and their works described and discussed fevers (of any kind) and infectious diseases in general. This, for example, is the focus of such works as Clark's *Observations on fevers* (1780), Grant's *An enquiry into the nature, rise, and progress of the fevers most common in London* (1771), Grant's *An essay on the pestilential fever of Sydenham, commonly called the gaol, hospital, ship, and camp-fever* (1775), Millar's *Observations on the prevailing diseases in Great Britain* (1770), Sims's *Observations on epidemical disorders, with remarks on nervous and malignant fevers* (1776), to name just a few. If the aim was to avoid the spreading of terrible and devastating diseases 'among mankind', then it was necessary to inform and instruct people on the preventative measures to adopt. This also meant the writing and the 'dissemination' of handbooks for a general audience, or textbooks and *practica* for colleagues. The marketplace of print (cfr. Fissel 2007) and book trade helped and supported the commercialisation of medicine to an «health-conscious lay readership» (Porter 1992: 106), since «the flood of self-care literature clearly fostered people's involvement in, and care for, their health» (Porter 1992: 108). Among the most known works addressed both to a lay and professional audience, there is Buchan's *Domestic medicine* (1769), which underwent many editions throughout the century since it

treated all the most relevant pathologies of contemporary society. According to Whitey (2011: 86-87) «the growing importance of medical books was argued to be an increasing source of orthodox medical knowledge [...]. The compiling of medical information was obviously a logical and necessary means of accumulating sufficient medical acumen to tackle a range of conditions within the home» in a new perspective, one in which the two roles of expert-practitioner on the one hand, and non-expert-patient on the other were clearly distinguished. The writer is a professional expert having and dispensing disciplinary know-how: he can interpret and cure diseases, or give advice to the lay people. The doctor-writer and orthodox medicine thus assume a more definite social function than in the past.

Medical knowledge pervades everyday discourse, and discourse is constructed, promoted and developed in multifarious medical texts, culturally and historically situated:

The production of scientific texts, then, is a process of situated rhetorical action, in which writers have an active role, constructing scientific knowledge through texts with particular reading audiences in mind, and at the same time positioning themselves and their commitments and ideological debts within the field of knowledge they represent, within the broader scientific community, and within society at large. (Pahta 2011: 335)

The social context is the setting in which medical professionals perform their activity, as practitioners and writers, and interact with lay people through texts. Discourse emerges as a complex network in which heterogeneous texts variously contribute to the construction of meaning. Scientific popularisation is then the surface level of an in-depth «epistemological shift from scholasticism to empiricism with its new methods and tools of observation, [...] for enquiry» (Pahta 2011: 339), which makes the communication and the dissemination of medical contents and notions to a large audience definitely possible.

These reference works are usually organised into subsequent thematic sections, focussed on specific topics (single diseases, groups of diseases, case studies, etc.), or more general issues (climate, environment, living conditions, non-naturals, etc.) according to the aims of the writer. Some include many diseases and their general causes (Buchan <sup>2</sup>1772), their description and possible cures (Millar 1770; Buchan <sup>2</sup>1772; Fisher 1785), and their categorisation, or classification, along with many case studies (Millar 1770). Others only introduce, describe and discuss more specific diseases, such as infectious and contagious diseases, and their causes (Borthwick 1784; Black 1788), their mortality rate (Black 1788), or the nature, rise, and progress of the most common fevers (Grant 1771, 1775; Sims 1776; Clark 1780).

Chapters, parts, sections and sub-sections may be titled with

- **descriptive headings**, such as *Of the continued fever which prevailed in Newcastle, in the latter part of the year 1777* and *Description of the scarlet fever attended with ulcerated sore-throat* (Clark 1780), *Of diseases which partake both of a putrid and inflammatory nature* (Millar 1770), etc.
- **explicative headings**, such as *Comparative view of the above epidemic with the scarlet fever of authors, and the angina maligna*, etc. (Clark 1780), *Variety of symptoms to be met with the pestilential fever with aphthæ* (Grant 1775), *Precepts and cautions necessary to be observed, when the fever hath either been mitigated or removed by the Peruvian bark* (Millar 1770), *Diseases of the stomach and intestines, and organs of digestion* (Black 1788), etc.
- **narrative headings**, particularly ‘case studies’ and accounts on the progress of diseases, such as *Case of a dysentery* (Grant 1775), *Pleuritic cases [...] CASE I. CASE II.* (Millar 1770), *Cases of continued fevers*, and *An account of the success of the practice which has been recommended in the scarlet fever* (Clark 1780), *Weather of 1765, 1766, and part of 1767* (Sims 1776), etc.
- the names of **individual diseases as headings**: headings partially overlap with the notion of headwords, and with their function, as in lexicographic works (especially in Fisher 1785).

In this last case, diseases may appear in alphabetical order as in dictionaries, *Appetite, want of, Apoplexy, Asthma, Bit of a mad dog-Hydrophobia, Black disease, Bleeding at the nose, Bleeding piles, Blind piles, Blood-spitting, Blood-vomiting*, etc. (Fisher 1785), or in thematic groups according to their nature, symptoms and signs, cures, etc. *Diseases of the lungs and organs of respiration, Pulmonary hæmorrhage, Pulmonary phthisis, [...], Asthma, Dyspnœa and coughs, Catarrh, Hooping cough, Croup* (Black 1788).

Other interesting sections at the end of some books are appendices, indexes, and tables of diseases, remedies, and data, previously discussed in the works. These sections are usually included for a quick reference. This may suggest that some of these writings were addressed to a semi-expert or expert audience of trained practitioners who performed medicine and needed to find solutions in haste. Appendices are organised as tables and focus on multifarious topics, *Tables of the diseases of the patients admitted to the Newcastle Dispensary, with remarks on the method of improving medical returns* (Clark 1780); they may be commented translations adding material to the main text, *Translation of some Latin quotations, with remarks* (Millar 1770); or they are mere lists of words and glossaries, *A glossary, explaining the terms of art* (Millar 1770), etc. Indexes may include lists of medicines and remedies

in alphabetical order and cross-refer to the sections and pages in which they are treated (Buchan <sup>2</sup>1772).

## 0.2. METHODOLOGY

The reference works under scrutiny here are investigated from two complementary perspectives: the lexicographic and the textual ones. The lexicographic perspective is based on McConchie-Curzan' (2011) approach, which focusses on definitional strategies in medical entries. This perspective highlights those textual, rhetorical and linguistic features typical of dictionaries and the way lexicographic works usually elaborate knowledge and discourse. The textual perspective focusses on the rhetorical and linguistic-stylistic features of the various texts exemplified. This latter perspective aims at discussing their dimensions of variation (ex. involved vs. informational, narrative vs. non-narrative, abstract vs. non-abstract, etc.), according to the approach elaborated by Biber (1988), Biber-Finegan (1989), and Biber-Conrad (2009).

### 0.2.1. LEXICOGRAPHIC APPROACH: SYSTEMATISING AND DEFINING MEDICAL CONTENTS

**Definitional Patterns & Symptomatological Defining.** According to McConchie-Curzan (2011: 77), in a study on Early Modern English medical writing, «the word 'definition' [...] encompass[es] a wide range of means for helping readers to understand and to use a term.» This perspective may also be applied to later texts, such as those at the core of the present analysis: it is relevant at a theoretical level as reference point, and appropriate at a practical level to collect, examine, and organise data.

The expression **extended definition** is used in this study to represent complex definitional patterns. These include basic – and complementary – components (taken and adapted from McConchie-Curzan 2011), such as

- a. **definition proper**  
or **lexical definition**, word meaning as usually expressed in dictionaries
- b. **etymology**  
introducing meaning and giving authority, thus supporting definition itself
- c. **glossing**  
mostly overlapping with the notion of *equivalence*<sup>9</sup>, either

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9 For the notion of equivalence, see Adamska-Sałaciak 2010: 393-395 and 397-399.

- i. *translational equivalence* (that is to say, *insertable*; it may consist of single-word lexemes and/or multi-word lexemes, both between English and a foreign language, either classical or modern and between different registers within the same language), used to establish a one-to-one correspondence between the ‘topic-headword’<sup>10</sup> and its (more prestigious, if Latinate) variant denomination, or
- ii. *explanatory equivalence* (that is to say *descriptive*), used to *reformulate-paraphrase* the ‘topic-headword’ (an ‘*in-other-words*’ expression, *descriptive* in nature)

**d. categorisation**

organising principle, mainly *genus-differentia* patterns, sense relation of hyponymy

**e. concise description**

the lexical definition is expanded (but not to the extent of symptomography, cfr. f. below), encyclopaedic contents are included such as the main symptoms and/or shared knowledge to make the context/situation more transparent to the average reader)

**f. definition in relation to symptoms**

elaborate descriptions (sometimes many pages long) characterised by accurate and all-encompassing lists of symptoms and disease details, alongside the course of illness (sub-sequent steps in the process are emphasised by (chrono)logical transition markers, verb phrases, etc.). This is known as «symptomatological defining, ‘symptomography’», that is to say «the listing of symptoms to understand disease» (McConchie-Curzan 2011: 85-86)

These strategies are not only exploited within dictionaries but adapted to different uses in different text typologies across genres, particularly handbooks and compendia: the relationship and exchanges between these two ‘macro’-genres (dictionaries vs. handbooks) are rather tight. Hence, the analysis considers the nature of such lexicographic features and their dynamic potential in organising and communicating contents, and in discussing similarities and differences across genres and text types.

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<sup>10</sup> The term *headword* is used here to refer to the main topic of the discussion which, more often than not, is introduced by a short title or the name of the disease, thus resembling the entryword of a lexicographic reference work, either dictionary or encyclopaedia. This terminological choice seems to be appropriate, since other elements typical of lexicographic entries are also exploited in the extracts exemplified (equivalence, etymology, glossing, categorisation, sense relations, description, etc.).

0.2.2. *TEXTUAL APPROACH: RHETORICAL CONTEXT AND LINGUISTIC FEATURES*

**Dimensions of variation.** The analysis is based on the following dimensions of variation (cfr. Biber 1988 and Biber-Finegan 1989; Biber-Conrad 2009), each dimension being characterised by two poles along a continuum. Polarity is highlighted between brackets:

1. **Involved** (face-to-face interaction) vs. **Informational** (academic prose)
2. **Narrative** (fiction, account, etc.) vs. **Non-narrative** (academic prose, official document, etc.)
3. **Abstract** (academic prose) vs. **non-abstract** (face-to-face conversation)
4. **Situation-dependent** (listener's knowledge of immediate context: place, time, other adverbs, etc., ex. personal letters) vs. **Elaborated/Explicit Reference** (official documents, professional letters, academic prose, etc.)

To be accurate and reliable, the analysis of a text, the identification of one or more text typologies and their function(s) within the text itself, are based on a set of linguistic features: no single and isolated linguistic items can provide reliable textual evidence. Linguistic features, if considered along a continuum between poles, may be more or less frequent (and thus more or less typical) of a given genre and/or text type, and can tell us a lot about the rhetorical situation in which the text was produced, alongside its rhetorical function(s). In other words, combined linguistic features are a fundamental resource to determine the rhetorical strategies used by medical writers for the elaboration of medical discourse and the dissemination of medical knowledge.

Text analysis and discussion are essentially carried out in four chapters: chapter 1. and 2. analyse and discuss medical discourse in dictionaries and encyclopaedias; chapter 3. is completely devoted to the presentation and discussion of textual examples drawn from handbooks and compendia; chapter 4. is devoted to the case study *fever* across genres (universal dictionaries of arts and sciences, medical dictionaries, handbooks and compendia). In the four chapters, the analysis will focus firstly, on the structure and use(fulness) of definitional patterns as communicative strategies in Late Modern English medical writing; secondly, on rhetorical variation and its impact at linguistic, stylistic and textual levels across genres.

For the general aim of the study, text analysis is always and necessarily related to – and contextualised in – the social, cultural, and historical backgrounds.

### 0.3. DEFINITION OF SOME KEY TERMS

This section is devoted to the explanation of some key terms as used in this study according to the variety of (con-)texts in which they may be found, their possible references, and their possible meanings. For this purpose, Samuel Johnson's *Dictionary of the English language* (1755) will be used to define some of them as appropriately as possible for the period under scrutiny here. This approach is considered a necessary step to avoid anachronistic overlapping(s) with present-day usage for the same terms, since it provides an outlook on eighteenth-century interpretation and representation of medicine. The approach also helps focus on and distinguish some general notions which could be taken for granted, according to the present experience of the world. These notions are designated by terms such as *science* (and its derivatives), *knowledge*, *learning*, *disease*, *symptom*, *practitioner* and *physician*.

The first distinction to be made is between (the notions of) *science* and *knowledge*. In the eighteenth century these two terms partly overlap, to denote either speculative reasoning, learning, erudition, or more practical skills and experimental, demonstrative approaches to reality:

KNO'WLEDGE. *n. s.* [from *know*.]

1. Certain perception; indubitable apprehension.

*Knowledge*, which is the highest degree of the speculative faculties, consists in the perception of the truth of affirmative or negative propositions. *Locke*.

2. Learning; illumination of the mind. [...]

3. Skill in any thing. [...]

4. Acquaintance with any fact or person. [...]

5. Cognisance; notice. [...]

6. Information; power of knowing. [...]

SCIENCE. *n. s.* [*science*, French; *scientia*, Latin]

1. Knowledge.

If we conceive God's sight or *science*, before the creation of the world, to be extended to all and every part of the world, seeming every thing as it is [...]. *Hammond*.

2. Certainty grounded on demonstration.

So you arrive at truth, though not at *science*. *Berkely*.

3. Art attained by precepts, or built on principles. [...]

4. Any art or species of knowledge. [...]

5. One of the several liberal arts, grammar, rhetoric, logick, arithmetic, musick, geometry, astronomy. [...]

SCIE'NTIAL. *adj.* [from *science*.] Producing science.

SCIENTI'FICAL. } adj. [*scientifique*, Fr. *scientia* and *facio*, Lat.]  
 SCIENTI'FICK. } Producing demonstrative knowledge; produc-  
 ing certainty.

Natural philosophy proceeding from settled principles, therein is expected a satisfaction from *scientific* progressions, and such as beget a sure or rational belief. *Brown's Vul. Err.*

[...]

The systems of natural philosophy that have obtained, are to be read more to know the hypothesis, than with hopes to gain there a comprehensive, *scientific*, and satisfactory knowledge of the works of nature. *Locke.*

SCIENTI'FICALY. *adv.* [from *scientific*.] In such a manner as to produce knowledge.

Sometimes it rests upon testimony, because it is easier to believe than to be *scientifically* instructed.

The term *knowledge* is more comprehensive and also refers to general, shared, notions, and everyday experience; instead the term *science* as specialised, professional, factual and practical knowledge, belonging to a limited disciplinary community of experts and strictly based on observation, experimentation, collection and interpretation of data is still to come. Johnson's entries testify to this progressive and complex epistemological change, and its lexicalisation. *Knowledge* is getting established as *learning* in general, *speculative learning*, but also as *acquaintance with any fact or person*, shared knowledge, and common experience. *Science* and *scientific*, instead, more often than not refer to *demonstrative* and *satisfactory knowledge*, grounded on facts and experimentation, thus *producing* 'scientific' *certainty*. *Medicine* and *medical knowledge* undergo the same process of distinction and differentiation, at conceptual and lexical levels: *medicine* as *shared, general knowledge*, and *medicine* as *speculative learning* (i.e. erudition) coexist with the gradual shift of *medicine* towards a more *restricted, disciplined, professional, scientific* approach:

ME'DICAL. *adj.* [*medicus*, Lat.] Physical; relating to the art of healing; medicinal. [...]

ME'DICALY. *adv.* [from *medical*.] Physically; medicinally. [...]

MEDICI'NAL. *adj.* [...]

1. Having the power of healing; having physical virtue. [...]

2. Belonging to physic. [...]

ME'DICINE. *n. s.* [*medicine*, Fr. *medicina*, Latin. ...] Physick; any remedy administered by a physician. [...]

PHY'SICAL. *adj.* [*physique*, Fr. from *physick*.]

1. Relating to nature or to natural philosophy; not moral. [...]
2. Pertaining to the science of healing.
3. Medicinal; helpful to health. [...]

PHYSI'CIAN. *n. s.* [*physician*, Fr. from *physick*.] One who professes the art of healing.

PHY'SICK. *n. s.* [...originally signifying natural philosophy, has been transferred in many modern languages to medicine.]

1. The science of healing. [...]
2. Medicines; remedies. [...]

The traditional lore of medicine as part of a more general knowledge, as a branch of learning belonging to *natural philosophy*, is still present in the adjectives *physical*~*relating to nature*, and *medical*~*physical*; whereas the entry *Medicine* highlights the shift towards its more specialised, experimental, practical, knowledge as *the science of healing*~*the art of healing*, or *any remedy administered by a physician*, *medicines*~*remedies*. Accordingly, the physician is one who *professes the art of healing*, but whose medical education is still grounded on traditional university learning, also including multifarious branches of knowledge such as botany, chemistry, natural philosophy, and the humanities as well. Performing medicine was the issue of other 'medical men', usually known as practitioners, mostly surgeons and apothecaries, regularly trained in private schools and/or institutional contexts since the end of the century. When used in the study, the two terms usually refer to this distinction. However, the activity of physicians and practitioners came closer in time: physicians starting to practice more regularly and frequently, practitioners being provided with a more regular training based on – and also including – fundamental theoretical notions.

In the last quarter of the century, medicine was gradually transformed into science, to be definitely established as such, in the following decades. In this study, the expressions *medical knowledge* and *shared medical knowledge* are used with their more comprehensive and general meaning; whereas *medicine* or *medicine as science* will be used with their restricted, more specialised meaning. However, the distinction between these two semantic notions is extremely complex and not easy to pin down. The effort is to be as clear, coherent and consistent as possible according to the contexts in which the terms – or the multiword expressions – are used to describe, discuss and comment on the original excerpts. Potential ambiguity, or vagueness in use, are always possible because of the polysemic values and clustered senses, embedded into one another, their semantic load blending in with new usage(s).

The other set of terms which deserves introduction and explanation here

includes *disease*, *distemper*, *disorder*, and *affection*; *symptoms*, *signs*, and *phenomena*. *Disease* is the term commonly used to refer to any medical event, of any kind and severity. It expresses an all-inclusive notion which may be variously expressed by near synonyms such as *distemper* (usually referring to a *slight illness* caused by a traditional imbalance in the body, *predominance of some humour*), *disorder* (usually meaning a *slight disease*, due to *lack of regularity in the animal œconomy*, probably humoral imbalance)<sup>11</sup>, and *affection* (more general term adopted in medical context):

DISEA'SE. *n. s.* [*dis* and *ease*.] Distemper; malady; sickness; morbid state. [...]

DISTE'MPER. *n. s.* [*dis* and *temper*.]  
[...]

2. A disease; a malady; the peccant predominance of some humour; properly a slight illness; indisposition. [...]
3. Want of due temperature. [...]
4. Bad constitution of the mind; predominance of any passion or appetite. [...]
5. Want of due ballance between contraries. [...]

DISO'RDER. *n. s.* [*dis* and *order*; *desordre*, French.]

1. Want of regular disposition; irregularity; confusion; [...].
5. Breach of that regularity in the animal œconomy which causes health; sickness; distemper. It is used commonly for a slight disease. [...]

AFFE'CTION. *n. s.* [*affection*, Fr. *affection*, Lat.]

1. The state of being affected by any cause, or agent. This general sense is little in use. [...]
2. Passion of any kind. [...]

In any of the previous definitions, the traditional notion of a disease as an imbalance in the individual body clearly emerges and still predominates. Hence, the terms *disease*, *distemper*, *disorder* appear to be interchangeable in use. The term *disease* sometimes overlaps with symptoms and effects of a disease proper (as we can conceive it nowadays). This intermittent connection between *disease*, *symptoms*, *effects* relates to the widespread perception of disease as an individual experience, the outer manifestation of an internal humoral imbalance (*disease*, *distemper*, *disorder*, cfr. above) to be cured by

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<sup>11</sup> Johnson's definitions of *distemper* and *disorder* still include traditional perspectives tracing back to the four bodily humours of ancient Galenic medicine. For this specific aspect and for a detailed analysis of some medical terms in Johnson's *Dictionary* cfr. Pireddu 2006.

traditional remedies such as bleeding, purging, sweating, etc. The notion of *disease* as an individual entity, with typical characteristic *signs*, independent of the patient and of occasional *symptoms*, only emerges toward the end of the period under scrutiny here, and is the consequence of an epistemological shift. This change essentially concerns the approach to the observation of diseases and the «virtues of the clinical gaze» (Foucault 2003: 85):

Analysis and the clinical gaze also have this feature in common that they compose and decompose only in order to reveal an ordering that is the natural order itself: their artifice is to operate only in the restitutive act of the original. (Foucault 2003: 94)

The clinical gaze focusses on diseases as independent entities, independent of the body hosting them but manifesting themselves regularly and systematically in it: the clinical gaze recognises *signs* and *symptoms* in different patients. By analogy, it establishes relations among elements (Foucault 2003: 100). Diseases can be recognised by specific identifiable *signs* in a number of cases and in similar situations:

SIGN. *n. s.* [*signe*, French; *signum*, Latin.]

1. A token of anything; that by which any thing is shown. [...]

SYMPTOM. *n. s.* [*symptome*, French; ...]

1. Something that happens concurrently with something else, not as original cause, nor as the necessary cause or constant effect.

2. A sign; a token. [...]

SYMPTOMA'TICAL. } *adj.* [*symptomatique*, French; from *symptom*]  
SYMPTOMA'TICK. } Happening concurrently, or occasionally.

*Symptomatical* is often used to denote the difference between the primary and secondary causes in diseases; as a fever from pain is said to be *symptomatical*, because it arises from pain only; and therefore the ordinary means in fevers are not in such cases to be had recourse to, but to what will remove the pain; for when that ceases, the fever will cease, without any direct means taken for that. *Quincy*.

*Signs* are the consistent and stable manifestations of a disease, their objective evidence, independent of the patient; whereas *symptoms* are usually circumstantial phenomena, and sometimes occasional manifestations of it perceived by the patient. However, the use of the two terms varies in eighteenth-century medical reference works. *Symptom(s)* is more widespread

than *sign(s)*, sometimes including both the meaning of *occasional symptoms* and *objective signs*, sometimes just focussing on occasional, circumstantial, individual perceptions and manifestations of the disease<sup>12</sup>.

#### 0.4. GENERAL OVERVIEW OF THE VOLUME

##### 0.4.1. CHAPTER 1. FRAMING MEDICAL DISCOURSE IN UNIVERSAL DICTIONARIES OF ARTS AND SCIENCES

This chapter introduces the two most relevant universal dictionaries of arts and sciences issued in the second half of the eighteenth century, and discusses the role they played in the dissemination of medical knowledge: the *Encyclopaedia Britannica* (1768-1771) and Rees's *Cyclopaedia* (1778-1788). It also investigates the inclusion of medical terminology and the treatment of individual sample entries (Abortion, Abscess, Absorbents, Abstergents, Head-ach, Paralysis, etc.). In particular, the analysis focusses on the lexicographic components structuring them (basic and recurrent components, such as *headword*, *equivalence*, *glossing*, *etymology*, *lexical definition*, *cross-references to internal sources-headwords*), and their contents (more complex lexicographic and textual components, such as *symptomatological definition*, *encyclopaedic expansion of contents*, *quotations*, *inclusion of case studies*, *cross-references to external sources*). In other words, the analysis highlights the construction of medical discourse both as *general knowledge* (for a general educated audience), and as *emerging science* (for a more professional and restricted readership) in the two works.

##### 0.4.2. CHAPTER 2. FRAMING MEDICAL DISCOURSE IN SPECIALISED DICTIONARIES

The analysis of the two specialised medical dictionaries is the focus of the second chapter: James's *A medicinal dictionary* (1743-1745) and Motherby's *A new medical dictionary* (1775) are introduced starting from their prefaces, in which their individual perspectives on, and their specific approach to, medicine are exposed in detail. James and Motherby declare their aims, define their target audience, explain their plan, and provide the internal organisation of their respective works. As in the previous chapter on universal dictionaries, the analysis focusses on the basic lexicographic components, and on more complex lexicographic and textual patterns in the elaboration of encyclopaedic contents, and medical discourse. A selection of topic-headwords already discussed in the first chapter, such as Abortion, Abscess, Ab-

<sup>12</sup> For a thorough analysis of the terms *token*, *symptom*, and *sign*, a relevant study by Jukka Tyrrkó was issued in 2006. The study discusses the use of *token*, *symptom*, and *sign* as *signifier terms* in English vernacular medical texts from late Middle English to early Modern English (up to 1725), and in dictionaries from 1530 to 1775.

sorbents, Abstergents, Head-ach, Paralysis, etc., are under scrutiny here.

#### 0.4.3. CHAPTER 3. FRAMING MEDICAL DISCOURSE IN EIGHTEENTH-CENTURY HANDBOOKS

Handbooks and compendia are the third group of texts at the core of this study: they represent a macro-genre which may display both similarities and differences across individual works. Differences lay in the degree of inclusiveness of contents (topics, diseases, medical events, case studies), and comprehensiveness of treatment (extension and detail). The starting point of the discussion is the analysis of their prefaces, to make their perspective(s) and their plan(s) clearly emerge, and to background further and more in-depth discussion of particular topics. The presentation of recurrent structural patterns in textual organisation follows: the rhetorical and linguistic strategies commonly used to introduce medical events and diseases (*denomination, definition, categorisation*), and to elaborate contents (*symptomography, logical sequencing, embedding*), are discussed in a series of thematic examples (*inflammation of the lungs* and *head-ache* in particular). The relationship – and the interaction – between widespread lexicographic practices and the elaboration of non-lexicographic text types in the construction of medical discourse is a key feature of this chapter.

#### 0.4.4. CHAPTER 4. CASE STUDY: FEVER IN DICTIONARIES AND HANDBOOKS

Chapter four is completely devoted to a single term or topic, that is to say *fever*, and to the multifarious, complex, clustered realities it represents in the second half of the eighteenth century. *Fever*, as linguistic and textual evidence of extra-linguistic medical events, is analysed in all the emerging and expanding macro-genres already investigated individually, but here taken together: universal dictionaries of arts and sciences (*EB* and *RCy*), specialised dictionaries (*MD* and *NMD*), handbooks and compendia. Moreover, before close treatment in selected examples, the lexical definition of the term in mid-century dictionaries of the English language is provided (Martin, 1749; Johnson, 1755; Scott-Bailey, 1755) as background information for further encyclopaedic development. Once again, the lexicographic approach, the textual approach, their relationship and interaction in different medical reference works, along with medical discourse issues, are highlighted and discussed.

0.4.5. *CHAPTER 5. CONCLUSIONS*

The concluding chapter summarises the most relevant findings of this qualitative study, as regards medical discourse and the communication of medical contents in different emerging macro-genres. Notwithstanding the particular nature of each individual text, and the use of recurrent linguistic, textual, and discourse features within the same genre (universal or specialised dictionaries vs. handbooks and compendia), the extracts analysed also provide strong evidence of similarities across genres. This may suggest shared needs – and shared habits – in the construction of medical knowledge (and medical knowledge as science), a common disciplinary core which deserves the same techniques to define medicine and to communicate contents. In other words, the discipline itself seems to determine and establish the rhetorical and linguistic strategies to be applied.



## I.

### FRAMING MEDICAL DISCOURSE IN UNIVERSAL DICTIONARIES OF ARTS AND SCIENCES

The first edition of the *Encyclopaedia Britannica* (1768-1771; hereafter *EB*) and Rees's *Cyclopaedia, or an universal dictionary of arts and sciences* (1778-1788; hereafter *RCy*) are the two general reference works under scrutiny here. They are the most relevant outcomes of this kind in the second half of the century. Rees still answers to a taxonomic approach, derived from Chambers, and is aimed at connecting the different branches of knowledge; the *EB*, instead, is not interested in this but in highlighting the unity of single independent subjects. In any case, their specific plan along with the alphabetical order enhance the distinction of individual topics: in *RCy*, many original entries in Chambers are put together under the same headword; in *EB*, monographic treatises embed disciplinary contents in sub-sections.

The *EB*, particularly interested in natural history and science in general, is the first to have the word encyclopaedia in its title and also the first to present it as a national – British – endeavour. In fact, it is a completely Scottish one and the outcome of Scottish Enlightenment (Yeo 2001: 170-173, 176-180). The title page announces – and the preface emphasises – the main features distinguishing this new dictionary of arts and sciences from the previous ones: «[t]he different Sciences and Arts are digested into distinct Treatises or Systems» (title page). The traditional schemes of classification, establishing comprehensive networks among contents disseminated under innumerable headwords, are abandoned:

Instead of dismembering the Sciences, by attempting to treat them intelligibly under a multitude of technical terms, they [i.e. compilers and editors] have digested the principles of every science in the form of systems or distinct treatises, and explained the terms as they occur in the order of the alphabet, with references to the sciences to which they belong. (*EB* Preface: v)

This is a truly innovative arrangement: the tree of knowledge is replaced by inclusive treatises (about forty, called ‘systems’) of «high scientific content» (Yeo 2001: 172). So it is no longer merely arts and sciences, or parts thereof, laid out in alphabetical order arbitrarily listing the single headwords and connecting them by cross-references; rather, cohesion is ensured by the many syntheses of the main branches of knowledge emerging and establishing themselves as individual disciplines. Their basic principles are thus explained discursively, as opposed to the fragmentary presentation based upon an alphabetical classification. These treatises are arranged in alphabetical order, but stand out from the rest of the text – the title being at the centre of the page in capital letters – and sometimes are so extensive that they largely exceed the size of an encyclopaedia article (some are more than one hundred pages, others more concise). They are used as disciplinary macro-areas, such as Medicine, Surgery, Midwifery, Anatomy, Botany, and many others. The organising principle at the basis of the *EB* was a

conscious rejection of Chambers’ model and, ultimately, of all such attempts to classify the sciences covered in an encyclopaedia. The preface [...] to the first edition was brief, reflecting the practical attitude of the owners who were men of business with an interest in science, not philosophers seeking to reorganise the intellectual world. (Yeo 2001: 179)

The plan is thus conceived as having a different epistemological perspective. The aim is strictly practical<sup>1</sup>. Usefulness for mankind in real life is the crucial assumption, and not philosophical and scholarly arrangements. The need and the effort to classify and unify the whole circle – or, rather, hierarchy – of knowledge in a map are disregarded. However, this choice was not spared bitter criticism, particularly in London where Chambers’s *Cyclopaedia* (1728 and later editions) still dominated the market, and the intellectual world.

The first edition of the *EB* includes very concise entries: the headword is usually followed by an essential, lexical definition and sometimes by a concise expansion of the topic. In the following editions, the innovative plan of the first edition would instead become the starting point for future developments and enlargements, which made the *EB* a very successful enterprise which is still published nowadays. The principal aim is twofold and in line with a more general attitude of the time, since «UTILITY ought to be the principal intention of every publication», as well as «To diffuse knowledge of Science, [which] is the professed design of the following work» (*EB* Preface: v). The compilers address

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<sup>1</sup> This practical attitude is particularly shared by the editors of the *EB* (1768-71) and by Motherby (*NMD* 1775) and, as such, mirrored in their works; whereas James (1743-45) and Rees (1778-88) echo a more traditional and scholarly approach in their dictionaries, though they also emphasise the practical benefits of their ‘innovative’ and comprehensive attempts. James and Rees are still rooted in traditional systematisation of knowledge, though stimulating and enhancing new outlooks as well.

to the educated readers, «both gentlemen and literati» (Yeo 2001: 172).

Medicine, in general, is discussed under three main treatises: Medicine (pp. 58-169), Surgery (pp. 640-679) and Midwifery (pp. 205-245). They are of uneven length, Medicine being the longest and the most relevant. It starts with a concise definition:

MEDICINE is generally defined to be, The art of preserving health when present, and of restoring it when lost.

[...]

Medicine being thus founded on a powerful instinct in human nature, its existence in some form must have been coeval with the first disease that appeared among mankind. (*EB Medicine*: 58)

To this general definition, Dr. Cullen's classification<sup>2</sup> of diseases follows, as presented in his *Synopsis nosologiae methodicae* (Edinburgh 1769, in Latin; 1792 first translation from Latin to English as *Synopsis and nosology*), containing the arrangement and definition of diseases (*Genera morborum praecipua*):

The doctor divides diseases into the four following classes, viz.

|       |      |  |
|-------|------|--|
| CLASS | I.   | PYREXIÆ, or Feverish Disorders.  |
|       | II.  | NEUROSES, or Nervous Diseases.   |
|       | III. | CACHEXIÆ; comprehending such disorders as proceed from a diseased state of the whole or any part of the body, without an original fever, or any nervous complaint. |
|       | IV.  | LOCALES; comprehending diseases which affect a part only, not the whole body.  |

(*EB Medicine*: 59)

Then, each class is further subdivided into orders (a kind of table of contents for the treatise Medicine) and, within each order, diseases are thematically listed and described. Interestingly enough, *medicine* – as a domain – is not subdivided into further branches as in previous and contemporary dictionaries of arts and sciences. However, most of its sub-branches are defined under their respective headwords, in alphabetical order (except for Hygieina/Hygeina)<sup>3</sup>:

PATHOLOGY, that part of medicine, which explains the nature of diseases, their causes and symptoms.

PHYSIOLOGY, [...] among physicians the term physiology de-

2 Dr. William Cullen (1710-1790) was professor of Medicine at the University of Edinburgh.

3 As regards *medicine* and the treatise Medicine in the *EB*, see also Kafker (1994a: 164-165) and Lonati (2002: 37-40). For the principles of inclusion and arrangement of medical contents in universal dictionaries of arts and sciences see also Lonati 2007 and 2014.

notes the history of the human body and its several constituent parts, with their relations and functions.

SEMIOTICA, that part of medicine which considers the signs or indications of health and diseases, and enables the physician to judge what is, was, or will be, the state, degree, order, and effect of health or sickness.

THERAPEUTICS, that part of medicine which acquaints us with the rules that are to be observed, and the medicines to be employed in the cure of diseases.

(*EB* s.v. Pathology, Physiology, Semiotica, Therapeutics)

These entries – in particular their conciseness – exemplify the definitional strategies as introduced in the preface to the *EB*. They also reflect the general features of most of them, often limited to the lexical definition or a moderate expansion of it.

The same subdivision is, instead, traditionally embedded s.v. Medicine in *RCy* (1778-1788), which is a revised edition, in five folio volumes, of Chambers's *Cyclopaedia* (1728).

Medicine is introduced in general terms as «MEDICINE, MEDICINA, the art of healing», and defined as «*Medicine* popularly called *physic*, consists, according to Boerhaave, in the knowledge of those things by whose application life is either perceived sound and healthy, or when disordered is again restored to its pristine healthiness». The whole entry, two in-folio columns in length, synthetically introduces the history of medicine (here a very concise one indeed, if compared to Chambers's 1728 entry or to the long all-inclusive article in the *EB*) and the traditional subdivision into its five branches:

*Medicine* is divided into five principal branches. The first considers the human body, its parts and fabric, life and health, and the effects following from them: this is called *physiology*, the doctrine of the *animal œconomy*, or of the use of the parts; and its objects, now enumerated, are called *res naturales*, or things according to nature. The second branch considers the diseases of the human body, their differences, causes, and effects; and is called *pathology*, as it considers the diseases; *ætiology*, as it inquires into their causes; *nosology*, when it examines their differences; and lastly, *symptomatology*, when it explains their effects. The objects of this part are called *res præternaturales*, or beyond nature. For the modern method of classing diseases, see *NOSOLOGY*.

The third branch considers the signs or symptoms, and how to apply them to use; so as to judge, both in a sound and a diseased

body, what will be the degree, order, and effect, of the health or the disease: this is called *semeiotica*: its objects are things both natural, non-natural, and preternatural.

The fourth branch considers the remedies, and their use, whereby life may be preserved; whence it is called *hygieine*: its objects are what we strictly call non-natural. Lastly, the fifth furnishes the materia medica, its preparation, and manner of exhibition, so as to restore health, and remove diseases: and is called *therapeutica*, comprehending the *diætetica*, *pharmaceutica*, *chirurgica*, and *iatrica*<sup>4</sup>. (RCy s.v. Medicine)

However, everything pertaining to the medical field is disseminated in alphabetical order under the many technical headwords, whether pointing to diseases, remedies, tools, cures, etc. the length of the single entries may vary a lot.

Abraham Rees aimed at updating, and adapting to new needs and perspectives, Chambers's *Cyclopaedia* (1728), a work that still kept the market – and the intellectual world – among the multifarious encyclopaedic publications issued around the middle of the century and later. RCy exemplifies the lexicographic interest within the encyclopaedic enterprise, since many entries were reduced and definitions modernised and shortened. Actually, the basic principles structuring the work are the same as in Chambers's *Cyclopaedia*. The map of knowledge is included and serves as a unifying network, connecting different 'disciplines' and sub-disciplines. However, Rees updated contents and made them more 'scientific' and focussed:

Many of the original articles [...] have been either abridged or enlarged, as their respective nature and importance required; and that many new articles have been inserted in their alphabetical order; [...] the number of NEW ARTICLES amounts to more than FOUR THOUSAND FOUR-HUNDRED; several of which do not occur in any DICTIONARY OF SCIENCE [...] some of them are of considerable length; many comprehend subjects of moment; and the least important were thought too interesting to be omitted. The ORIGINAL ARTICLES, which seemed to require correction, abridgment, or addition, many of which have been very much altered or enlarged, are more numerous than those that are altogether new. [...] Besides, by [...] the

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4 Except for minor differences (ex. cross-references), this section overlaps with Chambers's 1728. The same branches are included in alphabetical order in Rees's work: the single entries include etymology and the definition starts from it and is essentially lexical. Such entries, for their characteristics (both structural and linguistic), could be regularly found in contemporary universal – or general – dictionaries of the English language (the etymological principle became systematic since the first decades of the century in language dictionaries and was also exploited by eighteenth-century encyclopedists as a starting point of their entries, when introducing technical terminology or scientific concepts and/or topics).

combination of articles under the same title, the abridging of those that were needlessly diffuse, an alteration in the references by cancelling some that were of no importance, and printing the subject of reference in a different character in the body of the article itself, and by a minute attention to many other circumstances, the Editor has made room for introducing a variety of new matter within the same compass. (*RCy* 1778-1788, Preface 1786: iii)

His aim was to enlarge the scientific perspective, including «inventions and improvements in trades, industries, and technology» thus giving «prominence to this interest in a reference work conceived of as a dictionary of science rather than as a mere storehouse of knowledge» (Werner 1994: 190). As a consequence, *RCy* is not just a revision, but it may be considered the starting point of an innovative approach, mirroring issues typical of the enlightened, and rapidly developing, pre-industrial British society.

### 1.1.1. INTRODUCING, ORGANISING, AND DEFINING MEDICAL CONTENTS

The general and most frequent structure of the entries in the *EB* and *RCy* has been discussed in the previous paragraphs. The attention may now focus on a few headwords, the same in the two dictionaries to facilitate comparison. The selection is mainly qualitative, and the terms represent some of the most frequent topics of description and in-depth treatment in medical writing<sup>5</sup>. The lexical items under scrutiny here are *abortion*, *abscess*, *absorbent/s*, *abstergent/s*, *head-ach*, *hemicrania*, *hemiplegia*, *hemitritæus*, *parachynanche* (*parasynanche*), *palsy*, *paralysis*. The headwords and their respective entries will first be analysed in universal dictionaries of arts and sciences, and further on in medical dictionaries. Further analysis is carried out on a specific topic in chapter four, that is *fever*. This widespread phenomenon has been chosen for the impact it had both on society, as shared – and more often than not frightening – experience, and on medical practice and research. The following tables include some of the sample entries taken from the *EB* and *RCy*.

#### 1.1.1.1. ENCYCLOPAEDIA BRITANNICA

The examples in Table 1 demonstrate that the structure of entries in the *EB* is not particularly complex. This fact supports and confirms the compilers' premises in the preface, and seems to fit in with their aims. Complexity obviously regards the treatises on Medicine and Surgery: they are inserted in alphabetical

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<sup>5</sup> Here, the expression *medical writing* refers to those reference works investigated in the present study, also including the handbooks analysed in the following chapters.

order, like all other headwords, but the articles are absolutely not just normal entries. As regards the entries under scrutiny here, they are transcribed – some of them necessarily shortened – in the table below. Abortion, Abscess, Head-ach (sub-entry), Hemitritæus, Palsy And Parasyanche are included as individual entries: they cross-refer to particular sections in the main treatises where the topic is expanded and explained in detail but, to avoid dispersion, cross-references are not used to connect the single entries among themselves.

Definitions are the main part of the medical entries in the *EB*: they are very short and spare – generally two or three column lines (Abortion, Abscess, Abstergent *Medicines*, Hemiplegia/Hemiplexia, Hemitritæus, Parasyanche). Indeed, most of the entries provide – apart from the headword and label – only a lexical definition (which is more or less condensed):

Table 1

|  |
|--|
| <i>Encyclopaedia Britannica</i>  |
| <p><b>ABORTION</b>, in midwifery, the birth of a foetus before it has acquired a sufficient degree of perfection to enable it to perform respiration and the other vital functions. See MIDWIFERY, title, <i>Of abortion</i>.</p> <p style="text-align: center;">***</p> <p style="text-align: center;">MIDWIFERY<br/><i>Of Abortions.</i></p> <p>A MISCARRIAGE that happens before the tenth day, was formerly called an efflux, because the embryo and secundines are not yet formed, and nothing but the liquid conception, or geniture, is discharged. From the tenth day to the third month it was known by the term expulsion, the embryo and secundines being still so small, that the woman is in no great danger from violent flooding. If she parted with her burden betwixt that period and the seventh month, she was said to suffer an abortion; in which case she underwent greater danger, and was delivered with more difficulty than before; because the uterus and vessels being more distended, a larger quantity of blood was lost in a shorter time, the foetus was increased in bulk, and the neck of the womb is not yet fully stretched: besides, should the child be born alive, it will be so small and tender that it will not suck, and scarce receive any sort of nourishment. When delivery happens between the seventh month and full time, the woman is said to be in labour: but, instead of these distinctions, if she loses her burden at any time from conception to the seventh or eighth, or even in the ninth month, we now say indiscriminately, she has miscarried.</p> <p>The common term of pregnancy is limited to nine solar months, reckoning from the last discharge of the catamenia: yet in some, though very few, uterine gestation exceeds that period.</p> |

**ABSCESS**, in medicine and surgery, an imposthume, or any tumor or cavity containing purulent matter. See SURGERY, title, *Of tumors or abscesses*.

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SURGERY

*Of Inflammations and Abscesses.*

As almost all abscesses are the consequences of inflammations, and these produce a variety of events, as they are differently complicated with other disorders, it will be proper first to make some enquiry into their disposition. Inflammations from all causes have three ways of terminating; either by dispersion, suppuration, or gangrene.

But though every kind of inflammation will sometimes terminate in different shapes, yet a probable conjecture of the event may be always gathered from the state of the patient's health. Thus inflammations happening in a slight degree upon colds, and, without any foregoing indisposition, will most probably be dispersed: those which follow close upon a fever, or happen to a very gross habit of body, will generally imposthume: and those which fall upon very old people, or dropsical constitutions, will have a strong tendency to gangrene. [...]

**ABSORBENT Medicines**, testaceous powders, as chalk, crabs-eyes, &c. which are taken inwardly for drying up or absorbing any acrid or redundant humours in the stomach or intestines. They are likewise applied outwardly to ulcers or fores with the same intention.

**ABSTERGENT Medicines**, those employed for resolving obstructions, concretions, &c. such as soap, &c.

**HEAD**

[...]

**HEAD-ACH**, a most troublesome sensation in the head, produced by various causes, and attended with different symptoms, according to its different degrees, and the place where it is seated. See **MEDICINE**.

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**MEDICINE**

*Of the HEAD-ACH.*

The head-ach is a most troublesome sensation in the nervous membranes of the head, produced by various causes, and attended by different symptoms, according to its different degrees, and the place where it is seated.

The most common seat of this disease is the pericranium; a membrane which invests the skull, coheres with the muscles next the skull, and is joined to the dura mater by some fibres which pass through the sutures. It is a thin nervous membrane of exquisite sense. It may be likewise in the skin that covers the skull, and in the dura matter [sic]. This last but seldom happens; but when it does, it is very dangerous. There may likewise be a very acute pain in the thin membrane which covers the sinus of the os frontis.

If the head-ach be slight, and affects a particular part of the head, it is called cephalgia; if the whole, cephalæa; if one side only, hemicrania; if there is a fixed pain on the forehead, which may be covered with the end of the thumb, it is called clavus hystericus.

The general cause of the head-ach is a hindrance of the free circulation of the blood through the vessels of the head.

[...]

**HEMIPLEGIA**, or **HEMIPLEXIA**, among physicians, a palsy of one half of the body.

**HEMITRITÆUS**, among physicians, a kind of intermitting fever, being a semitertian. See **MEDICINE**.

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**MEDICINE**

*Of the SEMITERTIAN FEVER.*

This is an epidemic [sic] fever, compounding of an intermitting tertian and a continual quotidian.

It generally makes its onset before noon, with coldness, shaking, and a contracted pulse; to which succeeds a frequent pulse, with heat, which continues some hours till a warm sweat appears, without a complete intermission. The heat, after a slight chillness, increases towards night, with a quick pulse; which is more moderate the next day, without thirst, till the evening, when a slight shivering comes on [sic], and the symptoms return. On the third day, the shaking fit appears again with more intense heat, and proceeds in the same track as before; so that the fever is never quite off, but has an exacerbation in the evening: however, the shaking fit is most conspicuous every third day in the morning.

Besides the foregoing symptoms, [...].

**PALSY**, in medicine. See **MEDICINE**, p. 97.

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**MEDICINE**

*Of the PALSY.*

A **PALSY** is a lax immobility of any muscle, not to be overcome by the will of the patient. Sometimes the sensation of the part is absolutely abolished, and sometimes there remains a dull sense of feeling, with a kind of tingling therein.

It may be caused by all things that bring on an apoplexy; that render the nerves unfit to transmit the animal spirits; that hinder the entrance of the arterial blood into the muscle. Hence the nature of a paraplegia or hemiplegia, and the palsy of a particular part, may be understood.

Hence a palsy may proceed [...].

**PARASYNANCHE**, in medicine, a kind of angina, or quinsey. See **MEDICINE**, p. 84.

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**MEDICINE**

*Of the QUINSEY.*

A **QUINSEY** is an inflammation of the fauces, with a burning pain, tumor and redness; a difficulty of breathing or swallowing; and a fever, proceeding from a stasis of blood, or a viscid acrid serum in the sanguineous or lymphatic vessels.

It begins with a fever, which is followed with a pain and inflammation of the fauces, causing the uvula, tonsils, and larynx to swell; whence great difficulty of breathing and swallowing ensues.

This disease may be seated at the root of the tongue near the *os hyoides*; the *soramina* of the nostrils opening to the bone; the beginning of the *æsofagus*; the muscles of the pharynx; the internal and external muscles of the larynx; the greater and lesser glands; the tonsils, or the muscles moving the jaws.

When the quinsey affects the internal muscles [...].

Mainly, the approach is that of a language dictionary, usually providing lexical definitions. Sometimes, though rarely, definitions are moderately expanded by explanations merged with them – or sometimes following them – as is the case with *Absorbent Medicines* and *Head-ach*. In the case of *Palsy*, instead, the definition is completely omitted, and the headword is directly cross-referred to *Medicine*.

In the *EB*'s medical entries the etymology is never included. The compilers did not consider the etymology a necessary requirement in a work that aims to present the world through language. The absence of etymology is a more or less clear reflection of the compilers' epistemological approach as regards their work as a whole. Indeed, the compilers maintain in the preface (p. v) that «they have had recourse to the best books upon almost every subject, extracted the useful parts, and rejected whatever appeared trifling or less interesting». This also applies to linguistic data, which add nothing to the body of the argument. The information must be pertinent. Only what is indispensable to the stated aim has the right to be included and, obviously, the etymology of a term is not essential in explaining the phenomena under consideration. In the management of the work, it is merely extra information.

As regards spelling variants (*hemiplegia-hemiplexia*, *palsy-paralysis*) and lexical variants, or equivalents (*abortion~miscarriage*, *absorbent medicines-tes-taceous powders*, *parasynanche-angina/quinsey*, *abscess-imposthume/tumor/cavity*), few are included in the *EB*. Headwords usually have one single form, which can be either in Latin, or English, or both. In the case of lexical variants, most of them are translation equivalents generally used to gloss the headword before its definition, if present, or replacing it, if missing. Equivalents may also be used to categorise and organise contents; in this

case, equivalence shifts towards hyponymy (*parasyranche~a kind of angina*).

Symptomatological defining is present s.v. *Hæmitritæus-Semitertian Fever* and s.v. *Parasyranche-Quinsey*. S.v. *Hæmitritæus-Semitertian Fever*, specific and detailed symptoms are framed within the progress of the disease. The process is strictly defined by time markers: «onset [...] coldness, shaking, and contracted pulse»; «succeeds [...] frequent pulse, with heat, which continues some hours till a warm sweet»; «heat, after [...] chillness, increases [...] with a quick pulse [...] moderate the next day, without thirst, till the evening, when», etc. S.v. *Parasyranche-Quinsey*, symptomatological defining is preceded by the explanatory equivalence «inflammation of the fauces», and characterised by two phases: one introduces general symptoms such as «burning pain, tumor and redness; difficulty of breathing or swallowing; and a fever»; the other frames symptoms in time «begins with a fever, which is followed with a pain and inflammation of the fauces», and space, the seat of the disease «the uvula, tonsils, and larynx [...] disease may be seated at the root of the tongue near the os [...] the beginning of the œsophagus; the muscles of pharynx; the internal and external muscles of the larynx; the greater and lesser glands; the tonsils, or the muscles moving the jaws».

Examples of categorisation and denomination may be found under the sub-entry *Head-ach*. In this case, after a general introduction on the multifarious causes, on the complexity of the «most troublesome sensation in the nervous membranes», and on «the most common seat of this disease», the different kinds of head-ache are provided. Various denominations are introduced according to the circumstances defining and characterising each of them: «if the haed-ach be slight [...] cephalalgia; if the whole [head], cephalæa; if one side only, hemicrania; if there is a fixed pain [...] clavus hystericus.»

Hypothesising specific situations is another relevant discourse strategy exploited by the *EB* for the elaboration and communication of medical events. This approach is useful to build up more complex paragraphs for the description of the disease. The most frequent, and easiest, frame of hypothesising is the use of introductory *if* and *when*: «If she parted» (s.v. *Abortion*); «if the [...] if one [...] if there is» (s.v. *Head-ach*). However, more complex structures of thought are signalled by the co-occurrence of linking expressions of cause-consequence and opposition, such as «If she parted [...] in which case [...] because the [...] besides, should be the [...] it will be [...]; When [...] but, instead of [...] if [...] we now say» (s.v. *Abortion*); «As almost all abscesses [...] inflammations, and these produce [...] as they are [...] it will be proper [...] But though every kind of inflammation [...] yet [...] Thus inflammations happening [...]: those which follow [...] and those which fall» (s.v. *Abscess*).

### 1.1.2. REES'S CYCLOPAEDIA, OR AN UNIVERSAL DICTIONARY OF ARTS AND SCIENCES

RCy presents a very different situation. The extracts in Table 2, whose head-words correspond to those analysed in the *EB*, highlight different compiling

strategies. The average entry in *RCy* is longer – sometimes, much longer – than the corresponding one in the *EB*. The micro-structure is complex, rich in details and encyclopaedic load, which further expand the lexical definition. This is the case with all the examples provided, except for *Paracynanche* (directly cross-referred to *Angina*), and testifies to a divergent epistemological approach and lexicographic practice, different from the *EB*.

Linguistic information, particularly concerning etymology (s.v. *Hemicrania*, *Hemiplegia/Hemiplexia*, *Hemitritæus* and *Paralysis*), spelling variants (*hemiplegia~hemiplexia*, *palsy~paralysis*) and equivalents (*abortion~miscarriage/abortus/abactus*, *abscess~apostema/imposthume/imposthumation*, *abstergents~abstersive medicines/detergents*, *palsy~paralysis*), is sometimes provided. The practice of including etymology was widespread in general dictionaries of English and was transferred to dictionaries of arts and sciences as a means to introduce encyclopaedic contents. The original meaning of words, their derivation (both semantic and morpho-syntactic) was, in fact, considered to be the first step to familiarise with a new topic.

The entry is usually opened by a lexical definition, sometimes preceded or followed by etymology. Definitions unfold and delimit the topic-headword, and may be moderately expanded for reason of clarity: for example, «the unseasonable exclusion of an imperfect human *fœtus* [definition], either alive, or dead, before the natural time of delivery [expansion]» (s.v. *Abortion*); «a kind of inflammatory TUMOR [definition], containing purulent matter, pent up in a fleshy part, and corrupting and consuming the fibres, and other substance thereof [expansion]» (s.v. *Abscess*); «a species of cephalalgia, or head-ach [definition]; wherein only one hemisphere, or half, or one side of the head, is affected; and owing to a congestion of blood in the vessels of that half [expansion]» (s.v. *Hemicrania*). Lexical definitions, in their more concise form, may overlap with the notion – and the function – of equivalence: this is the case with *abscess~inflammatory tumor*, *hemiplegia~a palsy of one whole side of the body*, *angina~an inflammation about the muscles of*. In other cases, they start by declaring the nature of the medical entity described: «a disease wherein» (s.v. *Palsy*), «this disease being supposed» (s.v. *Paralysis*). Sometimes, they introduce the topic with expressions such as «is used [...] for the» (s.v. *Abortion*), «is used for such things as» (s.v. *Abscess*), «they are» (s.v. *Abstergents*).

No treatises in the manner of the *EB* are included, hence almost everything concerning a specific topic is gathered and clustered under its respective headword. Cross-references are present but reduced to a minimum, to avoid dispersion of information across many smaller entries: «ABORTION [...] See MISCARRIAGE», «HEMIPLEGIA [...] See PALSY and Medical ELECTRICITY», «PARACYNANCHE [...] See ANGINA».

The strategy of packing information under a ‘key’ headword (backgrounding sub-topics), and partially reorganising Chambers’s *Cyclopaedia* (1728 and later editions), helps emphasise individual subjects as disciplinary areas and conceptual units, as announced by Rees in his preface. This focussing process

– obtained both by the expansion of the original entry and by the reduction in the number of cross-references – is achieved s.v. Absorbents, Head-Ach, and Palsy. However, more concise entries (lexical definition with moderate expansions), sometimes shortened if compared to Chambers’s original model (Abstergents), or reproducing them (Hemiplegia/Hemiplexia, Hemitritæus), are still present in *RCy*, but they are not as systematic as in the *EB*.

The following entries represent the most typical entry structures in *RCy*, alongside their most frequent and recurrent features:

Table 2

|   |
|---|
| <p>Rees’s <i>Cyclopaedia</i></p> <p><b>ABORTION</b>, is used, in Medicine, for the unseasonable exclusion of an imperfect human <i>fœtus</i>, either alive, or dead, before the natural time of delivery.</p> <p>In this sense, <i>abortion</i> amounts to the same with what we popularly call <i>miscarriage</i>; the Latins <i>abortus</i>, and sometimes <i>abactus</i>.</p> <p>This may happen at any time of pregnancy, but if before the second month after conception, it is properly called a <i>false conception</i>, or effluxion.</p> <p>The causes of <i>abortion</i> are very various. The most usual are, distempers, either acute or chronical; immoderate evacuations, all strong passions, violent exercises, frights, lifting of weights, weakness from any cause whatever, fullness of blood, stimulating medicines, offensive smells, excessive use of venery, and, in general, any thing which tends to promote the <i>menses</i>. But the most frequent causes of abortion are either too great stricture, or laxity of the <i>uterus</i>, which are more particularly pointed out by Hippocrates. The ancient Greek legislators [...] the Romans [...].</p> <p>[...]</p> <p>The practice of artificial abortion is chiefly in the hands of women and nurses, rarely in that of physicians; who in some countries, are not admitted to the profession without abjuring it. Hippocrates, in the oath he would have enjoined on all physicians, includes their not giving the <i>pessus abortivus</i>; though elsewhere he gives the formal process, whereby he himself procured a maid to miscarry.</p> <p>[...]</p> <p><i>Abortion</i> may be produced by whatever immediately affects the child, the placenta, the membranes, or the mother. When the time of miscarriage is just at hand, the pains are much the same as those in labour.</p> <p><i>Abortion</i> is dangerous where the time of pregnancy is far advanced, so that the <i>fœtus</i> must be large, where the cause is very violent, or the patient strongly convulsed, and where a large hæmorrhage precedes, or ensues, or the <i>fœtus</i> is putrefied, &amp;c. Under other circumstances it rarely proves mortal.</p> <p><i>Abortion</i> is also used, somewhat abusively, for a <i>fœtus</i>, which, dying in the womb, continues there beyond the natural term; sometimes several years, and even during the whole life the mother.</p> <p>To prevent ABORTION. See MISCARRIAGE.</p> |
|---|

**ABSCESS**, in *Medicine*, a kind of inflammatory TUMOR, containing purulent matter, pent up in a fleshy part, and corrupting and consuming the fibres, and other substance thereof. *Abscess* is the same with what the Greeks call *apostema*, and the English, *imposthume*, or *imposthumation*.

Almost all *abscesses* are the consequences of inflammation.—The ripening of *abscesses* is promoted by poultices, &c.—*Abscesses* are opened either by caustic, or incision; but the latter way is in most cases preferable.

*Abscesses* arise often in women after delivery; and though dangerous in themselves, yet they often appear to be the crisis of the disease, that gave rise to them.—For the cure, if they cannot be discussed, i.e. carried off by proper artificial evacuations, as phlebotomy, purging, &c. with the occasional use of calomel, and gentle perspirative fotes, liniments, and cataplasms; recourse is to be had to the contrary method, and they must be brought to suppuration.

**ABSORBENTS**, in a general sense, is used for such things as have the faculty of *absorbing*, or swallowing up others.

**ABSORBENTS**, in *Medicine*, remedies which, by the softness or porosity of their component parts, become proper to sheath the asperities of sharp pungent humours; or to imbibe or dry away, as with a sponge, superfluous moistures; and are of divers kind; simple, compound, saline, cinnabarine, marine, fixed, earthy, acid, alkaline, &c. In the *Pharmacopœias*, we meet with several forms of *absorbents*; such are the testaceous powder, hartshorn, coral, crabs eyes and claws, calcined bones, burnt ivory, *terra sigillata*, and even iron itself: also divers woods; as sanders, mastic, *guaiacum*, sassafras: and divers roots; as china, *sarsaparilla*, &c.

[...]

*Absorbents* consume the humors without fusing them, and have sometimes the effect of strengtheners, sometimes of purgatives, oftener of calmers, to allay fermentations. They are of use for tempering acrimonies, [...] *Absorbents* have also their ill effects; [...].

They are generally prescribed as the only remedy for the acute diseases of infants [...].

They are sometimes applied to ulcers; but it is to be observed that [...]. Monro, in *Med. Ess. Edinb. vol. V art. 24.* [...] See *Phil. Trans. N°. 459. sect. 2.* Van Swieten, in his comment to Boerhaave's *Aphorisms*, observes [...] M. Homberg has a discourse on the quantity of acids absorbed by [...] M. de la Hire gives an experiment for ascertaining the quantity of water *absorbed* by plants. *Mem. Acad. R. Scien. an. 1700, p. 81.*

**ABSTERGENTS**, or *ABSTERSIVE Medicines*, more usually called among physicians *DETERGENTS*; they are cleansing *medicines* of a saponaceous nature, capable of dissolving concretions formed of earth and oil, which water simply, as an abluent, cannot effect.

## HEAD

[...]

**HEAD-ach**, in *Medicine*. Physicians commonly distinguish the *head-ach* into two kinds, according to its degree and continuance. The gentlest kind, and which commonly affects a particular part of the *head* only, they call *cephalgia*, and the more violent and obstinate *cephalæa*; when the pain is on one side only, it is called *HEMICRANIA*, and when it is a fixed pain in the forehead, which may be covered with the end of the thumb, it is called the *CLAVUS hystericus*.

*Cephalgia* is defined to be a pain in the *head*, proceeding from a copious congestion of the blood and humours in that part, which do not find any exit or passage from thence. They generally distinguish it also into two kinds, the idiopathic and the symptomatic.

[...]

**HEAD-ach**, *causes of the*. Among the natural and internal causes, the principal are too great a quantity of blood, [...] The external or accidental means that may bring on this pain are very numerous: [...].

[...]

*Prognostics from it*. The *head-ach* is a pain rather troublesome than dangerous in itself, but it too easily degenerates into worse complaints, and not unfrequently presages defects of the sight or hearing, or the gout; [...].

[...]

*Method of cure*. The congestions of humours are to be derived from the superior to the inferior parts, and, above all things, the bowels are too loosened by clysters and purges, for they are usually bound up in this disorder.

[...]

*Cephalæa* is a violent and continual pain in the *head*, occasioned by a rheumatic congestion of humours in the *head*. [...] *Signs of it*. [...] *Causes of it*. [...] *Method of cure*. [...]

Junker's *Consp. Med.* P. 96. 100. 104. 116. and Buchan's *Dom. Med.* p. 283 edit. 1776.

**HEMICRANIA**, Ἡμικρανία, in *Medicine*, a species of cephalalgia, or head-ach; wherein only one hemisphere, or half, or one side of the head, is affected; and owing to a congestion of blood in the vessels of that half.

Physicians divide the *hemicrania* into four kinds. 1. The idiopathic, when it is properly a disease of itself. 2. The symptomatic, where it is properly only the symptom of some other disease. 3. The continual or fixed, where it admits of no absolute intermissions. And, 4. The periodic, where the patient is regularly free from it at certain stated periods.

*Signs of it.* Among these are vibrative and very acute pains: the pain occupies only one part of the head, while the other part is wholly free and at ease. The left side of the head is usually the part in pain.

[...]

*Prognostics.* This species of head-ach not unfrequently brings on suffusions, and other disorders of the eyes, and often is a fore-runner of the gout, especially if it be imprudently treated during the fit; [...].

[...]

*Method of cure.* As the primæ viæ are almost always obstructed in this complaint, the regular beginning of a cure is by emptying them; and a gentle vomit, and purging medicines are to be given.

[...]

Junker, *Consp. Med.* p. 118.

**HEMIPLEGIA**, or **HEMIPLEXIA**, compounded of ἡμισυς, *half*; and πλεσσω, *I strike, or seize*, in *Medicine*, a palsy of one whole side of the body. See **PALSY** and **Medical ELECTRICITY**.

**HEMITRITÆUS**, Ἡμιτρίταιος, compounded of ἡμισυς, *half*, and τρίταιος, *third*; or, as modern Latin authors express it, *semitertian*, in *Medicine*, an irregular intermitting fever, which returns twice every day; by which it is distinguished from the quotidian, which only returns once in the day.

**PALSY**, *paralysis*, in *Medicine*, a disease wherein the body, or some of its parts, lose their motion, and sometimes their sensation, or feeling.

The causes of the palsy are, an impeded influx of the nervous spirits into the villi of the muscles, or of the arterious blood into their vessels: this may happen from some fault, either in the brain, the nerves, the muscles, or their vessels.

The occasional or predisposing causes are various; as drunkenness, wounds of the brain or spinal marrow, pressure upon the brain or nerves, very cold or damp air, the suppression of customary evacuations, sudden fear, want of exercise, and whatever relaxes the system, as drinking much tea, coffee, &c. The palsy may likewise proceed from wounds of the nerves themselves, from the poisonous fumes of metals or minerals, as mercury, lead, arsenic, &c.

The *palsy* is said to be *perfect*, or complete, when there is a privation of motion and sensation at the same time. *Imperfect*, when one of the two is destroyed, the other remaining.

This disease is more or less dangerous, according to the importance of the part affected. A *palsy* of the heart, lungs, or any part necessary for life, is mortal. When it affects the stomach, the intestines, or the bladder, it is highly dangerous. If the face be affected, the case is bad, as it shews that the disease proceeds from the brain. When the part affected feels cold, is insensible, or wastes away, or when the judgment and memory begin to fail, there is little hope of a cure. Buchan.

Hoffman distinguishes *palsies* into serous and sanguineous. [...]

The *palsy*, again, is either *universal*, *lateral*, or *partial*.

**PALSY**, *universal*, called also *paraplegia*, or *paraplexia*, is a general immobility of all the muscles that receive nerves from the cerebrum, or cerebellum, except those of the head. [...]

**PALSY**, *lateral*, called also *hemiplegia*, is the same disease with the paraplegia, only that it affects but one side of the body. [...]

**PALSY**, *partial*, is that where some particular part, or member, alone is affected; e.gr. where the motion is destroyed. [...]

**PALSY**, *electary for the* [...].

**PALSY** *drops* [...].

**PALSY**, *infusion for the* [...].

**PARACYNANCHE**, in *Medicine*. See **ANGINA**.

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**ANGINA**, in *Medicine*, an inflammation about the muscles of the *larynx*, or *pharynx*, attended with an acute fever, difficulty of swallowing, and danger of suffocation.

The word is derived immediately from the Latin *ango*, formed of [...] *suffoco*, *strangulo*.

The angina is the same with what we popularly call **QUINZY**, or *squinancy*. It is an inflammation in the parts of the throat subservient to respiration, speech, and deglutition. When the disorder is epidemic, it is usually between spring and summer, after a long continuance of cold and rainy weather. The true *quinzy* is an acute inflammatory disorder; and the fever that accompanies it is not acute, but rather chronic.

**ANGINA gangrena**, or *aquosa*, the ulcerated, malignant, putrid, *sore* THROAT; on which there are various treatises by Fothergill, Huxham, Northcote, &c.

[...]

**ANGINA pectoris**, in *Medicine*, a name given to a disease, dangerous, and not extremely rare, first described by Dr. W. Heberden, and so called from the seat of the disorder, and the sense of strangling and anxiety with which it is attended. The doctor's account of it is in the second volume of the London Medic. Trans. p. 59, &c. See also Medic. and Phil. Comment. vol. ii. p. 95. [...]

This disease has been since accurately described, and suitable preventives or remedies proposed, by Dr. Fothergill. Med. Obs. and Inq. vol. v. p. 233. 252.

**PARALYSIS**, in *Botany*, [...].

**PARALYSIS**, *παραλυσις*, formed from *παραλωω*, *I unbind*; this disease being supposed to unbind the nerves and muscles, in *Medicine*, a disease popularly called **PALSY**. The *paralysis* only differs from the **PARESIS**, as the greater from the less. Authors distinguish the *paralysis* into a paraplegia or paraplexia, and a hemiplegia, and a partial *paralysis*.

The second, of one side of the body. See **HEMIPLEGIA**.

The third of some particular member; which is the proper palsy. See **PALSY**.

The frame of symptomatological defining is used to introduce, list, and cluster the causes of some diseases as s.v. Abortion, «very various. The most usual are, distempers [...] immoderate evacuations [...] passions, violent exercises, frights, lifting of weights, weakness [...] fullness of blood, stimulating medicines, offensive smells»; and s.v. Palsy, «causes are various; as drunkenness, wounds of the brain or spinal marrow, pressure upon the brain or nerves, very cold or damp air, the suppression of customary evac-

uations, sudden fear, want of exercise, and whatever relaxes the system, as drinking much tea, coffee, &c. [...] from wounds of the nerves themselves, from the poisonous fumes of metals or minerals, as mercury, lead, arsenic, &c.» In both cases, ‘symptomatological defining’ is characterised by accumulation.

Rees’s entries are also characterised by categorisation, which is carried out through hyponymic relations: the entry is organised according to different degrees of detail introduced by new, more specific terms or attributes. This linguistic, hierarchical frame, is thus used to structure discourse within the entry, embedding sections and sub-sections through words. This is the case with Absorbents «of divers kind; simple, compound, saline, cinnabarine, marine, fixed, earthy, acid, alkaline»; with Head-ach, distinguished «into two kinds, according to its degree [...] *cephalalgia*, and [...] *cephalæa*», and also into «HEMICRANIA, and *CLAVUS histericus*». *Cephalalgia* is further subdivided into «the idiopathic and the symptomatic» or, again, Hemicrania «into four kinds [...] idiopathic [...] symptomatic [...] continual or fixed [...] periodic». Paralysis is distinguished «into a paraplegia or paraplexia, and hemiplegia». Sometimes, as s.v. Palsy («*PALSY universal*», «*PALSY lateral*», etc.), Head (Head-ach), a series of sub-headwords are included, thus introducing semi-independent sections.

Discourse within the entry is also organised by the use of titled paragraphs, mainly focussing on the causes, the consequences, and the possible cures or remedies for the disease: «HEAD-ach, *causes of the*. [...] *Prognostics from it*. [...] *Method of cure*. [...]»; «HEMICRANIA [...] *Signs of it*. [...] *Prognostics*. [...]». Further information within the dictionary is guaranteed by a number of cross-references, whereas more specialised, in-depth and up-to-date materials are signalled through detailed external reference s.v. Absorbents, «Monro, in *Med. Ess. Edinb. vol. V art. 24*. [...] See *Phil. Trans. N° 459. sect. 2*. Van Swieten, in his comment to Boerhaave’s *Aphorisms*, observes [...] M. Homberg has a discourse on the quantity of acids absorbed by [...] M. de la Hire gives an experiment for ascertaining the quantity of water *absorbed* by plants. *Mem. Acad. R. Scien. an. 1700*, p. 81»; s.v. Head-ach, «Junker’s *Consp. Med. P. 96. 100. 104. 116*. and Buchan’s *Dom. Med. p. 283 edit. 1776*»; and s.v. Hemicrania, «Junker, *Consp. Med. p. 118*.»

Rees also includes historical sections in some of his medical entries, as s.v. Abortion: «*causes of abortion* [...] which are more particularly pointed out by Hippocrates. The ancient Greek legislators [...] the Romans [...]». This choice highlights the importance of tradition, and may reveal a scholarly attitude which considers the authority of the past as necessary to background, understand and interpret the present (similar to the introductory function of etymology). However, it is also widespread lexicographic practice in dictionaries of arts and sciences as repositories of general knowledge.

### 1.1.3. EB AND RCY: TEXTUAL ORGANISATION

The two universal dictionaries of arts and sciences display and unfold their contents in a different manner, according to their own epistemological perspective. The entries analysed are of uneven length and complexity, and this aspect is reflected in their textual organisation.

Definitions are very neat and concise in the *EB*, often cross-referring to Medicine, Surgery, Midwifery. In-depth technical exposition is carried out within these comprehensive treatises, which also include specific titled sub-sections such as «*Of Abortions*», «*Of Inflammations and Abscesses*», «*Of the HEAD-ACH*», «*Of the SEMITERTIAN FEVER*», «*Of the PALSY*», «*Of the QUINSEY*» (cfr. Table 1). These sub-sections may cover a few paragraphs («*Of Abortions*»), others expand from a single in-quarto column («*Of the SEMITERTIAN FEVER*», «*Of the PALSY*») to as many as nine («*Of the QUINSEY*»), the average length being about four («*Of Inflammations and Abscesses*», «*Of the HEAD-ACH*»). Descriptions and explanations of the disease are essential, they are systematically focussed on the topic (or on a specific aspect of the topic), and usually on contemporary approaches and perspectives. Digressions and historical passages are generally reduced to a minimum, if not completely omitted. As regards the linguistic features and their relevance in the construction of coherent and cohesive texts, topicalisation («*A MISCARRIAGE*», «*As almost all abscesses*», «*The head-ach*», «*A PALSY*»), the repetition of key terms (*inflammation* s.v. Abscess), hyponymic and synonymic sense relations (*abortions~miscarriage~efflux~expulsion*), the frequent use of linking verbs and passive voice («*was formerly called [...]* are not yet formed [...] is discharged [...] was known [...] she was said [...] was delivered» s.v. Abortion) are the most relevant.

In *RCy*, definitions are the starting point for further in-depth treatment within usually extended, complex, articulate entries (cfr. Table 2, the average length for the examples analysed and discussed is about two in-folio columns) in which textual and discourse granularity is higher than in the *EB*. This means that the focus shifts from the main topic to satellite topics, from the present (usually descriptive, or expository texts, from «*The causes of abortion*» to «*promote the menses*», s.v. Abortion; «*Absorbents consume the humors without fusing them [...]* They are of use for [...] *Absorbents* have also their ill effects; [...] They are generally prescribed as [...] They are sometimes applied» s.v. Absorbents) to the past (digressions on traditional or historical approaches, «*But the most frequent causes [...]* which are more particularly pointed out by Hippocrates. The ancient Greek legislators [...]. Hippocrates, in the oath» s.v. Abortion). The macro-text of the entry is thus fragmented into shorter sections with their own focus, making reading and the elaboration of contents more difficult and laborious. Some sections are distinguished by sub-headings dealing with *causes, signs, prognostics, method*

of *cure*, as in handbooks and compendia. This textual and discourse strategy provides formal and ideational order to the sequence of paragraphs and ideas (s.v. Head-ach, Hemicrania), but it is not a systematic approach. Other entries include many sub-headwords (s.v. Palsy), organising and differentiating specific pathologies. In general, the amount of information included is dense. The linguistic features already discussed in the *EB* may be found also in *RCy*. However, due to ideational density and focus shift, they result in being less effective at a textual and discourse level or, rather, their effectiveness is intermittent.

## 1.2. CHAPTER SUMMARY

This chapter has introduced the two most relevant universal dictionaries of arts and sciences issued in the second half of the eighteenth century: the *Encyclopaedia Britannica* (1768-1771) and Rees's *Cyclopaedia* (1778-1788). For each of them, the epistemological inspiring principles – and their relevance at lexicographic and encyclopaedic levels – have been thoroughly discussed. Their prefaces are explicit as regards their respective general aims and the methods to achieve them.

The *EB* focusses on the unity of contemporary disciplines, providing comprehensive treatises essentially based on the present state of the art. The approach is practical, and the perspective of classifying the arts and sciences is completely avoided. Medicine, Surgery, and Midwifery are not 'dismembered' under multifarious entries in alphabetical order, and reconnected in an ideal tree of knowledge. The unity is built within the individual discipline, as science. The definitions of technical terms are concise, and essential, systematically cross-referring to the unifying medical treatises.

*RCy* assumes a more traditional perspective in comparison to the *EB*: it reproduces the tree of knowledge as a unifying principle across disciplines in an ideal universal whole. This approach reflects the organisation of Chambers's *Cyclopaedia* (1728), and its attempt to provide detailed and specific contents under individual headwords in alphabetical order. However, *RCy* also introduces some innovations: some entries are rearranged and expanded under the same headword (ex. Head-ach, Hemicrania, Palsy), in order to establish a sense of unity at disciplinary level, as science. Rees's entries are longer and more complex than the *EB*'s entries: they include linguistic information (etymology, synonyms, hyponyms, etc.), historical details (digressions on medical history and traditional approaches), internal cross-references (fewer than in Chambers's *Cyclopaedia*, and not to comprehensive treatises as in the *EB*), and references to contemporary external sources.

## 2.

### FRAMING MEDICAL DISCOURSE IN SPECIALISED DICTIONARIES

James's *A medicinal dictionary* (1743-1745; hereafter *MD*) and Motherby's *A new medical dictionary* (1775; hereafter *NMD*) are the two major specialised reference works of the period<sup>1</sup>. They represent the effort to illustrate and delimit the medical field by an extensive inclusion and thorough exposition of its terminology. These works, organised in alphabetical order, declare to be of general interest, in particular, James argues that medicine is a common experience and everyone should be correctly informed about medical events and remedies. However, they are specially addressed to medical students or practitioners, that is to say to people who, at different levels, are involved in the profession. This specificity is particularly true for Motherby's work.

#### 2.1. JAMES'S *A MEDICINAL DICTIONARY* (1743-1745) AND MOTHERBY'S *A NEW MEDICAL DICTIONARY* (1775): AN INTRODUCTION

The starting point to introduce the two medical dictionaries is the entry *Medicina* (not the English version *medicine*), which is not treated in detail as in the *EB* and in *RCy*, and which does not frame medical contents or the history of medicine. In both these works, the two entries are very concise, including equivalents, cross-references (*MD* and *NMD*) or lexical definitions followed by encyclopaedic expansions (*NMD*):

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<sup>1</sup> Two other relevant dictionaries were Barrow's *Dictionarium medicum universale: or, A new medicinal dictionary* (1749), which aimed to explain ancient and modern medical terms, by emphasising etymology as «the truest method of fixing just and lasting Ideas of them [terms] in the mind» (Preface: A); and Hooper's *A compendious medical dictionary* (1798), a portable dictionary which aimed «to deliver, in a concise and perspicuous manner, the explanation, &c. of all the terms used in the whole science of medicine [...] acceptable to medical students» (Preface).

MEDICINA. Medicine. See the PREFACE. (*MD* s.v. Medicina)

MEDICINA. Medicine. It is the art of preserving present health, and of restoring it when lost, more properly the last. It is usually divided into Physiology, Hygiene, Pathology, Semejotice, and Therapeutice, which see. (*NMD* s.v. Medicina)

James's work is a huge, bulky body of medical scholarship. Extensive inclusion, detailed exposition, and exhaustive discussion are its outstanding features. Robert James (1703-1776), a university-educated physician, studied medicine at Oxford and Cambridge, practised in various cities across the country and arrived in London in the 1740s. Here, he decided to publish some medical works to make his name known among colleagues and patients (Brack-Kaminski 1984: 378). In his *Proposals for printing a medicinal dictionary* (1741)<sup>2</sup>, he states that «this Useful and Laborious Performance being undertaken by the SOCIETY OF BOOKSELLERS for promoting Learning» (*MD*, *Proposals*, *Conditions*, 1741: 3). Alongside evidence of medical specialisation as a disciplinary field, the epistemological perspective is still one in which medicine is perceived as widespread, shared knowledge: «Physic is an Art which every Man practices» and «almost every Family is furnished with general Axioms of Physic» (*MD*, *Proposals*, *General Account*, 1741: 5 SELECT). The distinction between professional medical men – their prerogatives as experts, and their role in contemporary society – and the laymen status is still to come. The boundary between these two emerging communities will be defined (and delimited) towards the end of the century. Thus, the general aim of James's performance is

To establish juster Notions in the Bulk of Mankind, and introduce more useful Medicines into Families, [...] to supply all the Defects of those that have gone before us, and at once to familiarize the Knowledge, and reform the Practice, of Physic, by publishing A MEDICINAL DICTIONARY.

MANY MEDICINAL DICTIONARIES have been already written [...]. They endeavour to explain the *Terms* only; we, together with the

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2 According to O.M. Brack Jr. and Thomas Kaminski (1984: 398), Samuel Johnson may have helped James by writing sections of *Proposals* and *Conditions* (1741) for Robert James's *A medicinal dictionary* (1743-1745): «That Johnson “helped” in writing the proposals would seem the most likely explanation. James, a physician of some learning and ability, [...] could be expected to know how he planned to compile his own dictionary and must have provided the more technical information. Johnson, who was still in the process of gaining his “knowledge of physic ... from Dr. James,” appears to have added some paragraphs and done some revising. The set of “Conditions” which precedes the proposals does not have a distinctive style and may or may not have been written by Johnson. When we turn to the “General Account of the Work,” perhaps the first eight paragraphs, and even less certainly paragraphs 19 and 26, all of which deal with medicine in general, nontechnical way, sound more Johnsonian than not.»

Terms, the *Science of Physic*. They enable their Readers to *name* Distempers, which we instruct them to *cure*. Their Attempts were indeed useful, and are therefore to be mentioned with Gratitude: The Knowledge of Words must necessarily precede the Study of Science; this Knowledge they undertook to facilitate, and have succeeded so well, that often nothing can be added to the Accuracy of their Explications; and such Passages we have carefully translated without the weak Ambition of concealing the Benefit of unnecessary Variations.

The Diligence with which we have consulted and compared them, will probably make them less necessary to future Students, as we have not only transfused all their Collections into our Work, but added many Terms hitherto omitted; so that what is not to be found in *this* Dictionary, it will be generally in vain to seek in *any other*; but what is wanting in *others*, may be more successfully inquired for in *this*. (*MD*, Proposals, General Account, 1741: 5 SELECT)

The work is thus structured as a kind of ‘scholarly collection’, in which modern innovations and contemporary perspectives (*science of physic*), «to explain [...] together with the Terms, the *Science of Physic*», are treated alongside what «has been transmitted by the Antients» (*Ibidem*), that is to say the history of medicine and the exposition of the various doctrines. The benefit to mankind in spreading knowledge, the need and the effort to go beyond the lexical definition of the terms included in the lemmata and distinguish the nature and aims of an encyclopaedic work from ‘a dictionary of words’, the importance of language and accuracy of expressions to explain contents, the legacy of previous works alongside further developments and innovations are received assumptions in encyclopedic prefaces and lexicographic works in general (cfr. Harris 1704, Chambers 1728, eighteenth-century dictionaries of the English language, etc.).<sup>3</sup> The target audience is ‘mankind’ and ‘families’ in general, but also ‘future students’, that is to say a far more restricted discourse community. This double perspective is one of the reasons why Brack and Kaminski (1984: 381) maintain that

The Medicinal dictionary, typical of large-scale eighteenth-century compilations, is primarily an assemblage of existing scholarship, relying heavily on the translation of various works for much of its material. James appears to have been little more than an editor, selecting and ordering his materials, perhaps

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<sup>3</sup> For essential reference to Harris’s *Lexicon Technicum* (1704) and Chambers’s *Cyclopaedia* (1728), see Bradshaw 1981: 107-121 and 123-140, respectively. For further reference on Chambers’s *Cyclopaedia*, see Yeo (1996 and 2001).

translating much of them himself, perhaps relying on others for such assistance.

Hence, on the one hand, *MD* is still rooted in a well-established lexicographic and encyclopaedic tradition; on the other hand, the plan also announces a selection of case studies to be treated and exemplified, along with accurate descriptions of diseases, the method of cure according to different, sometimes contrasting, past and present approaches. These aspects will be analysed further on in a selection of entries.

The *MD* includes the five branches of medicine in alphabetical order. In this case, as later with Motherby (1775), the definitions are essentially lexical (providing the meaning of the term). Etymology is an important aspect in both works, and the etymological principle – included in general lexicography since the very start of the century – is highlighted as a central strategy when introducing and defining specialised terminology:

PATHOLOGIA, παθολογια, from παθος, a Disorder; and λέγω, to speak, or commemorate. That Part of Medicine, which explains the Nature of Diseases, their Causes and Symptoms. (*MD* s.v. Pathologia)

PATHOLOGIA, from πάθ[ος], a disease, and λέγω, to speak or commemorate. That part of medicine which explains the nature of diseases, their causes, and symptoms. In order to understand a disease, we should consider the morbid causes, parts affected, symptoms, crisis, diagnosis, and prognosis: hence pathology is divided into all three parts. (*NMD* s.v. Pathologia)

PHYSIOLOGIA, φυσιολογία, from φύσις, Nature, and λέγω, to treat of Physiology. That Branch of Medicine, which considers Nature, with respect to the Cure of Diseases, particularly the Human Body, its Parts, Structures, health, Life, Functions, and Economy. (*MD* s.v. Physiologia)

PHYSIOLOGIA, from φύσις, nature, and λεγω, to treat of. That branch of medicine which considers nature with respect to the cure of diseases, particularly the human body, its parts, structure, health, life, functions and œconomy. Physiology depends much on the knowledge of anatomy. See Sauvage, Pemberton, or Haller on this subject. (*NMD* s.v. Physiologia)

SEMEIOTICE. That Part of Medicine which treats of the Signs of Health and Diseases. (*MD* s.v. Semeiotice)

SEMEIOTICE. That part of medicine which treats of health and diseases. See Dr. Wynter's Translation of Lommius's Obs. (*NMD* s.v. Semeiotice)

HYGIEINE, υγιεινή, from υγιής, sound, healthy, is the first Part of methodical Medicine, being that which prescribes Rules for the Preservation of Health. *Castellus*. (*MD* s.v. Hygieine)

HYGIEINE, υγιής, sound or healthy. It is the first part of methodical medicine, being that which prescribes rules for the preservation of health. (*NMD* s.v. Hygieine).

THERAPEUTICE, θεραπεύτικη, is that Part of Medicine, which is particularly concerned in the Cure of Diseases. (*MD* s.v. Therapeutice)

THERAPEUTICE, from θεραπεύω, to heal or cure. It is that part of medicine which particularly respects the cure of diseases. (*NMD* s.v. Therapeutice)

The definitions are identical: in this case, the tradition repeats itself across dictionaries – typical of the lexicographic practice – with some variations and up-to-date expansions, particularly external references, in the *NMD*. This fact also signals well-established basic taxonomic principles, a kind of medical 'scaffold', on which medical men definitely agree. However, the two physicians live and compile their works in different periods and different contexts; their disciplinary perspectives and their aims are different and their experience in performing medicine is different. Their works reflect such diversity, though starting from and dealing with a common disciplinary, medical basis.

The previous definitions introduce George Motherby's *NMD* (1775). It opens the last quarter of the century, a period in which British medical reform was starting to operate: the spreading of hospitals and infirmaries, the clinical approach and observation, the collective experience for medical men, the multiplication of case studies, the possibility to discuss them and experimenting new remedies are the main innovations. All this brought to the institutionalisation of practical training and experimentation not only for surgeons and apothecaries, but also for physicians. This also implied the redefinition of the relationship between the medical men and their patients in contemporary civil society: each of them now with a definite and – self-defining – role. The medical men – either physicians or trained practitioners – were becoming medical professionals. Along with traditional university education, new courses were established at different levels of specificity to

encompass a larger cohort of future medical practitioners. This would help reduce, if not eradicate, quackery and the fringe of lay practitioners so typical of and widespread in late eighteenth-century British society.

This is the innovative and changing climate in which Motherby (1732-1793) compiles his dictionary<sup>4</sup>. His preface, while stating the «utility of propagating what the ancients taught, and the modern improved» (*NMD*, Preface 1775: iii), also highlights how this «additional publication [...] in affording general instructions, enables the reader to *select*, rather than *increase* his volumes» (*Ibidem*). Improvement does not necessarily mean expanding or inflating contents, since «[s]ystematic productions are doubtless adapted for a student's regular pursuit; but speedily to assist the memory in practical researches, alphabetical digest justly claim the preference» (*Ibidem*). This is the reason why «each respective article will terminate with a reference to some of the most eminent writers on the subject» (*Ibidem*). This process of selection is a process of distinction, delimitation and identification of medicine as a professional domain, and as science.

The preface thus reveals how different the perspective and the method applied are in Motherby's work, if compared to James's *MD*. A selection of topic-headwords, instead of a large-scale collection, and a selected readership of students and practitioners are the key points: the dictionary would enable «those for whom it is designed to expand their knowledge in the art they profess» (*Ibidem*). His readership and his customers have a job, and their profession implying technical skills, contents and expertise, is not based on shared knowledge. Their role and function in society are changing, and their interlocutors are specialists. Two separate discourse communities are then envisaged. Motherby is mainly dealing with experts, and his work may assist them in their profession:

One principal use of a Medical Dictionary is, to discover in haste what the present urgency requires; therefore, in the prosecution of what follows, peculiar care has been taken that the busy practitioner may refresh his memory, or derive a hint, without the tedious labour of searching over many leaves. [...] (*NMD*, Preface 1775: vi)

The approach is practical, strictly connected to the needs of a busy professional looking for clear tips and answers to cope with real cases: *haste*, *urgency*, performance (*busy practitioner*) and *hint* are the key words. This paragraph also highlights the new attitude and the innovative usage of medical dictionaries in general, «[o]ne principal use of a Medical Dictionary», thus marking a turning point in medical lexicography. To *discover*, *refresh*, *derive* useful information «in haste» are the essential, characterising fea-

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4 On Motherby's *A new medical dictionary* (1775), cfr. McConchie (2009).

tures. This approach is further highlighted by the detailed description of the meta-lexicographic principles at the basis of his work and its macro-structure, as well as the meta-linguistic thought emerging from such a detailed plan. Moreover, this is the only work of the four analysed which provides the ideal micro-structure of the entry<sup>5</sup>, according to Motherby. He also adds meta-lexicological considerations. The following extract displays some relevant key points:

- I. Technical terms, proper names, &c. have their etymology given; and where a farther explanation is required, it is added with conciseness and perspicuity.
- II. That wanton variety to which some authors have yielded, in giving different names to the same subject, and the same names to different ones, serves but to perplex the inquirer; care hath therefore been taken to obviate this error, and each article is discussed under that name which is most in use; [...].  
[...]
- IV. Anatomical subjects have,
  - 1. Their various names immediately succeeding that by which they are most commonly known.
  - 2. A concise description, as far as may be of service to the medical practitioner.
  - 3. Where an account of their use can contribute any advantage, as far as art hath enabled us, this is also regarded.
- V. Diseases according to their importance, either as to inconvenience to the patient, tediousness in the cure, or danger of life, are considered with respect to some or all the following particulars.
  - 1. Their various names, or at least the most generally known.
  - 2. – general rank.
  - 3. – different species.
  - 4. – seat.
  - 5. Who, and when they are more subject to them.
  - 6. Their causes.
  - 7. – signs } Diagnostic and prognostic.
  - 8. What diseases they resemble.
  - 9. Their occasional symptoms.
  - 10. Preventives.
  - 11. Indications of cure.
  - 12. The proper regimen.
  - 13. The method of cure, both manual and medical.

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<sup>5</sup> Micro-structure refers to the internal organisation of the entry, its lexicographic constituents (etymology, equivalent(s), lexical definition(s), cross-reference(s), sub-headwords and sub-entries), and its lexicographic construction of knowledge (encyclopaedic matter).

## 14. Their usual modes of terminating.

(NMD, Preface 1775: vi)

As previously said, *etymology* is referred to as an important – or, rather, fundamental – strategy in medical lexicography. Also widespread in general dictionaries of the English language, it serves as a starting point for further definitional and encyclopaedic development. To know the origin of a word was considered as an essential step towards the definition, explanation and representation of things, here medical things.

*Conciseness* and *perspicuity* refer to the contemporary linguistic and meta-linguistic debate on the standardisation of English and on what should characterise it, particularly when used to write about disciplinary contents requiring precision (avoid redundancy, obscurity, ornament, figurative language, pompous words and overload of information) and clarity (avoid lexical and morpho-syntactical ambiguity). The need to establish an educated, formal, prestigious, and appropriate standard is the focus of prescriptive attitudes and the publications of grammars of English (Priestly and Lowth, for example). The general linguistic and discursive principles are thus borrowed, exploited, moulded and popularised by disciplinary discourse communities, medicine being one.

Clarity, precision and accuracy also imply the reduction of what Motherby calls «wanton variety». This expression refers to the many denominations used to deal with the same medical event. This phenomenon would cause confusion and obscurity in communicating science. A clear, univocal, one-to-one connection between a term and its specific referent is the aim. Lexical variation and graphic variants are to be eliminated in technical and scientific vocabulary. Use and frequency would determine the choice, «the most generally known» (NMD, Preface 1775: vi).

Motherby is particularly detailed in providing meta-lexicographic information, and in explaining how entries are built. An interesting section is the one on diseases: the use of their most known and recurrent denominations is again highlighted; their classification according to their distinctive characteristics, such as rank, species, seat, and causes, reveals the state of the art in medical approach at that time (many works were issued by authoritative and competent medical men), and helps organise the entry itself.

*Rank* and *species* refer to a hierarchical connections among diseases – their similarities and differences – and medical events in general, and to their external and multifarious outcomes. *Seat* highlights the relevance of location of diseases, the possibility of discovering the place in which they originate(d), the original *causes* within the body. This gives also prominence to anatomy (and pathological dissection) and changes the relationship between what can be seen (symptoms and external signs) and what is usually hidden away from the human gaze (internal causes and conditions).

The interest in causes, whether internal (degeneration of organs, diseases, hidden changes) or external (environmental causes, viral, etc.), even violent, sudden, unexpected causes (violent deaths) represent another focus of contemporary medical research. Two other key words in Motherby's plan – *signs* and *symptoms* – tell a lot about the state of the art in medical thought of the time: the disease is perceived as an entity, independent of the body hosting it. Signs are typical of and depend on a specific disease and distinguish such disease from others, they are not the same as symptoms. Symptoms, or «occasional symptoms», can manifest themselves in different bodies and in different manners (ex. intensity) according to the individual patient reaction to the same disease. This is an important key point in the evolution of medical approach and medical epistemology, since it allows physicians and practitioners (medical men in general) to identify a disease or a group of disease according to shared features-*signs* and study them as such, «What diseases they resemble». This also promotes the recording of case studies to be shared with other medical men, becoming a collective experience in observing and reading about patients.

A more precise diagnosis based on clinical observation also means a more definite prognosis and *cure*, this may be medical or regulated by the six non-naturals of Hippocratic origin, that is *regimen*. The «method of cure» is actually performed by apothecaries and surgeons, since medicine is essentially practical, particularly in case of manual, or surgical operations.

Another relevant feature in the *NMD* is systematic external reference: this practice is not innovative in itself, since reference to external sources was common in other dictionaries as well, if not systematic. The innovative feature is Motherby's commitment to professional needs in including inter-textual information:

VII. At the conclusion of each subject, there is a reference to the most approved authors who have written upon it: the reader will hereby be enabled to proceed to an acquaintance with all that hath been said (or at least that merits his attention) respecting his enquiry; and thus, as inclination favours, he may proceed to obtain a competent skill in those branches to which his avocations more directly lead, or extend his pursuits to every part that compleats the character he professes.

VIII. This dictionary closes with an English Index, as well to facilitate the general enquiry, as to trace many articles that are not arranged in the particular order of the preceding Work. (*NMD*, Preface 1775: vi)

Motherby's disciplinary commitment emerges in the following expressions: «as inclination favours», «to obtain a competent skill», «his avoca-

tions more directly lead», «extend his pursuits», «compleats the character he professes». They emphasise the dynamic function of the *NMD* and the unceasing, regular training process of professional experience. As for previous dictionaries, a selection of entries will be analysed to make Motherby's plan emerge in his lexicographic practice.

As regards the history of medicine, in a very concise section Motherby summarises the major issues. He recognises that «in some instances the improvements of the moderns are little more than recurring to the instructions laid down by the great father of the healing art [Hippocrates]» (*NMD*, Preface 1775: iv) and, in this case, he traces back to traditional approaches. However, he continues, «it must be justly asserted, that the moderns claim the honour of having advanced medicine to its present state: for, with regard to the former, their physiology was extremely defective, their skill in anatomy very imperfect, and their knowledge of chemistry proportionably confined» (*Ibidem*).

These particular considerations refer to the many advances in anatomical dissection, which was going to be regularised, and came to be socially accepted as a necessary medical practice. In this perspective, surgery was acquiring higher status than decades before, and surgeons were becoming trained professionals, operating in the navy, in the army, in hospitals and infirmaries. Under the same circumstances, pharmacy and chemical improvements for the production of medicines and cures were acquiring prestige and independent status.

## 2.2. INTRODUCING, ORGANISING, AND DEFINING MEDICAL CONTENTS

The following sections present the works which have been introduced so far in further detail: a selection of entries on specific topics is discussed and compared in the two dictionaries to highlight some of the lexicographic techniques applied by the compilers: the headwords are *Abortus*, *Abscessus*, *Absorbentia*, *Abstergentia*, *Cephalæa*, *Cephalalgia*, *Paralysis*.

The entries represent a variety of interesting micro-structures which – according to their length, contents, amount of information, complexity of definitions and encyclopaedic expansions – are helpful to exemplify and establish both the compilers' lexicographic practice and their epistemological perspective in compiling the work(s) as a whole. The analysis is carried out on a qualitative basis to make the general features of each dictionary emerge, but it cannot be considered as an exhaustive one, though relevant. This sample analysis aims at giving an overview of the frequent and most typical organisational patterns used by the authors-compilers, according to their specific plans.

The entries exemplified for the two specialised dictionaries are the same which have already been analysed in the *EB* and *RCy* (cfr. Ch. 1, Table 1 and Table 2), but their treatment undergoes at least three processes in compari-

son with the *EB* and *RCy*: expansion (particularly in the *MD*, all-embracing and comprehensive), specialisation (*MD* and *NMD*), and selection (particularly in the *NMD*, entries are neat and essential in their contents).

### 2.1.1. JAMES'S A MEDICINAL DICTIONARY

Expansion is a recurring feature of the *MD*: it includes very long, detailed and complex entries, such as *Abortus* (twenty-two in-folio pages), *Abscessus* (seventeen in-folio pages), *Cephalagia* and *Paralysis* (five and seven in-folio pages). Actually, these are monographic articles framed into a lexicographic structure: after the introductory section defining the headwords, or providing equivalents (*Abortus~aborsus~miscarriage*, *Cephalæa/Cephalalgia~head-ach*, *Paralysis~palsy*), different sections dealing with and describing every possible detail on the topic follow each other. The historical dimension is a key feature and serves as a background for contemporary and future medical developments: among the ancients Galen and Hippocrates are the cornerstones, almost always cited for their fundamental contributions. The choice among the moderns varies according to the topic: La Motte and Mauriceau s.v. *Abortion*, Wiseman s.v. *Abscess*, Dr. Harris s.v. *Absorbentia*. The entries are characterised by sections and sub-sections which may be variously organised. Some of these sections are titled *observation(s)*: these are case studies recording real medical events in the practice of medicine (s.v. *Abortus* they are one hundred fifteen; s.v. *Cephalalgia*, twelve) and providing concrete examples. Other paragraphs are titled according to the 'kind of' circumstance they describe: «*ABSCESSSES in the URETHRA*», «*AN ABSCESS of the LUNGS*», «*AN ABSCESS of the LIVER*», etc., and have the function of sub-headwords.

Etymology is another feature exploited by the *MD*, not always but frequently present, as in similar contemporary reference works: it is used to introduce the subject and support definitions. Sometimes the etymology becomes itself a starting point for the discussion, particularly on the variability of present usage: «Hence the word *Abscess*, generally used by modern authors to signify [...] though sometimes it signifies [...]. These words seem originally, by their derivation [...] signifying to recede [...]. Accordingly they are generally used by Hippocrates to express», s.v. *Abscessus*.

In general, James's entries are extremely dense in details, with many digressions, making reading a slow and demanding activity. However, the *MD*'s complex and composite textual pattern also highlights a growing degree of specialisation, requiring an expert or a semi-expert approach to the matter: «for the sake of those who shall make the disorders of women their peculiar study», s.v. *Abortus*.

James's style varies according to the contents and to the needs of the different communicative aims. Some sections are highly informative and expository, particularly those concerning the description of the phenomenon under

scrutiny. Causes, consequences, and possible remedies are relevant topics: «The signs of a future Miscarriage are», s.v. Abortus; «Inflammation from all causes have three ways of terminating», s.v. Abscessus; «The Cephalæa frequently proceeds from», s.v. Cephalalgia. Some other sections are more argumentative, in this case the compiler presents alternative or complementary perspectives, quoting the ancients or contemporary colleagues: «as was observed by Hippocrates», «La Motte also observes», «Galen in his *Commentary*», s.v. Abortus; «Castellus seems to think these the same as», s.v. Abstergentia; «Physicians are much divided in their Opinions [...] Some extol them as [...] whilst there are others, who affirm», s.v. Absorbentia.

On the contrary, further sections are characterised by a more involved (cfr. § 0.2.2.) and personal approach: this happens with *observations*, or case studies, included in the micro-structure of the entry but not integrated within or adapted to the new text. They usually are reports of real medical events exemplifying the main topic: their style reveals their origin, which is practical and situation-dependent (vs. generalisation, abstraction, elaboration). The perspective is narrative and personal, witnessing and reporting a process of decision making in time and place (use of first person pronoun, dynamic verbs, present and past tenses, usually active voice, use of time and manner adverbs, etc.):

When I dissected her, I found [...]  
 I had cut through it  
 I was immediately called [...]  
 nor could I discover [...]  
 I ordered her  
 (MD s.v. Abortus)

I was sent to him [...]  
 I found the outside [...]  
 I laid it open [...]  
 I dressed the Escar  
 (MD s.v. Abscessus)

Personal involvement also emerges when James himself enters the debate and comments on it, announcing what will happen further on in the entry («which I shall give particular examples», and «I have omitted *Longing*, which frequently occurs, though taken no notice of by the ancients», s.v. Abortus), evaluating («I must not omit remarking singular excellence of the last mentioned author. He seems to have observed nature with great diligence [...] accuracy», s.v. Abortus), or generalising («From this case we may learn that the exclusion of», s.v. Abortus; «Women are more subject to this Disorder than Men, because they are so much employ'd about the Care of their Hair», s.v. Cephalalgia). The following table exemplifies the entries just commented above:

Table 3

|   |
|---|
| <p>James's <i>A medicinal dictionary</i></p> <p><b>ABORTUS</b>, or <b>ABORSUS</b>. A Miscarriage.</p> <p>Some authors tell us that <i>Aborsus</i> signifies a Miscarriage during the first months of pregnancy; and <i>Abortus</i> one that happens near the full time of gestation. But there is no foundation for such a distinction, both signifying exactly the same thing.</p> <p>Miscarriages happen at any time, and from various causes; but most frequently about the end of the third month, as was observed by Hippocrates. The Grecians courtesans [...].</p> <p>La Motte also observes, that [...].</p> <p>Galen in his <i>Commentary on the Third Book of Epidemics</i>, says, [...]. But there are many other causes of <i>Abortion</i>, of which I shall give particular examples.</p> <p>A continued and obstinate looseness in a woman with child, endangers her fruit. If milk flows out of her Breasts, it is a sign of the weak condition of her child; but plump and hard Breasts, are evidence of a sound and healthy <i>Fœtus</i>. [...]</p> <p>The signs of a future Miscarriage are an evacuation first of an acqueous, and then a sanious [sic] and bloody matter. [...]</p> <p>For this reason, and for the sake of those who shall make the disorders of women their peculiar study, I shall end this article with a considerable number of cases, which will instruct much more than any general rules that can be laid down, and will in some degree supply the place of practice.</p> <p>These cases are principally extracted from some new authors of our own country, Mauriceau, and La Motte.</p> <p>I must not omit remarking singular excellence of the last mentioned author. He seems to have observed nature with great diligence, and to have given the history of her operations with great accuracy; insomuch that many of his cases seem almost made with a view to confirm some important maxims of Hippocrates, whom, I dare say, La Motte never read; otherwise he would not have failed to mention him, with a degree of ostentation peculiar to his countrymen.</p> <p style="text-align: center;">OBSERVATION I.</p> <p style="text-align: center;">A Miscarriage from a Stone in the Kidneys.</p> <p>A woman of quality was many years afflicted with tormenting pains in the Kidneys, especially on the Left-side, where she was first seized; and though she was no less than fourteen times with child, she constantly came before her time in the eighth, or beginning of the ninth, month.</p> <p>When I dissected her, I found the left Kidney quite wasted, but the Right swelled to a prodigious bigness, in which, after I had cut through it, appeared a large Stone. <i>Bonetus</i>.</p> |
|---|

[...]

OBSERVATION XXV.

July 19. 1693, a labourer's wife of the parish of Gourbeville had such a violent fall from her horse, that she remained a considerable time insensible. At this time she had been with child six months. I was immediately called, and found her come a little to herself; but upon examination could not find her Head had received any injury, nor could I discover any signs of approaching Labour, except that the child moved in an extraordinary manner, which was no wonder, considering the concussion she had received from the fall.

I ordered her to be laid on a sort of litter, and carried home; and then directed that she should take some good nourishment, and keep her bed for seven or eight days. From this time she never felt the child move, but it seemed like a weight which fell spontaneously to the side she lay on, which incommoded her much, but especially when she stood up, when pressing on the Bladder, it caused frequent inclinations to make water. In this situation she remained till her full reckoning was completed, her fall having neither advanced nor retarded the Birth. At this time I was called to deliver her, but the child was born long before I arrived, but was so weak that it died a few hours after, and the mother did very well. *La Motte.*

REMARK.

From this case we may learn that the exclusion of the Foetus should never be precipitated, unless some dangerous accident renders it necessary for the preservation of the mother. Because all the symptoms usually attending the gestation of a dead Foetus may occur, and yet the child may be born alive at the full period.

[...]

OBSERVATION LXXIII.

March 7. 1682, I attended a woman gone with child no more than two months and a half, who miscarried in my presence of a living child, that plainly moved its Legs and Arms, and even opened its Mouth for the space of half an hour. It came into the world without assistance, with a great Flooding. But as it was very small, and the Womb had only dilated itself in proportion to it, the After-birth remained behind, there being no room to bring it away; because the thickness and hardness of the Internal orifice, which was very close shut, could not bear to be stretched without too great violence, which might have brought on a very dangerous Inflammation in that part. But the Flux of Blood was so increased by this retention of the After-birth, that the poor woman had several bad Fainting fits the first day; after that it stopped a little, but only for a day or two, and then returned in a dismal manner, which it did, at several intervals, for the space of three weeks, the Womb all the while not sufficiently dilating so as to be able, of itself, to throw off its burden, nor to admit assistance to get rid of it without violence. And as it stuck all that time to the bottom of the Womb, so its sticking there was the cause that it did not at first resolve by Suppuration, as it usually does, when, being intirely loose from the Womb, it has no longer communication

with it. So that the true Suppuration of the After-birth not beginning till at the end of three weeks, the patient was afterwards more than eight days in voiding it piecemeal, and consequently was a full month in getting rid of the Appendage to this diminutive Fœtus, though most women are no longer about it than three or four days, and seldom above eight. But what contributed very much to lengthen out the time was, that the living roots of this foreign mass hindered its separation from the Womb, where it stuck close, and could not be expelled without Pain, which was not little aggravated by the straitness of the Internal orifice. In these eight days of the Suppuration, the woman, as it usually happens under such circumstances, had a Fever, with several Exacerbations, accompanied with a great Pain in the Head, and Hysteric fits. The part being afterwards purified from the infection of the Suppuration, the woman recovered her health, having run the less risk by committing the work of Expulsion to Nature, which if I had tried by Hand, as I must have used violence, the remedy might have proved worse than the disease. It is remarkable that this little *Abort*, which I saw living half an hour, had strength enough to move its Arms and Legs, but had not the power to put forth a cry, though I plainly saw it open its Mouth several times. For *Abort*s have commonly no voice till the end of the third month, their Lungs not having strength enough till then to push the air with an impetuosity sufficient to form a cry. *Mauriceau*.

[...]

In the general account of the causes of Miscarriages, I [James] have omitted *Longing*, which frequently occurs, though taken no notice of by the ancients, that I remember, and by little by any modern author of credit; though I have seen a few treatises wrote with a view to prove or disprove the reality of many effects attributed to it. [...]

This entry is extremely long: contents are detailed, and often refer back to medical men of the past, such as Hippocrates and Galen, and of the present, such as La Motte and Mauriceau. Ideas, interpretations, and works are compared. The history of medical thought is still relevant in this work. This entry may be considered as a long monothematic treatise in line with other contemporary non-lexicographic works of reference moulded within – but not adapted to – dictionary structure. The innumerable case studies are included after a long debate on remedies.

The many observations included constitute most of the lexicographic entry: the case studies are essentially taken from Mauriceau and La Motte, and the majority belongs to the last quarter of the seventeenth century. The frequent usage of the first person pronoun 'I' does not refer to James, but to the original physicians, practitioners, surgeons, or apothecaries dealing with the specific medical circumstances reported. Sometimes observations are followed by remarks, which evaluate the case study, its progress, cure and remedies applied. Some observations are very concise, others long and complex.

The following entry (Table 4) concerns Abscessus: this, as the preceding one, is a long and comprehensive lexicographic article.

Table 4

|   |
|---|
| James's <i>A medicinal dictionary</i>   |
| <p><b>ABSCESSUS</b>, Ἀπόζημα. [...] translated by Celsus <i>Abscessus</i>, and sometimes <i>Vomica</i>. Hence the word <i>Abscess</i>, generally used by modern authors to signify a Suppurated Phlegmon, or Inflammatory Tumor, though sometimes it signifies a Tumor of another kind, which would not admit of discussion, as all Encysted Tumours. These words, seem originally, by their derivation, to import any sort of exclusion of morbid matter [...] signifying to recede and retire. Accordingly they are generally used by Hippocrates to express any critical removal of offending humours from the vital parts [...].</p> <p>ABSCESSES in the URETHRA. [...]</p> <p>An ABSCESS of the LUNGS. [...]</p> <p>An ABSCESS of the LIVER. [...]</p> <p>An ABSCESS of the SPLEEN. [...]</p> <p>ABSCESSES of the KIDNEYS and BALDDER. [...]</p> <p>For ABSCESSES in the REINS and BALDDER. [...]</p> <p>For ULCERS in the BLADDER, attended with an INFLAMMATION. [...]</p> <p>For an HÆMORRHAGE from the BLADDER. [...]</p> <p>An ABSCESS of the UTERUS. [...]</p> <p>An approved SUPPURATORY for ABSCESSES, is this, viz. [...]</p> <p>To break ABSCESSES. [...]</p> <p>As almost all Abscesses are the consequences of Inflammations, and these produce a variety of events as they are differently complicated with other disorders, it will be proper to make some inquiry into their disposition. Inflammations from all causes have three ways of terminating, either by Dispersion, Suppuration, or Gangrene; [...].</p> <p>A decayed old gentleman walking in the streets one evening, was crushed up to a wall by a cart; the wheel passing too near him, bruised the outside of his Left-leg, but did not break the Skin: it was suddenly swelled, and very painful. His friends chafed it with Brandy, and dipping a cloth in the same, bound it about the part. By this way of dressing, that side of his Leg swelled and inflamed very much. Others advised him Lucatellus's Balsam; by which improper application the Fluxion was increased, and the patient confined to his bed. [...] I was sent to him. I found the outside of his Leg swelled and apostemated from the Gartering to the Small. I laid it open by Caustic an inch or two, according to the length of the Member. In dividing the Escar, there was discharged a large quantity of Matter, with clotted Blood in it. I dressed the Escar with Lenients, and embrocated the parts affected with Oil of Roses and red Wine, and applied an Emplaister of Armenian Bole over the Tumour, with Compress and Bandage. [...] <i>Wiseman</i>.</p> <p>[...]</p> <p>ABSCESSES in the HEEL. [...]</p> |

The entry is very long, with sub-headed sections. As in the case of *Abortus*, the lexicographic structure actually embeds a short treatise on the topic-headword *Abscessus*. It includes internal cross-references and references to external contemporary sources, relevant for the compilation of the entry itself. The attention for the historical dimension is substantial in James's scholarly approach: what happened in the past constantly backgrounds the present, and is essential, as Hippocrates and Celsus are. Once again, James's work is rich in details, situations, and perspectives which make it a kind of *summa* of medical knowledge up to the 1740s, not a reference work to be consulted in haste.

A long list on the different typologies of abscess is introduced, as well as a long series of ancient and modern remedies to cure abscesses. In the sub-sections, case studies are included alongside the description of the disease and its multifarious manifestations. The lexicographic article also includes some references to external sources for further reading (ex. Richard Wiseman)<sup>6</sup>. James's style is multifaceted: from an expository, informative, argumentative dimension (describing medical events, processes, perspectives), to an evaluative and conversational tone (genteel conversation), less formal and more involved attitude when 'summing up', or concluding the entry or single sub-sections (particularly case-studies). Case studies, strictly situation-dependent, may be followed by paragraphs which usually abstract from individual circumstances more general issues for further similar use.

Table 5 below includes more than one headword: these are shorter entries than *Abortus* and *Abscessus*, and replicate some of the features already discussed for them.

Table 5

|  |
|--|
| James's <i>A medicinal dictionary</i>  |
| <p><b>ABSORBENTIA.</b> ABSORBENTS.</p> <p>Thus all medicines are called, which have the Power to drying up redundant Humours, whether applied externally to Ulcers, or taken into the Stomach. The Testaceous Powders of all Sorts are Absorbents, and are much recommended by Dr. Harris, in Disorders of Children especially.</p> <p>Physicians are much divided in their Opinions concerning the Efficacy of this Sort of Medicines. Some extol them as the most Sovereign Remedies in almost all Distempers, whether Acute or Chronical; whilst there are others, who affirm they are very pernicious, because, if taken in considerable Quantities, as they must be to have any Effect, they mix with the Mucus of the Stomach and Intestines, and, concreting therewith, line the Instestinal Tube, or some Part of it, with a crustaceous Coat, and thereby stop up the Orifices of the Lacteals, and of the Excretory Vessels of the Intestines, by this Means both preventing a fresh Supply of Chyle from being carried into the Blood, and a Discharge of Redundancies by the usual and most proper Way, that of the Intestinal Glands. [...]</p> |

<sup>6</sup> Richard Wiseman (1621-1676) was a royalist surgeon (*serjeant-chirurgion*) who is considered one of the father of British surgery. He wrote *A treatise of wounds* (1672) and *Several chirurgicall treatises* (1676).

**ABSTERGENTIA. ABSTERGENTS.**

Castellus seems to think these the same as *Abluents*, from which they appear to me to differ very much, Abluents being Fluids which can only dissolve and wash away Salts, which are dissolvable in Water; whereas *Abstergents* are of a Saponaceous Nature, and capable of dissolving Concretions formed of Earth and Oil[s] of the Nature of a Resin, which cannot be dissolved by simple Abluents, or a watery Menstruum.

**CEPHALÆA, κεφαλαία.** A sort of Head-ach. See CEPHALALGIA.

**CEPHALALGIA, κεφαλαλγία,** from κεφαλη, the Head, and άλγος, Pain, A Head-ach.

CEPHALÆA [...] and *Cephalalgia*, are Affections of the Head, which differ in Degree; for a *Cephalæa* is an inveterate and obstinate *Cephalalgia*, according to Aretæus [...].

[...]

OBSERVATION XII.

A certain Lady of Distinction, who had long labour'd under a pungent Head-ach, which resembled the Pricking of Needles or Darts in the Part affected, and which was sometimes more, and sometimes less violent, at last fell a Sacrifice to her Disorder.

Upon opening her Cranium there was found, under the Dura Mater, near the torcular Harophili, a certain indurated stony Matter, resembling a small rocky Protuberance, unequal rough, with many Points, variegated, as it were, with Appearances like Cats Claws, the Images of Shell-fishes, and several other Figures, and adhering strongly to the Dura Mater. Between the Inequalities of this Protuberance small Veins were distributed, which moisten'd this Substance. Above the Pia Mater there was a certain mucous Humour found. *Cattierus, Observ. Medic. 15.*

The Cephalæa frequently proceeds from Refrigeration, or Cold, or, on the contrary, from the Heat of the Sun's Rays, or from long want of Sleep; and Women are more subject to this Disorder than Men, because they are so much employ'd about the Care of their Hair. [...]

CURATORY INDICATIONS. [...]

CAUTIONS AND CLINICAL OBSERVATIONS. [...]

**PARALYSIS**, παραλύω, to dissolve or weaken. A palsy.

Among the Diseases arising from the Want of a due Tone of the Viscera, and solid Parts, none are more considerable than such as affect the Head, and Parts situated therein: And, of these, the most important are, those Resolutions of the Nerves, commonly, by Physicians, called an Apoplexy, an Hemiplexy, and a Palsy; which three Disorders are so nearly connected, that we shall consider them in one joint View.

That all these Disorders affect Sensation and Motion, the primary Organs of which are, the Nerves, and the nervous and membranous Parts formed of them, is universally allowed.

Now a Nerve is [...].

[...]

Hence we are to account for a spasmodic Apoplexy, and a sanguineous Hemiplegy, which happen to hypochondriac and hysteric Patients; a memorable Instance of which is found in *Fred. Hoffman. Consult. Med.* For this Reason 'tis, also, often observed in Practice, that the Menses, and hæmorrhoidal Discharge, when not duly carried on, contribute much to the Production of Palsies.

[...]

If, when the Physician is called immediately after the Invasion of the Disorder, he finds the Pulse quick, and the Face red, there is no more present and efficacious Method of removing the Cause of the Disorder [...]

If the Disorder is inveterate, besides the above-mentioned Remedies, proper Evacuants are to be called in

[...]

Those who, by paralytic Disorders, have their Heads greatly weaken'd, and their internal Senses, especially, their Memories, injur'd, ought to abstain from an incautious internal Use both of the hot and cold mineral Waters ; [...]

[...]

A Palsy in the Iris. [...]

A Palsy of the Upper Eye-lid. [...]

Absorbentia is a single in-folio column in length, whereas Abstergentia is a very concise entry, just a few lines including an equivalent and a short lexical definition of the term, «are of a Saponaceous Nature, and capable of dissolving», in opposition to *Abluents*. S.v. *Cephalæa* (eleven in-folio columns), as elsewhere in James's *MD*, a series of observations and situation-dependent case studies, adapted and translated from external sources, alternate with more descriptive, informative, and expository sections, along with more general and elaborated considerations for further medical use. Paralysis (thirteen in-folio columns) includes a detailed description and further explanation on the function of nerves, on the different clinical severity of paralysis, on its multifarious typologies. To

support and exemplify the general treatment of paralysis, some observations and case studies are included. However, the observations-case studies are here completely integrated within the text: «Hence we are to account», «If, when the Physician», «If the Disorder is», «Those who».

### 2.2.2. *MOTHERBY'S A NEW MEDICAL DICTIONARY*

The *NMD* is mainly characterised by processes of selection and specialisation. Both concern the informational load to include in the entries and the degree of detail to be focussed on in view of their utility for an expert or a semi-expert readership. Indeed, Motherby is particularly selective, since his aim is to be useful to the practitioner 'in haste', as well to the student, and not to be exhaustive and all-inclusive in his entries. In his opinion, in-depth disciplinary knowledge may easily and more appropriately be found in monographic works other than his dictionary. External sources, essentially contemporary and up-to-date texts, are systematically referred to in general terms (the expert's name) or in detail (author, title, volume and page number):

Dr. Monro, senr. of Edinburgh, says that [...]  
 And, as Dr. Hunter hath observed [...]  
 Further satisfaction [...] by Dr. Wilkinson, in the Medical Museum, vol. ii. p. 117, &c. [...]  
 Dr. Hunter's Medical Commentaries; also observations thereon by Dr. Garner, in the Med. Mus. vol. ii. p. 229, &c.  
 (*NMD* s.v. Absorbere)  
 Hippocrates, in the 13<sup>th</sup> section of his book De Flatibus  
 (*NMD* s.v. Cephalalgia).

This methodological perspective clearly emerges at first glance, if *NMD* is compared, for the same headwords, with the *MD*. The extension of *NMD*'s entries is generally more limited than the corresponding *MD*'s entries: from very concise ones (headword only followed by equivalents or cross references, or by lexical definitions, *Abstergentia*, *Cephalæa*, *Cephalalgia*), to medium length (*Absorbentia*, half in-folio column; *Cephalalgia*, two in-folio columns; *Paralysis*, three in-folio columns), to more expanded ones (*Abortus*, five in-folio columns; *Abscessus*, thirteen in-folio columns). They usually include a very neat lexical definition, which may be preceded or followed by a gloss (usually a translation equivalent or a lexical variant), and by etymology and derivation. Greek transcriptions, instead, are not systematic. Sometimes definitions are moderately expanded to make the meaning – and the topic – clearer (s.v. *Abscessus*, *Absorbentia*, *Abstergentia*):

**ABORTUS**, a miscarriage. The birth of a child before its due time; or, the destroying a child in the womb.

ABSCCESSUS, an Abscess; from *abscedo*, to depart. A cavity containing pus, or a gathering of matter in a part. So called, because hereby the parts which were joined are now separated; one part recedes from another to make way for the collected matter.

ABSORBENTIA, Absorbents: from *absorbeo*, to swallow or drink up into themselves. All medicines which have the power of drying up redundant humours, either internally or externally, are thus denominated. These consist of sea shells, coral, burnt hartshorn, crabs-eyes, chalk, boles, &c.

ABSTERGENTIA, abstergents or cleansing medicines. They are of the saponaceous nature, capable of dissolving concretions formed of earth and oil, &c. which water, simply as an ablent, cannot effect.

CEPHALALGIA, from *κεφαλη*, the head, and *άλγος*, pain. The head-ach. It is also named *cephalæa*, *cephalagia*, and *cephaloponia*

PARALYSIS, *παράλυσις*, to dissolve or weaken. A palsy.  
(NMD s.v. Abortus, Abscessus, Absorbentia, Abstergentia, Cephalalgia, Paralysis)

Definitions are regularly followed by sections developing – describing, exposing, and explaining – the topic-headword: the amount and the kind of information encompassed in the entries is usually to the point and strictly focussed on the subject for practical usage. This means that the historical perspective, as well as digressions, are reduced and what actually emerges is the state of the art of Motherby's times in performing medicine, in everyday practice. Expressions such as

If the foetus is dead [...]  
If pains come on [...]  
If an hæmorrhage attends [...]  
If a cough attends, etc.

(NMD s.v. Abortus)

Abscesses are opened by either incision or the caustic, but in general the first is to be preferred

(NMD s.v. Abscessus)

reveal the operational goal of the work, providing practical issues to real situations. In this perspective, these sections are sort of instructive texts, as may be found in handbooks. Other sections categorise contents starting from hyponymic relations: this is the case with *Cephalalgia*, further subdivided into *cephalalgia* and *cephalæa* (co-hyponyms), and *hemicranias*, distinguished in *critaphos* and *clavus istericus* (co-hyponyms); and *Paralysis*,

subdivided into *apoplexy*, *hemiplexy*, and *palsy*.

As in the preceding works, sections dealing with causes, effects, signs and symptoms are included. Informative and expository paragraphs come in succession, and usually omit personal involvement and evaluation. Topicalisation is instead a structural feature:

Miscarriages happen at any period [...]  
 The causes are various [...]  
 An approaching miscarriage is to be apprehended by [...]  
 (NMD s.v. Abortus)

The matter in abscesses is formed by [...]  
 The progress of an abscess [...] is generally as follows [...]  
 Abscesses are opened by [...]  
 (NMD s.v. Abscessus)

In the beginning, the palsy, which is caused by [...] is acute  
 A palsy is when [...] When the muscles of the face  
 (NMD s.v. Paralysis)

What emerges is that *NMD*'s entries are more homogeneous in their lexicographic structure, and more consistent as regards textual organisation and contents, than the corresponding entries in the *MD*. In other words, they seem to be more coherent and cohesive as a whole. The Tables 6, 7, and 8 below partially reproduce some of the preceding entries to exemplify and clarify Motherby's textual arrangement and discourse strategies.

Table 6

|  |
|--|
| <p>Motherby's <i>A new medical dictionary</i></p>  |
| <p><b>ABORTUS</b>, a miscarriage. The birth of a child before its due time; or, the destroying a child in the womb.</p> <p>Miscarriages happen at any period of pregnancy, and from innumerable causes; most frequently in the third and beginning of the fourth month; but those which happen in the sixth or in later months, are more difficult and more dangerous.</p> <p>Women who are very thin, or very fat; women who have miscarried before, and who easily or without any particular inconvenience, during the time of miscarriage, or soon after, part with their burden, are more subject to this accident.</p> <p>The causes are various: violent motions, frights, poisons, violent purges, too much blood, great loss of blood, an obstinate diarrhoea, the small-pox, and other acute diseases. Habitual miscarriages happening at stated periods, without manifest cause, are very common among women of fashion, from these general causes of weakness, viz. indolence, laying long in the morning, and sitting up late at night; fear, grief, or indeed whatever debilitates, may be a cause; longings not indulged, &amp;c. In general, the causes may be reduced to what immediately affects the child, the placenta, the membranes, or the mother.</p> |

Whatever causes the death of a child, causes abortion sooner or later. If the membranes are too weak, they may easily break, and so prove a cause, against which no help can be proposed.

The funis may be too short, or the placenta separated or diseased, in which cases no care can prevent the ill effects.

As to the mother, beside the causes above enumerated, the two following are very common ones. The first is too great a stricture of the uterus; in which case it is not capable of a dilatation sufficient to make room for the foetus as it increases in bulk: this is known by a great tension and hardness of the belly, and violent pain therein. Bleeding, and whatever relaxes, are indicated in this case. The second is a relaxation of the uterus, which renders it unable to support the inosculation of the vessels of the placenta into itself, after the foetus and the placenta, &c. are grown to a certain weight: and, of all others, this is the most frequent. In these two cases, the miscarriage always happens about a stated time of the woman's pregnancy.

An approaching miscarriage is to be apprehended by the following signs: The breast growing flabby on a sudden; the loins have a painful weight, which reaches to the thighs; pains about the navel, head, and eyes; a gnawing at the stomach; coldness in the extremities; when violent means have been used to expel the foetus, convulsion [sic] sometimes come on; pains in the belly, like a cholic, and sometimes more like labour pains; shiverings; fainting; and, if it is past the time of quickening, the motion of the foetus is more languid, and less frequent than usual: as the miscarriage draws nearer being effected, the pains in the loins increase, extending to the hips; the orifice of the womb begins to be dilated; a watery discharge from the womb is perceived, which becomes bloody, at length pure blood or clotted comes away.

[...]

If the foetus is dead, [...]. If pains come on, [...]. If an hæmorrhage attends, [...]. If a cough attends, [...].

If acute diseases are the cause, [...]. If a tenesmus produces the danger, [...]. If the child is supposed to be dead, [...].

CONVULSIONS and FLOODINGS [...].

CONVULSIONS [...].

FLOODINGS [...].

The entry is five in-folio columns in length, an expanded one if compared to Motherby's average length, but much shorter than James's *Abortus*. It includes 'integrated observations', exemplifying different circumstances which are introduced by 'if' or 'when'; besides the general – but detailed – treatment of the topic, three titled sub-sections follow, in this case the focus is on some specific and recurrent effects accompanying miscarriage.

The next entry (Table 7) is *Abscessus*:

Table 7

Motherby's *A new medical dictionary*

**ABSCESSUS**, an Abscess; from abscedo, to depart. A cavity containing pus, or a gathering of matter in a part. So called, because hereby the parts which were joined are now separated; one part recedes from another to make way for the collected matter.

Ἀπόστημα and ἀπόζασις, used by Hippocrates, are translated by Celsus, abscessus, and sometimes vomica. Paulus Ægineta seems to limit the signification of abscessus to suppuration, [...] or a corruption of the fleshy parts, muscles, veins, and arteries. The words [...] signifying to recede or retire, are used by Hippocrates with great latitude. He signifies by them any critical removal of offending humours, however discharged; also the change of one disease into another, as a quinsy into a peripneumony, &c. But the present practice seems universally to consider an abscess as that tumor which follows an inflammation, for almost all of them are the consequence thereof.

The proper seat of abscesses is the cellular membrane.

The matter in abscesses is formed by the heat of the part acting on the humour collected there, and dissolving the adjacent fat; these two fluids are also concocted by the same heat.

[...]

The progress of an abscess on the external parts of the body is generally as follows: the tumour encreases, so does the heat, pain, and redness thereof; a pulsation is also perceived therein, a fever sometimes attends, which is increased every night, when the contents are all suppured, the pricking pain gives way, and an itching, with a growing numbness, is complained of, the hardness of the part at length yields to the touch, and the skin bursting, gives a vent to the contained matter.

An abscess should be carefully distinguished from an hernia, an aneurism, and from a varicous tumour. If during the treatment of an abscess [...].

Abscesses are opened by either incision or the caustic, but in general the first is to be preferred, especially if a knife is used, for it is less painful than the caustic, and does not bruise in cutting like the scissors. The opening may be as far as the skin is discoloured, or a circular piece may be taken out if the discolouration spreads. The opening must be, if possible, in a depending part, tho' where nature points out, the operation must be performed. When the bad quality of an abscess is likely to retard its future incarnation, an opening made by a caustic best prevents the lips of the wound from growing callous. [...] For the application, &c. of a caustic, see the article CAUSTICA.

Many advise not to open [...]. When the knife is used [...].

[...]

An ABSCESS in the Maxillary Sinus [...]. An ABSCESS of the Anus [...]. An ABSCESS in the Arm-pit [...]. An ABSCESS in the Back and Loins [...]. An ABSCESS of the Belly [...]. An ABSCESS in the Urinary Bladder [...]. An ABSCESS of the Bones [...]. An ABSCESS in the Brain [...]. An ABSCESS of the Breast [...]. An ABSCESS of the Diaphragm [...]. An ABSCESS in the Ear [...]. An ABSCESS in the Eye [...]. An ABSCESS in the Eye-lid [...]. An ABSCESS in the Feet [...]. An ABSCESS in the Gums [...]. An ABSCESS of the Heel [...]. An ABSCESS of the Fingers and Toes [...]. An ABSCESS in the Groin [...]. An ABSCESS on the Hands [...]. An ABSCESS on the Head [...]. An ABSCESS in the Hip [...]. An ABSCESS about the Jaws [...]. An ABSCESS in the Intestines [...]. An ABSCESS in the Kidney [...]. An ABSCESS in the lachrymal Glands [...]. An ABSCESS of the Liver [...]. An ABSCESS of the Loins [...]. An ABSCESS of the Lungs [...]. An ABSCESS of the Mediastinum [...]. An ABSCESS of the Mesentery [...]. An ABSCESS of the Neck [...]. An ABSCESS of the Nostrils [...].

[...]

The entry is a long one for Motherby's standards: thirteen in-folio columns, including many sub-headwords. Descriptions, explanations, and particular circumstances are essentially provided from a contemporary perspective: «the present practice seems universally to consider an abscess». Scholarly and useless details, empty learning, are systematically omitted. Etymology introduces the topic and explains the reasons for Hippocrates's lexical choice: «The words [...] signifying to recede or retire, are used by Hippocrates». Immediately after the etymological introduction, Motherby describes the nature of an abscess, «matter in abscesses is formed by», and where it usually seats in the human body «proper seat of abscesses». He then proceeds by describing the «progress of an abscess» and its external manifestations, enumerating its symptoms and their evolution. Subsequent detailed paragraphs are strictly devoted to the medical remedies, and surgical operations to cure abscesses: «opened by either incision or the caustic, but in general the first is to be preferred», «if a knife is used [...]. The opening may be as far as», «an opening made by a caustic best prevents». The procedures are described in technical detail, as often happens in manuals and practical compendia.

Table 8

|   |
|---|
| <p>Motherby's <i>A new medical dictionary</i></p> <p><b>ABSORBENTIA</b>, Absorbents: from absorbeo, to swallow or drink up into themselves. All medicines which have the power of drying up redundant humours, either internally or externally, are thus denominated. These consist of sea shells, coral, burnt hartshorn, crabs-eyes, chalk, boles, &amp;c.</p> <p>Under this class are included such medicines as are called Edulcorants, for that term can only signify that the animal fluids are by then rendered less sharp; and this is the only effected by breaking off the points of their particles, or by so absorbing them by soft and porous bodies that they cannot be perceived; increase of motion does the first, absorbent medicines do the latter.</p> <p>[...]</p> <p>The fixed alkaline salts, besides their absorbent virtue, [...].</p> <p>Iron, coral, bole, chalk, &amp;c. have a degree of astringency. [...]</p> <p>If the intention is to absorb, astringe and strengthen at the same time, give chalk, coral, oyster or egg-shells; if to restrain [...] if to loosen the belly [...] if to provoke urine [...] if to promote perspiration [...] if to dissolve [...].</p> <p>The word Absorbentia is also applied to several vessels in the human body, viz. the lacteals which absorb the chyle; the cutaneous vessels, which admit of water from the atmosphere, and from baths, &amp;c. to enter into the body; and other vessels [...].</p> <p>See the next Article.</p> <p><b>ABSORBERE</b>, to absorb, drink up, or suck up. The absorbent vessels are called also lacteals and lymphatics, which see.</p> <p>[...]</p> <p>Dr. Monro, senr. of Edinburgh, says that [...]. And, as Dr. Hunter hath observed, [...]. Further satisfaction [...] by Dr. Wilkinson, in the Medical Museum, vol. ii. p. 117, &amp;c. [...] Dr. Hunter's Medical Commentaries; also observations thereon by Dr. Garner, in the Med. Mus. vol. ii. p. 229, &amp;c.</p> |
| <p><b>ABSTERGENTIA</b>, abstergents or cleansing medicines. They are of the saponaceous nature, capable of dissolving concretions formed of earth and oil, &amp;c. which water, simply as an abluent, cannot effect.</p>  |

**CEPHALÆA.** See CEPHALALGIA.

**CEPHALALGIA,** i.e. Cephalalgia.

**CEPHALALGIA,** from κεφαλή, the head, and ἄλγος, pain. The head-ach. It is also named cephalæa, cephalagia, and cephaloponia.

It is sometimes acute, and sometimes chronic.

In some the pain is in the back part of the head, from a contraction of the occipital muscles. When mild it is called cephalalgia, when inveterate it is called cephalæa. When one side of the head only is affected it takes the name of hemicranias. In one of the temples only it is entitled critaphos. And that which is fixed to a point, and that is generally in the crown of the head, is distinguished by the name of clavus hystericus.

The nervous membranes of the head are the general seat of pains there, as the pericranium, the skin, dura mater, the membrane which covers the sinus in the os frontis, &c.

Women, on account of their care about their hair, and children, because of the irregular indulgences that are allowed them by improper foods, are the most subject to this disorder.

The causes are very numerous. Hippocrates, in the 13<sup>th</sup> section of his book De Flatibus [...].

[...]

Among the variety of causes are, suppressed or diminished customary evacuations; the acrid matter of some diseases, by fixing particularly on any part of the head; a caries in the bones of the head; polypuses, &c. obstructing the blood's passage through the jugular veins and sinuses of the brain; stony concretions in the brain; acrid humours repelled from the external parts of the head; abscess in the brain; a want of sleep; exposure of the head either to heat or coldness; a spasmodic constriction of the nervous membranes in the head; uneasiness in the stomach, and the faulty quality of its contents; cold feet; inanition; repletion; hardness and adhesion of the meninges. The hemicranias is usually from disorders in the stomach; and periodical pains have their cause in the stomach or other viscera, &c.

When the pain is in the back of the head, [...]. When a suppressed usual evacuation of blood from the nose is the cause [...]. When a catarrh is the cause, [...]. When a lues venerea is the cause, [...]. When the cause is from a hot bilious habit, [...]. When Hysteric affections are the cause, [...]. When the cause is within the cranium, and the pain is attended with a considerable degree of fever, there is danger of phrenitis.

[...]

**PARALYSIS**, παραλύω, to dissolve or weaken. A palsy. Celsus and Coelius Arelianus say that the most ancient writers give the name of attonitus morbus to that species which follows an apoplexy.

The apoplexy, hemiplexy, and palsy, are so nearly connected, that they may be considered in one view. In the beginning, the palsy, which is caused by an excess of good blood, is acute; but it soon becomes chronic; the other palsies are all, and at all times, chronic.

A palsy is when there is an abolition of voluntary motion, or of feeling, or both. When all the parts below the head are affected, or to the lower half of the body, it is called paraplegia; if one whole side, or one side of the head and face, it is an hemiplegia; and when confined to a particular limb, it is a paralysis, or a particular palsy; when both sides are seized, and reason is lost, it is then an apoplexy.

When the muscles of the face are paralytic, the source of the disorder is in the brain; but if these be free, the nerves only of the spine, or medulla oblongata, are affected.

[...] the same disorder will require different remedies, according to the varieties of its origin. Occasionally the palsy may proceed from an apoplexy, an epilepsy, violent pains, suppression of usual evacuations, a transflation of the morbid matter of acute diseases, whatever distends, distorts, compresses, or contracts the nerves, strong ligatures, luxations, fractures, wounds, gangrenes, inflammatory or other tumours in the coats of the nerves, extreme heat, violent cold, mineral effluvia, a too frequent use of hot water, &c.

[...]

A palsy sometimes attacks suddenly without any previous symptoms by which it might be expected; but sometimes an hemiplexy succeeds an apoplectic fit, and begin with a refrigeration of the side to be affected, and a preceding vertigo, and gradually terminates in an abolition of sensation and motion; the sound side is often racked with spasmodic and convulsive motions; the mouth is frequently distorted like that of a dog, and as the disorder proceeds, the functions of the mind, and especially the memory, begins to be weakened. A particular palsy is sometimes preceded by a sensation of weight in the part about to suffer, a slow motion accompanied with stupor, paleness, and torpor; the part affected is lax, flaccid, soft to the touch, and cold, like as it is affected in an atrophy or an œdematous tumour.

[...]

Blisters are not so well applied on the nape of the neck as on remoter parts, for in some instances they have produced convulsive twitchings when placed on the neck or back. In general palsies, blisters are useful by their stimulus; but they are most so when only particular parts are affected, and then the properest place of application is where the nerves of the respective part have their origin; for example, when a palsy seizes the upper extremities, blisters should be applied to the vertebræ of the neck and obliquely towards the shoulders; if the lower extremities are affected, the region of the sacrum is the properest part of blisters.

[...]

See Archigenes, Ætius, Celsus, Coelius Aurelianus, [...] Hoffman, and Boerhaave, Shebbeare's Theory and Practice of Physic, Lond. Med. Obs. and Inq. vol. iii. p. 160, &c. p. 237, &c. For many useful elegant forms of medicine, see Brook's and the London Practice of Physic.

Absorbentia (half in-folio column) introduces the topic in general terms, but it also describes those chemical substances which possess the quality of absorbing other substances, and which may be used as remedies. The entry closes with a cross-reference to the following entry Absorbere, in which many external and more specialised sources are included. The works and the names of the authors provided are almost contemporary of – or just preceding – Motherby's work. Cephalæa-Cephalalgia (two in-folio columns), besides including the etymology of the term, along with some graphic variants and lexical equivalents, classifies and defines the different typologies according to their specific nature. In most cases, distinguishing features are introduced by *if*, *when*, *in one of*, and *that which is*. Paralysis is three in-folio columns in length: the entry opens with the etymology, followed by the English equivalent *palsy*, the very general clinical conditions characterising the «nearly connected» types known as *apoplexy*, *hemiplegia* and *palsy*, to conclude with its main cause, «an excess of good blood». These general features set the scene for further, more detailed treatment of paralysis. It is at this point that the lexical *when*-definition «A palsy is when» is provided. This is immediately followed by specific distinctions which broadly categorise different types, introduced by *if* or *when*: «when all the parts below the head are affected [...] paraplegia», «if one whole side [...] hemiplegia», «when confined to a particular limb [...] paralysis», «when both sides [...] apoplexy». No symptomatological defining, as a list or cluster of symptoms, is provided here. However, Motherby uses a symptomatological defining frame to list and cluster the possible causes, «the varieties of its origin», and to describe the changing states – effects and symptoms – in the narrative progression of the disease, «A palsy sometimes attacks». As in the preceding entries, Motherby is detailed and precise in his exposition and explanations: he also adds sections in which practical instructions are provided for the practitioners, remedies, cures, and external sources at the end of the entry.

### 2.3. CHAPTER SUMMARY

This chapter has analysed and discussed two of the most relevant medical dictionaries of the period: James's *A medicinal dictionary* (1743-1745) and Motherby's *A new medical dictionary* (1775).

The *MD* is a huge work of medical scholarship, which aims at extensive and detailed treatment of any medical topic – and topic-headword – included in it. The *MD* is a comprehensive, complex, articulated reference work, structured as a scholarly collection in which the traditional approaches of the Ancients, their various doctrines, remedies and cures, along with contemporary discoveries and practices, are provided. It is the outcome of medical erudition: this emerges in the macro-structure of the work (many pages long, complex, and clustered entries) in which some entries actually are treatises with titled sections and sub-sections displayed as lexicographic entries. It aims at exhaustiveness, also including the translations of many works. The target audience is ‘mankind’ in general, but also ‘future students’.

The *NMD* is a more dynamic work than the *MD*: the general aim is practical, and professional. This means that practitioners should be able to find rapidly the topic – or topic-headword – they need, and the solution to a ‘present urgency’. This marks a turning point in medical lexicography, more focussed on and restricted to a professional readership of medical men and students. Notwithstanding the inclusion of some historical notions, the attention is on contemporary medicine and present approaches. This up-to-date perspective is reflected in the macro-structure of the work, and in the micro-structure of the entries. Lexical and spelling variations are reduced, conciseness of description and perspicuity of expression are highlighted. Accounts and records are included when their contribution may be of help for the solution of present circumstances, neither as useless additional information, nor as erudition. The result is a visible reduction in the length of the entries, and a correspondent emphasis on the topic described. Further information is provided with references to external sources.

## 3.

### FRAMING MEDICAL DISCOURSE IN EIGHTEENTH-CENTURY HANDBOOKS

#### 3.1 GENERAL INTRODUCTION: EXPLANATORY PREFACES AND CONTENTS

The handbooks and *practica* analysed in the present study belong to the second half of the eighteenth century. It is a period characterised by dramatic changes in the medical field, by a growing and expanding social interest in medical events, as well as by the impact of medical research and practice on British society as a whole. The writing of medical books and their circulation among the lay people was also favoured by the expansion of printing – as a general trade – and the expansion of the book market. According to Sims, in the preface to his *Observations on epidemical disorders* (1776), the art of printing

with a noble profuseness has scattered knowledge and liberal sentiments to the most distant regions, publications have become so frequent that an author thinks it proper at present to apologize to the public in a preface for daring to step forth in print; [...] the medical list having of late increased so enormously by new writings. (Sims 1776: iii-A2)

For the present research, many texts were consulted and scrutinised, but just a selection was actually used to exemplify medical writing. This selection is mainly based on their relevance as reference works in both professional and lay settings at the time, on the repute of their authors, and on the medical events included, particularly widespread epidemic and inflammatory diseases. In this latter case, the tables of contents were fundamental for the choice.

The dissemination of medical knowledge, or «diffusing medical knowl-

edge among the people» (Buchan <sup>2</sup>1772: xxiii), became one of the principal aims of medical authors, either physicians (university-educated M.D.), or practitioners (trained surgeons and apothecaries). Writing was a means to sharing medical experience, to instructing, informing and explaining medical contents, and making them generally useful. Buchan (<sup>2</sup>1772) and Fisher (1785) are particularly effective on this point when they highlight that «people at large [...] are entitled to reap the benefit of the Practice of Physic» (Fisher 1785: vii), and that «DIFFUSING medical knowledge among the people would [...] render Medicine more universally useful» (Buchan <sup>2</sup>1772: xxvii).

The explanatory prefaces and general introductions to some of the reference works examined were valuable starting points to highlight the key topics to be included in this study, and to suggest the approach for their presentation and discussion. Considerations on medical writing and its socio-cultural function, the reading public, the growing importance of public health issues, the role of experience and experimentation in medicine (practical approach), medicine as a new and consolidating profession (and professional trade), medicine as expanding specialised knowledge (science), and medicine as shared knowledge – and the values they carry with them – frame the context in which medical men were establishing themselves as professionals (and expert writers). These basic principles define the new social role and social function of medical practitioners, and also define the conditions in which medical writing is produced, making these transformations emerge in everyday practice.

Among the most representative works, the following ones were chosen as source materials to exemplify medical discourse. As it may be evinced from their titles, some of them focus their attention on specific affections (such as fevers), others include infectious and epidemical disorders, a third group instead considers multifarious diseases:

- Millar's *Observations on the prevailing diseases in Great Britain* (1770)
- Grant's *An Inquiry into the nature, rise, and progress of the fevers most common in London* (1771)
- Buchan's *Domestic medicine: or, a treatise on the prevention and cure of diseases by regimen and simple medicines* (<sup>2</sup>1772)
- Grant's *An essay on the pestilential fever of Sydenham, commonly called the gaol, hospital, ship, and camp-fever* (1775)
- Sims's *Observations on epidemical disorders, with remarks on nervous and malignant fevers* (1776)
- Clark's *Observations on fevers, especially those of the continued type; and the scarlet fever* (1780)
- Borthwick's *The method of preventing and removing the causes of infectious diseases* (1784)
- Fisher's *The practice of medicine made easy* (1785)

- Black's *A comparative view of the mortality of the human species* (1788)
- Wallis's *The art of preventing diseases, and restoring health, founded on rational principles, and adapted to persons of every capacity* (1793)

The socio-cultural function of medical writing is treated in detail by Buchan in his work (<sup>2</sup>1772), and introduced in more general terms by Fisher (1785) and Wallis (1793). All of them insist on the usefulness and the necessity to spread medical knowledge among mankind in order to avoid diseases by communicating «the *Prophylaxis*, or that part which treats of preventing diseases» (Buchan <sup>2</sup>1772: vi), by diffusing «simple and approved forms of medicine, and [...] cautions and directions» (Buchan <sup>2</sup>1772: xi), by promoting practical and affordable «relief for the sick and languishing» (Fisher 1785: vii), and by curing «those maladies, by which man is constantly attacked» or by preventing «their origin, or the mischiefs which are apt to succeed» (Wallis 1793: 1). In this perspective, medical writing establishes itself as a groundbreaking, and challenging experience, a kind of 'scientific experiment' itself, documenting and communicating the new scientific approach to medical events, and medicine as a whole:

WHEN I [Buchan] first signified my intention of publishing the following sheets [...] it would draw on me the resentment of the Faculty. [...] I was resolved to make the experiment, which indeed came out pretty much as might have been expected. [...] The reception which the book met with from the public was still more flattering, and deserves my most grateful acknowledgments. A persuasion that such a performance might be useful, and was even wished for by the public, encouraged me to print a large impression; [...]. (Buchan <sup>2</sup>1772: v)

Since

DISGUISED Medicine not only retards its improvement as a science, but exposes the profession to ridicule, and is injurious to the true interests of society. An art founded on observation never can arrive at any high degree of improvement, as long as it is confined to a few who make a trade of it. (Buchan <sup>2</sup>1772: xx)

Experience and experimentation, observation and data collection are the founding principles of the 'new medicine': «physic is cultivated upon a more rational plan, and faithful observation is allowed to be the sole foundation of medical knowledge» (Millar 1770: 3), before and against traditional scholastic learning, «conjecture» (Sims 1776: iii-A2), «extravagant hypotheses, [...]

fluctuating, mysterious, and fallacious» (Clark 1780: ix), and «the authority of system» (Clark 1780: x).

Expressions highlighting practical and accurate observations, data collection, personal experience and useful communication of medical facts, such as

[OBSERVATION AND USEFULNESS]

to endeavour to render practical observations more extensively useful (Millar 1770: 4)

a sagacious, careful and patient observation (Grant 1775: ii)  
the descriptions given [...] in the writings of those physicians who were the best and most accurate observers, as well as in the journals of my own practice (Grant 1775: iii)

ACCURATE attentive observation, and collecting useful facts, are the principal means of improving the practice of medicine. (Clark 1780: ix)

[FACTS]

the man who adds one single fact [...] does more real service to the art than he who writes a volume (Buchan <sup>2</sup>1772: xxi)

to establish any one medical fact (Sims 1776: iv)  
sensible of the importance of a medical fact (Sims 1776: vi)  
supported by obvious facts [...] recorded the result of their personal experience [...] observation, experiment, and the close inductive reasoning (Clark 1780: x)

[PERSONAL-PROFESSIONAL]

the sagacity and prompt discernment of the physician (Millar 1770: 4)

adding his own experience to that of others (Grant 1771: i)

[DESCRIPTION]

faithful description of the diseases (Grant 1771: i)

[COMMUNICATION]

inexcusable if he does not communicate it to the world (Sims 1776: v)

the laudable purposes of communicating practical instruction (Clark 1780: x)

are disseminated in the prefaces to emphasise that performing medicine was becoming the core of a revolutionary epistemological change. This

change would lead to the transformation from knowledge to science, since

To cure diseases they must first be known; to be known they must be seen, carefully attended to, and considered in their approach, progress, heighth, declension and final termination; in this way alone their nature can be investigated, and each disease critically distinguished, by its characteristic symptoms, from all others. This science is, indeed most difficult to attain; masters, books, or a knowledge of other sciences will avail little; these, it is true, have their use, and may afford some assistance in the study of physic; but to become an able practitioner in the art of healing, demands a long and unremitting attendance at the beds of the sick; a sagacious, careful and patient observation, and I might add, a turn of mind peculiarly adapted to, and delighting in this particular science. (Grant 1775: i-ii)

The way of conceiving, thinking, constructing medicine as a science, alongside the need and the effort to diffuse medical knowledge among the people, carried with it a change in writing. Metalinguistic issues expressing – and testifying to – this innovative attitude are included in the prefaces. Special attention is given to the rhetorical strategies, the register and the vocabulary used to encode medical events and to be understood by a non-expert and semi-expert (i.e. students) audience.

Since the aim is to «instruct and inform Persons of ordinary abilities in things which materially concern themselves» (Fisher 1785: iv), Buchan and Fisher insist on the necessity to avoid «a useless parade of learning by using technical terms» (Fisher 1785: iv), or «an useless parade of quotations from different authors» (Buchan <sup>2</sup>1772: xii). According to them, technical terminology and different perspectives – especially «quotations» and «observations» (Buchan <sup>2</sup>1772: xii) – may be sometimes introduced in the description of diseases, or discussion of medical events. In these cases, either «every word which is difficult to understand» should be «always explained the meaning in words immediately following» (Fisher 1785: iv), or just those terms «such as most people understand» (Buchan <sup>2</sup>1772: xv) should be included. A partially different viewpoint on the «simplicity of stile» is expressed by Wallis (1793: iii) in his Explanatory Preface, since ‘simplicity’ does not mean systematic omission, or deletion, of «the terms of the schools» (1793: ix). If duly explained, «the terms themselves, once understood, are infinitely more expressive, and involve more ideas than any other which might be thought more familiar» (1793: x).

This attention to the public awareness and understanding of medical facts mirrors a strong commitment to public health in civil society: the growing number of hospitals and public institutions in which people were

cured and medical men performed medicine expanded professional experience. Alongside ordinary and widespread common diseases, and epidemics, practitioners also dealt with occupational diseases. In hospitals and infirmaries, they had the «opportunities of observing the injuries which [...] useful people sustain from their particular employments» (Buchan <sup>2</sup>1772: vii), to cure, inform, and instruct them «in order that people may be upon their guard against them [diseases]» (Buchan <sup>2</sup>1772: viii). It is the representation of an emerging pre-industrial country and its social issues, such as the «cure of diseases» and, more important, «the preservation of health», for which «Medical knowledge [...] only teaches men how to make the most of themselves» (Buchan <sup>2</sup>1772: xxvii) both in public and in private life. The ‘physician’s attention’ is thus social, besides being medical: the profession requires both ‘scientific knowledge’ and ‘social awareness’, with a view

To assist [...] in relieving distress; to eradicate dangerous and hurtful prejudices; to guard the ignorant and credulous against the frauds and impositions of quacks and impostors; and to show men what is in their own power, both with regard to the prevention and cure of diseases, [...]. (Buchan <sup>2</sup>1772: xxxi)

As regards the term *disease*, it is worth noting that both Black (1788) and Wallis (1793) introduce the notion and try to represent its semantic load. In the introduction to the present study, the term *disease* is treated in association with such other terms as *affection*, *disorder* and *distemper*, as defined by Samuel Johnson in his *Dictionary of the English language* (1755). In Black’s and Wallis’s, the definition and the interpretation of *disease* and its meaning(s) precede its contextual use in medical handbooks, and help clarify its pragmatic potential in this kind of reference works. It is a relevant metalinguistic issue, since medical writers include the explanation of the key term they will use in their writing, to avoid ambiguity and vagueness. They also pragmatically exemplify the ideas they express, by adding a series of details to make the average reader understand their point. Black (1788: 70-71), in a comprehensive and extended definition, maintains that

A disease, in the pathological language, is when one or more of the various corporeal or mental functions, cannot be performed as in usual health. The symptoms of all diseases are indicated by few or many derangements of the corporeal functions, of the excretions, and of the sensible qualities: such are pain, disagreeable sensation, anxiety, irritation internal or external; the exercise of some of the external or internal senses impeded; of sleep and waking; of the muscular or moving fibres; of the digestive and intestinal functions: of the lacteal, lymphatic, or absorbent

system; of the respiration, sanguiferous circulation, and arterial pulsation; of the different excretions and secretions, the feces, urine, perspiration, bile, pancreatic fluid, saliva, milk, menses, semen, mucus, oil, lymph, and extravasated blood: by the countenance, actions, gestures, debility, strength, heat, colour, smell, taste, magnitude, hardness, softness, the nature and appearance of the excretions, &c. (Black 1788: 70-71)

The definition is followed by a long list of generic symptoms, or meta-symptoms, as when a specific disease is usually described: a helpful strategy to make ideas concrete. Wallis (1793: 313-314), in a more abstract and neat definition, affirms that

By DISEASE is meant a general or local affection, by which the system is disturbed, or the action of a part impeded, perverted, or destroyed—or, an appearance deviating from health, from some general, partial, or local affection, by which the system in general, or in a part, is oppressed or disfigured—and this is *discovered* and *distinguished* by an enumeration of certain symptoms or appearances with which it is always associated.—But diseases differ; hence it is necessary to distinguish them from each other, with which they may seem to have a near affinity—this is done by the causes and peculiarities that are connected to them; and from whence the deviation arises. (Wallis 1793: 313-314)

Hence, a disease can include a great amount of symptoms or «appearances», some of them are present in many different diseases and cannot be of use for their distinction. However, diseases must be distinguished, identified – and then categorised and described – according to their peculiarities (their characteristic signs), and their causes.

The effort to classify diseases clearly emerges from the table of contents of reference works: writers group diseases and organise materials in order to describe similarities and differences, as regards their nature, their causes, their manifestations, their effects. For example, Buchan (<sup>2</sup>1772) distinguishes individual diseases in separate chapters in his «PART II. Of Diseases», each chapter including similar diseases according to their nature and external manifestations. Millar (1770) identifies macro sections such as «PART I. Of Inflammatory Diseases», «PART II. Of Putrid Fevers», and «PART III. Of Diseases which partake both of a Putrid and Inflammatory Nature», each of them including more specific chapters on «*Inflammatory Fevers*», «*Pleurisy and Peripneumony*», «*Inflammations of the Abdominal Viscera*», «*Inflammation of the Liver*», «*Inflammation of the Intestines*», «*Remitting Fevers*», etc. Black (1788) uses a mixed-type organisation: some diseases are grouped according

to their similarities, such as «*Of fevers*», «*Diseases of the lungs and organs of respiration*», «*Diseases of the external senses*», «*Diseases of the Stomach and intestines, and organs of digestion*» etc.; others are treated individually «*Headach, Night mare, Apoplexy, Lethargy, coma, and carus, Vertigo, Palsy, Epilepsy, Tetanus*», etc. Wallis (1793) organises his materials into specific sections devoted to «*Febrile Affections*», including continued fevers, inflammatory fevers, mixed fevers, remittent fevers, bilious fevers, intermittent fevers, eruptive fevers, etc.; «*Inflammation*» of the brain, of the eye, of the ear, of the breast, of the pleura-pleurisy, of the lungs-peripneumony, etc.; «*Diseases where Pain is the characteristic Symptoms*» [sic], such as head-ach, or cephalalgia, cephalæa, hæmicrania, tooth-ache, pains of the stomach, of the liver, in the kidneys, etc.; «*Morbid Evacuations*», «*Nervous Affections*», «*Diseases of the Skin*», etc.

It can be argued that the complexity of the structure changes according to the principle of inclusion vs. selection, the principle of grouping and clustering vs. listing individual diseases (sometimes just in alphabetical order as in Fisher, 1785), and the principle of abstraction to identify macro-similarities, such as the inflammatory nature, to organise contents. However, it is almost clear that certain diseases frequently recur in every work (some of them are even devoted to specific diseases, or specific class of diseases such as *fevers*, cfr. Ch. 4.), and this testifies to the endemic or epidemic affections which characterise the period.

The following sections present and discuss a series of extracts treating the most frequent affections as they emerge from the works. The aim is to highlight the rhetorical strategies, the language and the textual features which frame medical contents for a large audience.

### 3.2. MEDICAL EXPERIENCE AND MEDICAL PRACTICE IN EIGHTEENTH-CENTURY HANDBOOKS

The examples discussed in this section are subdivided into two main groups: GROUP A (cfr. § 3.2.1.) introduces some lexicographic practices (lexical definition, etymology, glossing, equivalence, basic and concise descriptions; in other words, what constitutes an *extended definition*, cfr. § 0.2.1.), alongside their discursive function (categorisation, vernacularisation, expansion, etc.); whereas GROUP B (cfr. § 3.2.2.) discusses longer and more elaborate descriptions of disease, that is to say symptomatological definitions, alongside their systematisation in a descriptive-discursive framework (particularly stative or dynamic verbs featuring respectively the context or process under scrutiny, and discursive makers organising the text). Moreover, there are at least two main criteria to organise materials in handbooks, or *practica*: the alphabetical order, in the case of Fisher (1785), and the thematic one, the most frequently used by medical authors. However, in both cases, some rhetorical,

textual, and linguistic strategies recur, since medical writers select and combine them according to their specific communicative and discursive aims.

3.2.1. DENOMINATING, DEFINING AND CATEGORISING DISEASES: BASIC PATTERNS AND DISCURSIVE ISSUES (GROUP A: GLOSSING, EQUIVALENCE, ETYMOLOGY)

The first goal for medical writers in their works is to denominate individual diseases or groups of diseases to make them known to – and recognisable by – their diverse readership. Denomination is a key feature in all the handbooks under scrutiny here, and is the first basic issue to organise and introduce medical events of any kind (diseases as entities and their development in time). Usually, denominations are single- or multi-word expressions, and are often more than one for the same disease: such as *pleurisy~inflammation of the pleura*, *peripneumony~inflammation of the lungs*, *hepatitis~inflammation of the liver*, *hydrophobia~bite of a mad dog*, *phthisis~pulmonary consumption*, *convulsions~epilepsy*, *cyranche inflammatoria* and *maligna~throat sore*, etc. Some are in English (*convulsions*, *blood-spitting*, *head-ach*, *inflammations of the breast*, etc.), some are anglicised versions of Latin names (*pleurisy*, *dysentery*, *catalepsy*, *dropsy*, etc.), others are Latinised denominations derived from Greek (*pleura*, *peripneumonia*, *hydrophobia*, *cephalalgia*, *cardialgia*, etc.).

In reference works, the practice of using variant denominations, including lexical variation, graphic variation, or morpho-syntactic variation, was meant to connect lexical variants and different registers (specialised and formal vs. general and core vocabulary) to the same medical reality. This facilitated the non-expert, or the semi-expert, readership to associate background knowledge and experience, represented by shared vocabulary in everyday communicative situations, with more formal, technical – and, for this reason, more complex – expressions. If technical terminology had to be used, the association with well-known and widespread expressions was necessary to clarify the concept(s). This procedure – known as glossing, especially through equivalence – was systematically exploited in handbooks to gather and organise medical terminology, in order to introduce medical contents and notions to the ‘average’ readership<sup>7</sup>.

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7 According to Adamska-Sałaciak (2010: 393), there is a distinction to be made between translational-insertable (*tr*) and explanatory-descriptive (*ex*) equivalents (*eqs*). This distinction is not always clear-cut. The relationship between the two types is, instead, extremely complex: in general terms, *tr eqs* are directly insertable in a text, whereas *ex eqs* take the form of a short paraphrase, they are phrase-like (not overlapping with definitions, but sometimes similar to them). However, *tr eqs* themselves may be multi-word expressions and, at a certain extent, phrase-like (if they are not completely lexicalised in the target language): this means that nominal groups such as *inflammation of the ear* may be interpreted both ways (and, sometimes, also as definitions). The sequence is directly insertable in a text (and so behave as a single, independent lexical unit in the target language) but it is also phrase-like, since all its constituents may be moved independently according to their morpho-syntactic features and semantic load.

Generally speaking, variant denominations for the same disease – or for the same notion(s) or event(s) – precede any definition, description, or explanation. Hence, denominations – and their equivalent expression(s) – serve as headings and headwords at the same time, they are the starting point for any in-depth analysis.

This is the main technique used by Fisher (1785) to structure his work and introduce his contents. Fisher organises his materials in alphabetical order, not always consistently, as in a dictionary, for quick reference, and exploits denominations and glossing essentially as a vernacularisation strategy before further descriptions or explanations.

The table below lists a series of topic-headwords which are immediately followed by their respective English or Anglicised equivalents, either translation or explanatory. Some of them are transparent and easy to understand (*bite of a mad dog, blood-spitting*), others are opaque and more complex for the average reader to grasp (*fever intermittent, epilepsy, lethargy*). This aspect depends on register, as well as on the level of technicality expressed by the equivalent itself:

| Equivalence and Vernacularisation<br>Fisher (1785: 12 ff.) |  |
|--|--|
| AGUE, (See Fever Intermittent.)                            | CHOREA SANCTIVITI. (See St. Vitus's Dance.)            |
| ALBUGO, or Speck on the Eye.                               | [...]  |
| ANGINA. (See Throat sore.)                                 | COMA (See Lethargy.)                                   |
| [...]  | [...]  |
| APOPLEXY.  | CONVULSIONS. (See Epilepsy.)                           |
| ARTHRITIS. (See Gout.)                                     | CROOKED SPINE. (See Spine Crooked.)                    |
| ASTHMA.  | CYRANCHE INFLAMMATORIA AND MALIGNA. (See Throat Sore.) |
| BITE OF A MAD DOG.   | [...]  |
| [...]  | DELIQUIA. (See Faintings.)                             |
| CARDIALGIA. (See Heart-burn.)                              | DIABETES. (See Urine excessive.)                       |
| CARUS. (See Lethargy.)                                     | DIARRHŒA. (See Loseness.)                              |
| CATALEPSY. (See Epilepsy.)                                 | [...]  |
| [...]  | DYSENTERY. (See Bloody Flux.)                          |
| CAPHALALGIA. (See Head-ach.)                               | DYSURY. (See Urinary Passages, Diseases of)            |
| [...]  |  |

In other words, the sequence may be also considered as an *ex eq* and thus modified: *inflammation of the X, X of the ear*, etc. Here, it has been interpreted as a single unit of meaning at a semantic level (being its extra-linguistic referent a specific entity) and a single lexical item, at a structural, morpho-syntactic level, since it is directly insertable in the text. For a thorough discussion on this topic see Adamska-Sałaciak (2010) and Zgusta (1971 and 1987).

|  |  |
|--|--|
| <p>DYSPEPSIA. (See Stomach Complaints)<br/>                 [...]<br/>                 HERPES. (See Leprosy.)<br/>                 HÆMORRHOIS. (See Bleeding Piles.)<br/>                 HÆMOPTOE. (See Blood-spitting.)<br/>                 HEPATITIS. (See Inflammation of the Liver.)<br/>                 [...]<br/>                 HYDROPHOBIA. (See Bite of a Mad Dog.)<br/>                 HYDROPS (See Dropsy.)<br/>                 [...]<br/>                 INOCULATION. (See Small Pox.)<br/>                 INCUBUS. (See Night Mare.)<br/>                 ISCHURIA. (See Urinary Passages Diseases of)<br/>                 [...]<br/>                 NEPHRITIS. (See Inflammation of the Kidnies.)<br/>                 [...]</p> | <p>OPISTHOTONOS. (See Cramp.)<br/>                 OPHTHALMIA. (See Inflammation of the Eye.)<br/>                 [...]<br/>                 PARAPHRENITIS. (See Inflammation of the Pleura or Pleurisy.)<br/>                 PERIPNEUMONY. (See Inflammation of the Pleura.)<br/>                 PHRENITIS. (See Inflammation of the Brain.)<br/>                 PHTHISIS. (See Consumption.)<br/>                 PLEURISY. (See Inflammation of the Pleura.)<br/>                 [...]<br/>                 PSORA. (See Itch.)<br/>                 QUINSEY. (See Throat sore.)<br/>                 [...]</p> |
|--|--|

The single-word or multi-word equivalents are used both to get to the core meaning of the source expression and to cross-refer to those sections where the topic is thoroughly described and/or discussed. Frequently, the topic-headwords are Latinised expressions ultimately coming from Greek, whereas equivalents are familiar expressions appropriate for both laypeople and semi-experts (for example students or apprentices), or trained practitioners.

Occasionally, the equivalence, or the cross-reference, starts from the more familiar expression or denomination to the more technical and prestigious one, such as «CONVULSIONS. (See Epilepsy)»; more rarely, cross-referring is just a matter of internal alphabetical organisation, with the inversion modifier ⇔ head «CROOKED SPINE. (See Spine Crooked.)». Each of these heading + equivalent or cross-reference patterns are usually and immediately followed by more elaborate descriptive sections, known as symptomography. Definitions after glossing are sporadic in Fisher, since equivalence already introduces the meaning expressed by the technical terms. When definitions are included, they are very simple and essential, usually categorising the topic-headword as a *disease*, *distemper*, *disorder*, *complaint*, or *means of curing*, such as

BITE OF A MAD DOG. [...]

HYDROPHOBIA. This disease is too often the consequence

from a bite of a mad dog. Symptoms. [...]  
 BLACK DISEASE. This is a distemper which does not happen very frequently [...] owing I believe, to an effusion of blood [...]. Symptoms [...]  
 BLEEDING AT THE NOSE. This is often a means of curing some disorders, such as head-ach [...]  
 CATARACT. This is a disease of the crystalline humour of the eye by which the sight is impaired [...].  
 FEVER BILIOUS. This disease is only a continual remitting or intermitting fever, accompanied with a great discharge of bile upwards or downwards. [...]  
 HEAD-ACH. This is a disease the symptoms of which need no description. Regimen [...].  
 HICCUP or HICCOUGH. This complaint is so well-known, that I need give no account of the symptoms. (Fisher 1785: 21 ff.)

Denominations and definitions are followed by detailed ‘entries’ (or sections, or articles) including descriptions, symptoms, and cures (regimen and medicine), which is the primary interest and purpose of the author, and of his work.

Denominations and glossing, particularly equivalence, are a widespread practice in dictionaries and encyclopaedias, and this versatile strategy is also extensively applied and adapted to handbooks. Actually, glossing becomes a well-established and basic method to introduce specialised lexical items, and the contents they represent. Moreover, glossing is also a key feature which structures this kind of reference works, independent of the register used to discuss the medical events included, and of the length and complexity of subsequent paragraphs, sections, and chapters.

In the following examples, taken from Buchan (<sup>2</sup>1772), Wallis (1793), and Black (1788), single- or multi-word denominations are glossed by their respective translation or explanatory equivalents. Sometimes definitions are introduced immediately after a topic-headword without any equivalence; only later, further linguistic, lexicological, and etymological information is given. The examples 1-3 deal with what is generally called *inflammation(s) of the breast*, especially *pleurisy*; whereas the examples 4-6 deal with *aches*, especially *head-ach*.

The first example is taken from Buchan, the concept is introduced by the topic-headword *pleurisy* and immediately narrowed by a more specific denomination, i.e. «true pleurisy» (modifier-head). This is followed by an explanatory equivalent, which functions as a first phrase-like definition, very short and essential: «inflammation of that membrane». Further on, the more prestigious and technical term in Latin, i.e. «called the *pleura*», is introduced. Other modifier-head denominations follow, introduced by

«called the», and help categorise, «distinguished into», the species of *pleurisy*, «moist and dry», «*spurious* or *bastard*», to be treated later on by Buchan:

### Example 1

#### OF THE PLEURISY.

The true pleurisy is an inflammation of that membrane, called the *pleura*, which lines the inside of the breast. It is distinguished into the moist and dry. In the former, the patient spits freely; but in the latter, little or none at all. There is likewise a species of this disease, which is called the *spurious* or *bastard pleurisy*, in which the pain is more external, and chiefly affects the muscles between the ribs.

[...]

Of the BASTARD PLEURISY. That species of pleurisy which is called the *bastard* or *spurious*, generally goes off by keeping warm for a few days, drinking plenty of diluting liquors, and observing a proper regimen.

[...]

Of the PARAPHRENITIS. The *paraphrenitis*, or inflammation of the diaphragm, is so nearly connected with the pleurisy, and resembles it so much in the manner of treatment, that it is scarce necessary to consider it as a separate disease. (Buchan <sup>2</sup>1772: 202, 211)

Two sub-topics, or sub-headwords, are here included, i.e. *bastard pleurisy* and *paraphrenitis*: both are defined by the *genus-differentia* pattern, «BASTARD [...] species of pleurisy», «*paraphrenitis* [...] is so nearly connected with the pleurisy, and resembles», which is typically used in the attempt to categorise contents. In the case of *paraphrenitis*, the definition is preceded by the equivalent expression «inflammation of the diaphragm». Here, the notions of translational and explanatory equivalence overlap. What emerges from this linguistic and conceptual organising principle is that *pleurisy* (genus expression) is a *disease* (itself a genus expression, the most general notion) which can be subdivided into different species, such as *moist*, *dry*, *spurious/bastard*, and *paraphrenitis* (differentia).

The second example, taken from Wallis (1793), traces back to the same strategies used in the preceding extract: equivalence for introducing and vernacularising the topic, and its variant denominations; *genus-differentia* pattern for defining and categorising. However, the textual organisation is neater and more lexicographic in approach. The 'entry-article' is detailed, opening with a general and all-inclusive heading, «INFLAMMATIONS OF THE BREAST», and going on with more specific sub-headings or

sub-headwords. First, it provides the anglicised denominations, followed by its respective explanatory equivalent, «PLEURISY, OR INFLAMMATION OF THE PLEURA», «PERIPNEUMONY [...] INFLAMMATION OF THE LUNGS»<sup>8</sup>; or its translation equivalent «PULMONARY CONSUMPTION [...] PHTHISIS PULMONALIS». In this latter case, the more scholarly denomination follows. An interesting feature, which is almost always present in Wallis (1793), is etymology. The inclusion of the etymological principle in lexicographic reference works (dictionaries and encyclopaedias) dates back from the beginning of the eighteenth century to help readers understand the core meaning of the headwords, particularly as regards specialised or technical terminology. The same strategy is often adopted in non-lexicographic reference works with the same interpretative issue, and Wallis is extremely careful and systematic in including the original etymological meaning when introducing diseases (particularly from Greek and Latin). Wallis's 'entry-article' is well structured, the morpho-syntactic sequences well-organised, marking the different textual paragraphs, for example definitions vs. further expansions, «This is an affection of» vs. «It is divided into», «This disease is» vs. «Authors have divided them», and discourse units (introduction, detailed information, or treatment, cfr. example 2 below).

Two kinds of definitions are used in the following extract. On the one hand, the disease is defined according to its salient features, as an entity, «This is an affection», «This disease is»; on the other hand, the disease is defined as a process, according to what actually happens in context. In this case, Wallis uses what is known as *when*-definition (or, *when*-defining), a strategy aimed at popularising concepts otherwise difficult to be figured out by a non-expert readership. The general concept corresponds to the *genus*, whereas the *when*-definition introduces the *differentia*: «when the membrane itself», «when the intercostal muscles», etc. The *differentia* is also highlighted by the introductory expression «into different species», followed by a list of run-on modifiers, «DRY [...] MOIST [...] CATARRHAL [...] SANGUINARY», s.v. Pulmonary Consumption):

### Example 2

#### CHAP. II.

#### INFLAMMATIONS OF THE BREAST.

##### § I. PLEURISY, OR INFLAMMATION OF THE PLEURA.

This is an affection of the membrane called PLEURA, from the Greek word *pleos*, plenus, full, which lines the inside of the chest, covering the ribs internally, and intercostal muscles (27.)

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<sup>8</sup> Here, as in other contexts, the notion of translational and explanatory equivalence is fuzzy, since the explanatory equivalent (multi-word expression) may be directly insertable into the text, instead of the single-word denomination.

and lungs, (19.) and forming the mediastinum and pericardium, (19.) attended with an acute fever, great pain, and difficulty of breathing.

It is divided into the TRUE PLEURISY, when the membrane itself is affected—into the SPURIOUS, when the intercostal muscles; — and also into MOIST, when expectoration is an associate; and DRY, when there is no such appearance—indeed, at the onset it puts on generally the appearance of the latter, and of the former in its progress, if not conquered by resolution; for then most commonly expectoration takes place. (Wallis 1793: 512-513)

[...]

§ 2. PERIPNEUMONY, so called from the Greek words *peri*, circum, about, and *pneuma*, pulmo, the lungs.

INFLAMMATION OF THE LUNGS. (Wallis, 1793: 517)

[...]

§ 3. PULMONARY CONSUMPTION, called PHTHISIS PULMONALIS, from the Greek word *pthino* or *pthuo*, corrumpo, to corrupt.

This disease is a wasting away of the whole body, attended with a hectic fever, cough, and spitting up of matter, from an ulcer on the lungs.

Authors have divided them into different species: THE DRY, or TUBERCULOUS CONSUMPTION;—THE MOIST, OR CATARRHAL—and THE SANGUINARY, from their attendant symptoms and causes; [...]. (Wallis, 1793: 524)

The third example, on the same topic, i.e. *inflammations of the breast* in general, is drawn from Black (1788). His approach is different from the preceding ones, more descriptive and situation-bound, and less structured from a lexicographic perspective. The heading cannot, in this case, be completely overlapped with a headword, even though it is directly followed by a general definition, «is a frequent inflammation», or the most inclusive *genus* expression, and further on by «pleurisy and peripneumony», the more technical and prestigious anglicised denominations. These are diversified by a long list of modifiers, «bilious, erysipelalous, catarrhal» etc., the *differentia*, introducing kind of run-ons, without any further information or definition:

### Example 3

CHAP. XVI.

*Inflammation of the Lungs and Organs of Respiration*, is a frequent inflammation in northern climates [...]. Nosologists have enumerated several extraneous symptoms as complicated species

of pleurisy and peripneumony; such as bilious, erysipelalous, catarrhal, rheumatic, intercostal, arthritick, verminous, flatulent, scorbutick, putrid, and malignant: [...] The primary seat of pulmonick inflammation [...] is not clearly established in medical diagnosticks; and therefore we comprehend pleurisy and peripneumony under one genus: [...]. (Black 1788: 142-143)

The examples 4-6 concern *aches*, and again are drawn from Buchan (<sup>2</sup>1772) and Wallis (1793): *head-ach* and *otitis*. In «OF THE HEAD-ACH», Buchan introduces the general topic *aches* (*genus*), to focus on «those only which occur most frequently» (*differentia*). He systematically defines the different kinds of headache in a *when*-definition pattern (as Wallis in the preceding example 2 on *pleurisy*). Only after each single definition, the specialised denominations are given in Latin: from «when the head-ach», «when the whole head», «when on one side» (*when*-definition), to «it is called *cephalalgia* [...] *cephalæa* [...] *hemicranias* [...] is called *clavis hystericus*» (prestigious denomination). This strategy is used to popularise ideas and concepts before giving them formal – or technical – status, which would otherwise be incomprehensible to the readership. The approach is onomasiological. Buchan – as Wallis in the previous and following examples – starts from the concepts, in order to identify and include the terms expressing them only later on:

#### Example 4

CHAP. XXXIII.  
OF THE HEAD-ACH.

ACHES and pains proceed from very different causes, and may affect any part of the body; but we shall point out those only which occur most frequently, and are attended with the greatest danger. When the head-ach is slight, and affects a particular part of the head only, it is called *cephalalgia*; when the whole head is affected *cephalæa*; and when on one side only, *hemicrania*. A fixed pain in the forehead, which may be covered with the end of the thumb, is called *clavis hystericus*. THERE are also other distinctions. Sometimes the pain is internal, sometimes external; sometimes it is an original disease, and at other times only symptomatic. When the head-ach proceeds from [...]. When from a cold phlegmatic habit, [...]. (Buchan <sup>2</sup>1772: 448)

In extract 5, Wallis defines and categorises *head-ach* as a «complaint» (both words representing the *genus*). Then, a series of more specific definitions (*differentia*) introduced by *if* or *should* conditional patterns follow: «if there

is a heaviness [...] if the whole head [...] should the pain attack». These patterns have the same function of *when*-definitions, that is to say they make the reader imagine a single empirical situation – possibly a well-known one – to grasp the concept expressed. The technical denominations *cephalalgia*, *cephalæa*, *hemicrania*, introduced by explicit linking formulae, such as «it is denominated [...] by way of distinction [...] it is called», come later. Convinced of the importance of using and explaining scholarly terminology, to be perspicuous and appropriate at a disciplinary level, Wallis includes etymology. In his preface, Wallis highlighted that the inclusion of the derivation of every term was absolutely necessary since «the terms themselves, once understood, are infinitely more expressive, and involve more ideas than any other which might be thought more familiar» (1793: x). The inclusion of etymology is not systematic in medical writings (unlike many lexicographic works, either universal or specialised dictionaries); however, it serves as a starting point to approach both lexical meaning and extra-linguistic events.

The focus shifts from the definition, to the scholarly denomination, and finally to the unfolding of the original meaning (etymology proper) and its morphological constituents (derivation). The passage underlines the movement from the medical situation or concept to the not-always-necessary linguistic detail. However, it is through precise language that medical notions can be communicated:

Example 5

CHAP. I.

§ I. HEAD-ACH.

In this complaint, [...].

If there is a heaviness and uneasy dull sensation, occasioning a pain in the head, as it was too full, internally distended, and overloaded, it is denominated CEPHALALGIA, from *kephalos*, caput, the head, and *algos*, dolor, pain;—and, by way of distinction, CEPHALÆA, if the whole head should not only be affected, but the pain be acute and violent, having severe exacerbations, or increase of severity on slight occasions, with spasmodic tension, and soreness of the integuments.

And should the pain attack either side of the head, chiefly at the temples, forehead near the eyes, and that should be violent, and often periodical, it is called HEMICRANIA, from *emisus*, dimidium, half, and *kranon*, caput the head. (Wallis 1793: 549)

The function of etymology in Wallis (1793) is, once again, well represented in the extract «OTITIS, or OTALGIA» below:

### Example 6

§ 2. **OTITIS, or OTALGIA**—from the Greek words, *ous*, auris, the ear; and *algos*, dolor, pain;—**INFLAMMATION OF THE EAR**. By this is meant an inflammatory state of the internal parts of the ear, whose membranes, from their being well stored with nerves, are extremely sensible; and from being attached to bones, feel pain very acutely. (Wallis 1793: 493)

In this case, the Latinised denomination *otitis*, or *otalgia* is directly followed by its Greek and Latin equivalents (derivation) «*ous*, auris [...] and *algos*, dolor», then translated by their English equivalents «ear [...] pain». Etymology is followed by the self-explanatory – and highly explanatory – translation equivalent «**INFLAMMATION OF THE EAR**», defined as «an inflammatory state of the internal parts of the ear». The approach is semasiological, from the topic-headword, that is from the denomination of the concept (disease), to the notion expressed by it. Denomination and definition are linked by etymological information, both origin and derivation. Wallis's definition is further expanded by a concise description of anatomical details, and later repeated in the subsequent section including symptomatological defining patterns (cfr. § 3.2.1).

The examples 1 to 6 have highlighted recursive elements used to organise medical contents in handbooks: denomination, definition, equivalence (translational and explanatory), and etymology. Some of them are frequently found in medical texts, even though they may be used differently: definitions in Buchan, Wallis and Black, or the order of constituents within similar paragraphs (denomination-equivalent-definition vs. definition-denomination-equivalent), or the amount of information included. Others are systematically used only by Wallis: this may obviously depend on the general aims of the reference works under scrutiny as declared in their prefaces, or by the target readership. The ideal reader is the average educated one for all of them, either expert or non-expert. However, among the members of this 'average audience' there may be some differences, which emerge from the different linguistic and stylistic strategies the individual writers choose: register, occurrence and frequency of familiar vocabulary and construction vs. technical terminology and morphological information.

#### 3.2.2. *DEFINING TERMS AND EXPANDING KNOWLEDGE: SYMPTOMOGRAPHY AND ELABORATE DESCRIPTIONS (GROUP B)*

**Symptomography: listing, clustering, and recording symptoms.** Symptomography, or symptomatological defining, is another relevant fea-

ture in structuring and communicating medical contents in handbooks and *practica*, as it is in dictionaries. It is mostly used to define and describe in detail the many *diseases*, *distempers*, *disorders*, *affections*, and *complaints* which medical practitioners, at any level, experimented in their professional life and tried to cure. Actually, listing, connecting symptoms, and recording them, is considered one of the major and useful resources to identify diseases. Professional recording of symptoms and their manifestation in time is then used to share individual experience within the emerging medical community. This procedure allows medical men to categorise – or, try to categorise – individual diseases, and group of diseases, according to symptomatological similarities and differences. These are the reasons why descriptions are extremely detailed, even overflowed by major and minor symptoms, as they can be observed – and perceived as relevant manifestations – by an expert eye. Symptomatological defining is thus extensively and systematically adopted by medical writers. They also adapt symptomography to their textual and discursive perspectives: symptoms may be simply listed (often used in dictionaries, or in very practical and quick reference works), or included in more complex structures describing and interpreting them according to their progression in time (disease process) and space (site of their manifestation and parts of the body). In this case, symptomatological defining merges with textual and discursive analysis, since symptoms are embedded within rhetorical and linguistic features which frame contents and determine their communicative issues. The following excerpts highlight how symptomography is used by medical writers in their handbooks, and how differently (as regards their quality and their quantity) symptoms may be included, introduced and discussed in practical texts, for essentially practical reasons.

The first text to be analysed (example 7) is the continuation of Black's excerpt (1788) exemplified in the section on glossing and concerning «pulmonick inflammation» (cfr. § 3.2.1., example 3). Following the opening sentences on the prevailing characteristics of the disease, the subsequent paragraphs focus on a myriad symptoms introduced by a general statement, «The symptoms of pulmonick inflammation are», which frames the whole section:

#### Example 7

*Inflammation of the Lungs and Organs of Respiration*, is a frequent inflammation in northern climates [...]. The symptoms of pulmonick inflammation are fever, darting pungent pain fixed like a dagger in some part of the chest, the side, breast, or back; and sometimes shooting to the scapula and clavicle: sometimes the pain is more dull and obtuse; and its situation oftenest in the

side, about the middle of the ribs, between the sternum and spine; and commonly confined to one lobe. At the invasion there is shivering, restlessness, anxiety, succeeded by heat: hot accelerated laborious respiration; load and oppression at the breast; urgent, short, and painful cough; and very early in the disease more or less expectoration, streaked with blood; the pain is exasperated by inspiration and coughing, and mostly fixed, but sometimes veering or shifting: the pulse quick, full, hard, and tense, like a stretched chord; the blood drawn forms a buffy tenacious crust on the coagulum; the urine is of a florid colour: from the violence of pain, patients are often unable to lay on either side, but compelled to recline half-erect on their backs: when the inflammation is violent, or both pulmonick lobes assailed, there is inexpressible anxiety and struggle in respiration, florid countenance, prominent eyes; with other symptoms of obstructed circulation, and return of blood from the head, and menacing suffocation. In the advanced or dangerous stage of the disease, the pulse is weak, soft, and irregular. Sometimes there is nausea of the stomach; and sometimes delirium.

The termination of pulmonick inflammation is by resolution, by suppuration, by gangrene, by fatal effusion of blood, or exudation of coagulable lymph into the cellular texture. (Black 1788: 142, 144-145)

The above excerpt includes major symptoms, such as fever, pain, shivering, restlessness, anxiety, heat, respiration, load, oppression, cough, expectoration, pulse, nausea, and delirium. However, they are neither simply listed, nor only presented to the reader in a broad, vague, or ambiguous manner. Most of them are pre- and/or post-modified by adjectives and participles specifying their nature: «darting pungent pain [...] fixed [...] shooting», «pain [...] dull and obtuse», «hot accelerated laborious respiration», «urgent, short, and painful cough», «more or less expectoration, streaked with», «pain [...] exasperated [...] fixed [...] veering and shifting», «pulse [...] quick, full, hard, and tense», «inexpressible anxiety», «obstructed circulation [...] return of blood [...] menacing suffocation», «pulse [...] weak, soft, and irregular». These phenomena emerge in time, and expressions such as «At the invasion there is» (starting point), «succeeded by» (second stage), «and very early in the disease» (third stage), «In the advanced or dangerous stage» (fourth stage), «The termination of pulmonick inflammation» (final stage) mark the process going on until a final stage, characterised by «resolution [...] suppuration [...] gangrene [...] effusion of blood» etc., takes place. These textual and discourse markers also frame and announce bodily transformations, «the blood drawn forms a buffy tenacious crust on the coagu-

lum», «the urine is of a florid colour», «florid countenance», «prominent eyes», necessarily modifying the patient's habits and behaviour, «patients are often unable to lay on either side, but compelled to recline half-erect on their backs», «struggle in respiration», etc.

The process is ultimately dramatised, the body becomes a stage where symptoms play their role: symptoms and bodily changes highlight the relevance of space, they emphasise the fact that the disease is located in the body, it moves from one site to another and eventually transforms the body as a whole, alongside its parts: «pain [...] in some part of the chest, the side, breast, or back [...] to the scapula and clavicle», «pain [...] in the side, about the middle of the ribs, between the sternum and spine; and commonly confined to one lobe», «load and oppression at the breast», «both pulmonick lobes assailed», «blood from the head», «nausea of the stomach», etc. Symptoms become relevant according to the time when and the site(s) in which they emerge: in this context, symptomatological changes should help the reader recognise the disease itself, and draw a map of what, where, and when something happens. Symptomatological defining is here definitely embedded in a complex and multilayered frame, except for the last paragraph of the passage on favourable symptoms:

Favourable symptoms are, as in anginous excretion, facility in expectoration, without much exertion or coughing, copious, of due consistence, a little yellow, white, thick, slightly streaked with blood; the sooner this is concocted and excreted, the sooner is the crisis; less urgent and painful cough; freer breathing; abatement in the heat of the body and velocity of the pulse; general perspiration; deposition of sediment in the urine; nasal hemorrhage; dispersion of the pain, hitherto fixed in the thorax, about the shoulders, back, or arms; erysipelas in some external part; pustular eruption about the breast, neck, and scapulæ; abscesses in different parts. [...]. (Black 1788: 145-146)

In this case, symptomography is mainly characterised by a sequence of nominal groups: a more simple and direct structure. However, here as before in the text, clustering of sub-units of meaning is used to detail information. At a morpho-syntactic level, this is achieved by the embedding of prepositional phrases: «without much exertion or coughing», «of due consistence», «in the heat of the body», «of the pulse», «of sediment in the urine», «of the pain [...] in the thorax», «about the shoulders», «in some external part», «about the breast», etc.

The excerpts analysed in the following section will instead focus on the progression of the disease and the discourse markers structuring the changing situation and process. If some features of that have already been put

forward in the previous example (especially time and space expressions), the ensuing excerpts will be essentially dealing with the network in which symptoms are embedded.

**Symptomography: the progression of symptoms in medical records.** This section focusses on symptomography as part of more complex medical expositions and commentaries. Symptomatology defining – the listing and clustering of individual symptoms – plays here a central role in the construction and in the communication of medical experience: symptoms are not simply used to identify and define single diseases. They are organised and discussed alongside their manifestation in real-life circumstances: their step-by-step progression, their changing nature, their impact on everyday life, on human feelings and sensations, on patients' expectations and practitioners' views. They are (re)contextualised within the frame of medical discourse – and as medical discourse – as a whole.

For reasons of coherence, the extracts below treat some 'diseases of the organs of respiration', as previous examples do. This will help easier comparison among them, and make elaborate textual structures and discourse strategies emerge more directly.

The first extract (example 8, -bis, -ter) is drawn from Millar's *Observations on the prevailing diseases in Great Britain* (1770). The section devoted to «*Pleurisy and Peripneumony*» opens with an evaluative comment on previous records and discussions of the disease: the point is their excessive details, «affected precision [...] minute divisions [...] particular symptoms [...] distinctions [...] so minute or equivocal [...] subdivisions», which seem to «perplex» the reader rather than «elucidate the subject» (Millar 1770: 15). Detailed lists – and clusters – of simultaneous and minute symptoms are typical of symptomatology defining or symptomography.

On the contrary, Millar prefers an alternative approach. He highlights a different level of disciplinary – if not only personal – awareness in treating diseases, and in identifying their salient features, «the obvious, essential, and characteristic signs, [...] common to all of them». According to him, more consistent methods of inclusion vs. exclusion in symptomatology defining would stimulate «a more accurate knowledge» and «a more successful method of cure»:

### Example 8

CHAP. III.

*Of the Pleurisy and Peripneumony.*

SECT. I.

*Description of the Disease.*

THE love of novelty, or an affected precision, hath given rise to

many minute divisions in treating of the pleurisy, which tend rather to perplex than elucidate the subject. Distinctions have been made according to the different parts affected; particular symptoms have been attributed to an inflammation of the pleura, the lungs, their membranes, the mediastinum, and the intercostal muscles: but if such distinctions really exist, the signs of them are either so minute or equivocal, as to elude the investigation of attentive observers; and it will, perhaps, lead to a more accurate knowledge of the disease, as well as a more successful method of cure, to lay aside these subdivisions, and to view carefully the obvious, essential, and characteristic signs, which are common to all of them. (Millar 1770: 15)

This clearly represents a more specialised attitude in clinical observation and in the record of symptoms (as *signs*): reliability does not depend on long lists or clusters of indistinct – and decontextualised – items, but on their structuring function in the progression and development of the disease itself. Selection and contextualisation are the principles on which his approach is strictly based. Not all the perceived (patient) and observable (practitioner) symptoms are responsible for disease identification, control, and cure: not all of them may be considered as *signs*. Symptomography is integrated into an elaborate descriptive and informative record of the disease (example 8-bis). Symptoms are often preceded by explicit comments on their status, «constant attendant is a violent pain [...] essential to the disease», and on their possible – but still essential – variants, «sometimes accompanied with a hard cough», «generally introduced with coldness and shuddering», «sometimes attended with more deceitful appearances». Moreover, before foregrounding the consistent symptoms of pleurisy, Millar establishes the real life circumstances – and shared experience – in which the disease may emerge:

#### **Example 8-bis**

When a person, after breathing in a close room, where the air has been much heated, or drinking warm liquors, imprudently exposes himself to the violence of a keen, cold air, he is sometimes seized suddenly with a pleurisy, or peripneumony. The constant attendant of this complaint is a violent pain in the back, sides, or breast, darting through the chest, or toward one or both shoulders. This symptom, which is essential to the disease, is sometimes accompanied with a hard cough, which the patient endeavours to suppress, because it increases the pain. It is generally introduced with coldness and shuddering, but sometimes

the pain continues for some hours before the rigor is felt. The breathing is affected from the beginning, but becomes gradually more difficult in the progress of the disease. The pulse is quick, hard, and full; the face much flushed, the patient's rest disturbed, and being unable to shift to either side, he is obliged to lie on his back, or to sit erect.

Unless proper remedies are speedily applied, these symptoms gradually increase. [...]

But the disease is sometimes attended with more deceitful appearances; the violence of the symptoms is mitigated; and an inexperienced practitioner will be apt to pronounce his patient out of danger, when a very different termination is quickly to take place. (Millar 1770: 16-17)

Major symptoms, «violent pain in the back, sides, or breast, darting through the chest, or toward one or both shoulders», «hard cough, which [...] increases the pain», «coldness and shuddering», «breathing is affected [...] difficult», «pulse is quick, hard, and full», «the face much flushed», «the patient's rest disturbed», are structural to the disease and always present, «constant [...] essential», but they may vary according to the 'time when' they unfold, «from the beginning [...] becomes gradually [...] gradually increase [...] termination». The same symptoms are also defined according to the 'place where' they typically manifest themselves: the disease is mapped within the patient's body, «back, sides, or breast [...] chest [...] shoulders [...] pulse [...] face», and the progression is defined according to a complex network of elements (symptoms-signs, time, space) which combine and interact at textual and discourse levels.

Millar's presentation and discussion of pleurisy and peripneumony concludes with a study case section, the experimental, empiric side of medical discourse. This section provides a concrete situation and offers the author the possibility to exemplify his professional experience («I» as professional eye-witness, professional gaze) as a practitioner:

### **Example 8-ter**

#### CASE II.

In my early practice I was desired to visit a man of 60, who had laboured under a pleuritic fever for seven days, without being blooded, or taking any medicine. His pulse was hard, full, and quick; his breathing laborious, his breast violently pained, and he coughed almost incessantly. As the disease was too far advanced to be removed by the common methods, after bleeding

and applying a blister, a tea-spoonful of the antimonial wine was prescribed every four hours. The first dose excited a gentle diaphoresis, which greatly alleviated the severity of the symptoms, and gave the patient so good an opinion of the medicine, that he greatly exceeded the quantity prescribed, and took no less than an ounce of the wine in twelve hours. It sweated, vomited, and purged. In the morning his pulse was soft and regular, he breathed easily, the pain vanished, and no complaint but weakness remained. (Millar 1770: 34)

The same essential symptoms, «pulse [...] hard, full, and quick», «breathing laborious», «breast violently pained», «coughed [...] incessantly», introduced at the beginning are thus (re)contextualised in a narrative frame: symptomography/symptomatological defining adapts to new contexts of use and to different text types. It actually becomes a fundamental component in Millar's medical discourse.

The second extract (example 9, -bis) belongs to Fisher's *The practice of medicine made easy* (1785), a work for quick reference and immediacy of use for the practitioner. The macro-structure of the work partially reflects the organisation of dictionaries and encyclopaedias: the micro-texts devoted to individual diseases are in alphabetical order and are similar to lexicographic entries or, rather, encyclopaedic entries. Under the headword-disease, a series of titled sub-sections follow, usually treating «Symptoms», «Unfavourable symptoms», «Regimen» (healthy lifestyle habits) and «Medicine» (cure).

The headword «PLEURISY» – introduced by the equivalent expression *inflammation of the pleura* – exemplifies this usual and recurrent scheme. The entry opens by introducing the most typical symptoms and their progression in time: personal comments, or methodological hints, framing meta-discourse as in Millar's (1770: 15 ff.) «The love of novelty, or an affected precision, hath given rise to [...] Distinctions have been made according to [...] When a person, after breathing in a close room [...] In my early practice I was desired to visit», are omitted.

Fisher goes immediately to the point highlighting the gradual appearance of symptoms and their development: «begins with cold [...] succeeds heat [...] thirst and restlessness [...] after these [...] a violent pain [...] pain considerably increased by [...] quick, hard, and full pulse [...] high coloured urine, and a cough». He also highlights the changing nature of symptoms, their movement in space, «sometimes [...] in one side [...] in the other [...] under the [...] towards the [...] sometimes lower», and time, «sometimes in the beginning [...] and often», up to the most dangerous manifestations, appearances, and signs of the disease. It is at this stage that the unfavourable symptoms unfold, rapidly succeeding each other, and definitely leading to a «delirium»:

### Example 9

#### INFLAMMATION OF THE PLEURA, OR PLEURISY.

Symptoms. The disease begins with cold, to which succeeds heat, thirst and restlessness, after these the patient perceives a violent pain in his throat or breast, sometimes in one side, sometimes in the other, sometimes under the sternum or breast-bone, sometimes towards the back or shoulders, but most frequently in the side about the sixth or seventh rib, yet sometimes lower. The pain is considerably increased by drawing in a full breath. There is a quick, hard and full pulse, high coloured urine, and a cough sometimes in the beginning of the disease dry, and without expectoration of matter various in thickness and colour, and often streaked with blood, and the blood when drawn from a vein is covered with a tough crust or buffy coat.

Unfavourable symptoms. The breathing very difficult, the cough very violent, without expectoration, sweats about the head and neck, a flushed face, an irregular pulse, and a delirium.

Regimen. [...] (Fisher 1785: 125)

If in the first section major symptoms are provided and contextualised in a descriptive and well-balanced text, with a few expansions introducing some symptomatological details, «sometimes [...] but most frequently», «by drawing in», «dry, and without expectoration», «various in thickness and colour», «often streaked with», «covered with a tough crust», the paragraph on unfavourable symptoms is extremely concise, characterised by a more direct and essential approach which suggests clinical severity, and simulate its degenerating process in a sequence of juxtaposed noun and adjective phrases, separated by commas. Hence, symptomatological defining adapts to the changing needs of medical discourse and its textual organisation. The two sections are strictly related to each other: the first, setting the scene; the second, providing further developments. Later on, both of them converge into the last section, dealing with the method of cure:

### Example 9-bis

Medicine. Bleeding largely is the principal remedy in this disease. It should be repeated according to the strength of the patient, and urgency of the symptoms. [...] Bleeding is generally more requisite and advantageous during the first three days of the disease, but yet it is necessary at any period or time of the same, if the symptoms of a hard pulse, violent pain, and great difficulty of breathing, require it. When the pain abates, the

pulse growth softer, the breathing freer, and the expectoration copious, bleeding should be no more repeated. To prevent the difficulty of passing urine [...]. To promote expectoration [...]. If the body be bound, a clyster of barely water [...]. If the patient's skin is very hot and dry [...]. When the disease is far advanced, and the difficulty of breathing is abated, and yet the cough continues urgent with want of sleep, [...]. When the disease is over, and the patient has recovered a little strength, his diet should still continue for some time to be light [...]. (Fisher 1785: 126-128)

This paragraph gives Fisher the opportunity to restate and reorganise major symptoms – and symptomatological defining – in a new textual and discursive frame. The perspective is one of recovery and prevention, in which remedies obviously depend on the «urgency of the symptoms», such as «symptoms of hard pulse, violent pain, and great difficulty of breathing», and their gradual decrease, «When the pain abates, the pulse growth softer, the breathing freer», etc. Symptomatological defining is thus used to re-elaborate and modulate the same symptoms in new circumstances. The same elements are recombined in a positive background.

### 3.3. CHAPTER SUMMARY

The publication of medical handbooks and compendia noticeably increases in the second half of the eighteenth century. This fact testifies to a steady growth of interest in medical writing for an audience of experts and non-experts, and an expanding medical awareness both in society as a whole, and in emerging disciplinary communities of professionals. The prefaces to some of these reference works emphasise the expanding role of a practical, 'experimental' approach focussed on useful observation of medical facts, on faithful descriptions of diseases, and on the need to communicate medical experience among physicians and practitioners.

This new interest influences the structure of reference works, the linguistic features, and the construction of medical discourse as a whole. Materials may be arranged in alphabetical order (ex. Fisher 1785) for quick reference, others are usually organised around groups of diseases sharing causes and essential characteristics. Definitions are commonly used to introduce the topic-disease, sometimes etymology is included with the same function. Descriptions and explanations focus on the main topic-disease, and usually include expository sections in which the observations are elaborated and generalised (passive voice, linking verbs, topicalisation, nominalisation, etc.). Situation-dependent circumstances – or, case studies – are also included to provide evidence of previous experience. These situation-bound

texts usually display a high degree of personal involvement (ex. personal pronouns), and testify to the process of discovery through eye witnessing and decision-making (dynamic verbs, present or past tense, active voice, narrative text type, time and space markers).

## 4.

### CASE STUDY: FEVER IN DICTIONARIES AND HANDBOOKS

Fever is a term that pervades eighteenth-century medical texts and represents a very common and widespread medical experience in early and late modern times. This is one of the main reasons for fevers to be treated extensively by medical men trying to establish their causes and effects, describe their external manifestations (symptoms), and determine their typical signs (peculiar to each type of fever). The complexity and the variety of febrile experience, the multifarious environmental contexts in which fevers manifested themselves, the influence of climate and, not least, the partial overlapping with contagious and infectious diseases made it difficult to provide a clear-cut set of features and straightforward treatments. Observation and research were in progress, and medical writers documented all this in their effort to define, categorise, classify, predict, and prevent diseases, as well as to inform and instruct their readership. Besides medical handbooks and compendia, medical dictionaries and universal dictionaries of arts and sciences, fever is widely documented in contemporary dictionaries of the English language. Lexicographic evidence, alongside the extensive treatment of the term *fever* in specialised and general reference works thus testifies to the impact fevers had in civil society and in emerging disciplinary circles. The term carried with it a huge referential load of shared human and medical experience, pointing to scaring mass epidemics or isolated, more confined, episodes. It was difficult to interpret the term, because fever itself was a complex experience to delimit: a *distemper* (slight disease), a *disease*, a *disorder* (cfr. Lonati 2013: 107-109). Martin (1749), Johnson (1755), and Scott-Bailey (1755), the most relevant mid-century dictionaries, provided their definitions:

**Martin (1749):** FE'VER (of *febris*, L. of *ferveo* to be hot) a distemper accompanied with great heat and thirst. [...]

**Johnson (1755):** FE'VER. n.s. [*fièvre*, French; *febris*, Latin] A disease in which the body is violently heated, and the pulse quickened, N° LIV. or in which heat and cold prevail by turns. It is sometimes continual, sometimes intermittent. [...]

**Scott-Bailey (1755):** FE'VER [*febris*, Lat. ...] a disorder very differently defined by physicians: as, a strenuous endeavour or effort of nature to throw off some morbid matter, that incommodes the body. *Sydenham*. A velocity of the blood; a fermentation or great motion of it, with heat [and] thirst. *Quincy*. A disease wherein the body is violently heated, and the pulse quickened, or in which heat and cold prevail by turns.

How much better is that definition which Boerhaave has given? A swifter *contraction of the heart* than usual, joined with an *increased resistance* at the *capillaries*, completes the idea of every *acute fever*. Boerhaave's Aphorisms, 581. [...]

These definitions reveal the coexistence of traditional and innovative perspectives. On the one hand, fever is considered as a *distemper-disease-disorder* itself, with its own typical symptoms: violent heat and accelerated pulse. On the other hand, it is an effort (a strategy, a function, an effect) to eliminate «some morbid matter, that incommodes the body» (Scott-Bailey 1755).

Fever had traditionally been considered as a disease characterised by an excessive bodily heat. However, the perspective changed in the first decades of the seventeenth century, with the publication of Harvey's *De motu cordis* (1628). It is in this period that «heat came to be regarded more as an effect than a cause of fever» (Harrison 2010: 29). Sydenham (1624-1689) and his empirical attitude to medicine is another key point in approaching, describing, and curing fevers, since «he insisted that the only sound basis for knowledge was observation [...] experiential, practical medicine» (Harrison 2010: 31), besides considering climate and environment two relevant key factors in spreading diseases.

This interest in climate and environment is particularly widespread and developed in handbooks, and is based on practical experience in performing medicine. While treating fevers, for example, Grant and Clark emphasise both factors:

[...] I have endeavoured to describe the specific differences of fevers at different seasons of the year, and the different treatment required for the cure of diseases nominally the same; with some occasional observations on the fatal effects of the general practice of treating them indiscriminately. (Grant 1771: i-ii)

[...]

I shall then proceed to give an account of each of the common fevers, in a few words as possible, in the same order in which they succeed each other in the course of the year. (Grant 1771: xv)

or

After several years careful attention to the symptoms and nature of fevers, as they have occurred in different climates, I freely confess that I have never been able to follow authors through their numerous divisions and subdivisions. [...] fever is essentially the same, or, in other words, consists only of one *Genus*; [...]. (Clark 1780: 6)

or, again, with the focus on combined environmental causes

To communicate what I know of this matter, I have divided all fevers into two classes: the first I call common fevers; because they happen regularly every year, and seem to be the natural production of this climate, and of the manner in which we have lived for at least twenty years. The second I call uncommon or pestilential fevers; because they are not the constant and natural production of our climate, but are either of foreign importation, or the necessary consequence of some extraordinary combination, and produced in a gaol or hospital, by bad water, bad provisions, or some other cause, co-operating with the climate, and usual manner of life. (Grant 1771: 426-427)

The study of fevers was also disseminated in the colonies: many reports from surgeons and practitioners working abroad, in faraway countries, constituted a fundamental stimulus to an in-depth investigation of febrile manifestations in the mother country. These contributions led to a more detailed and systematic distinction among them. Causes and effects started to be separated and ascertained, and individual, accidental symptoms to be distinguished from essential symptoms, or signs. Fever itself was sometimes considered as a symptom, or sign, of some other disease.

As a consequence, the term *fever* – and *fevers* as medical events – will be investigated in lexicographic works (universal dictionaries of arts and sciences and medical dictionaries), as well as in handbooks and compendia (*practica*) as a case study to make the lexicographic (and lexicological), textual and discourse features emerge (cfr. Ch. 0. § 0.2.)

*Fever* represents – and carries with it in the imagination of eighteenth-century society – an appalling experience. It was, indeed, a widespread condi-

tion whose causes, more often than not, were difficult to discern: sometimes being just mild distempers, sometimes belonging to very dangerous contagious and infectious diseases.

*Fever* is treated in each of the four dictionaries under scrutiny, notwithstanding the difference in extension (some are actually inflated entries) and complexity among them: in the *MD* the entry *Pyretos* covers forty in-folio pages, followed by *RCy*'s *Fever* (fourteen in-folio pages), the *EB*'s section «*Of FEVERS*» s.v. *Medicine* (twenty-three in-quarto pages, 60-83), and the *NMD*'s *Febris* (two in-folio pages).

Some extracts of the lexicographic entries are compared and commented on in the following sections to highlight the definitional practice, the encyclopedic load (inclusion criteria, detailed information, sub-entries, etc.), the rhetorical and discourse strategies used by the compilers in the organisation of their (selected) contents.

Fever is also treated as a general disease (*of fevers in general*) and as a specific disease (*nervous fever, miliary fever, putrid fevers*) in handbooks and compendia. The most interesting reference works on this topic are Millar's (1770), Grant's (1771 and 1775), Buchan's (1772), Sims's (1776), Clark's (1780), Black's (1788), and Wallis's (1793). The introduction and the discussion on fever in handbooks, and the analysis on a selection of extracts are provided here below.

#### 4.1. ESTABLISHING A UNIT OF MEANING: GLOSSING, DEFINING, AND EXPANDING *FEVER* IN THE *EB*, *RCY*, *MD*, AND *NMD*

The starting point is the headword and its form: the two general dictionaries of arts and sciences use the anglicised and more familiar version of the term, that is to say *fever(s)*. The *NMD* chooses the Latin version *febris*, and the *MD* the latinised Greek version *pyretos*. The Latin and Greek forms are both followed by the English equivalent *fever*. The choice of the classical languages clearly suggests their specialised approach and audience, and the technical lexicalisation of this widespread medical event (variously defined as *disease, disorder, affection*, etc.).

The *EB* discusses *fever(s)* in a section included s.v. *Medicine*, and follows Dr. Cullen's subdivision of diseases as they appear in his *Synopsis nosologia methodica* (1769). The headword here functions as a caption. In the other dictionaries the term *fever/febris* is regularly found in its proper alphabetical order. All the entries open with a lexical definition: *fever* is said to be «a spasmodic affection» (*EB*), «a disease, or rather a class of diseases» (*RCy*), «a very frequent Disorder» (*MD*). Establishing the relationship *fever~affection~disease~disorder* means to conceptualise it as an independent entity, having the 'status of'. Fever is essentially defined by *genus-differentia*

categorisation ('a kind of' *affection, disease, disorder*). The *NMD*, instead, defines it as an event, a dynamic process, something happening to the body in time, «is when the natural heat of our bodies is converted into a fiery heat» (*NMD*). The emphasis is placed on time (process) and on space (the body), what can be observed, the external phenomenon (not the nature of it). This difference in defining the topic-headword implies a different conceptualisation of *fever(s)* and a different medical perspective. *RCy* and the *MD* have a more traditional approach, since they identify *fever* with a disease or disorder of its own: this may partly depend on their issue date, the *MD* in the 1740s, whereas *RCy* in the second half of the century, but as a partially updated version of Chambers's *Cyclopaedia* (1728). Their definitions seem to reflect their more conventional medical perspective. The attention on *fever*, and the interpretation of it as an effect, a consequence of some other *affection, disease, distemper, disorder*, is definitely established only later in the century. This new conceptual focus emerges in the *EB* – «spasmodic affection»<sup>9</sup> highlights a process, not necessarily a disease – and the *NMD*, which exploits a *when*-defining strategy. This apparently new perspective is the evidence of existing, but not yet mainstream, ideas. Things become clearer in each dictionary further on in the entries. Lexical definitions moderately expand to better contextualise the topic:

*Of FEVERS in general.*

HOFFMAN defines a fever to be, «A spasmodic affection of the whole nervous and vascular system, annoying all the functions of the body, arising from any cause which has power to irritate the nervous parts to a more intense contraction; [...]». (*EB* s.v. Medicine)

FEVER, FEBRIS, in *Medicine*, a disease, or rather class of diseases, whose characteristic is a preternatural heat felt through the whole body, or, at least, the principal parts thereof, attended with other symptoms. (*RCy* s.v. Fever)

FEBRIS. A Fever. See the Articles CATHARTICA, DEPURATORIA, MILLIARIS, and PYRETOS.

[...]

PYRETOS, πυρετός. A Fever.

A Fever is a very frequent Disorder, inseparably attended with an Inflammation, the Cause not only of many Diseases and Death, but, also, frequently of an happy and successful Cure. (*MD* s.v. Pyretos)

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<sup>9</sup> In his *Dictionary* (1755), Johnson defines *affection* as «7. State of the body, as acted upon by any cause».

FEBRIS. A fever. A fever is when the natural heat of our bodies is converted into a fiery heat: or it is when the heat in the body is increased, the pulse is quickened beyond its natural speed, and some one or more of the functions are disordered. (*NMD* s.v. Febris)

Once again, the *EB* and the *NMD* reveal their modernity – both being published in the Seventies – for the details they introduce: in this expansion, the *EB* considers *fever* as a consequence of «any cause which has the power to irritate the nervous parts». Studies on nerves and their irritability were lately carried out by Dr. Cullen, whose *Synopsis* is used as a basis for the classification of diseases in the article Medicine. The *NMD* just focusses on the characteristic signs of a *fever* and on functional physiological disorders. *RCy*, as above said, considers *fever* as a disease of its own and adds the general symptoms; whereas the *MD* goes even further, considering it as the cause of many diseases. These are traditional perspectives and, as regards the *MD*, in open contrast with the *EB*. These expanded definitions are followed by further expansions. These concise expansions are particularly interesting because, besides their contents, they highlight textual and discursive strategies, which can be found in the rest of their respective entries.

The *EB* focusses on the physiological process, the observable phenomena stimulated by a fever, of any kind. The process is expressed in the present tense and framed within the structure «when [...] and afterwards, when [...] with rapidity [...] till». Most of the verbs used are in the passive voice, except for «it operates, it drives [...] vanishes», typical of not involved, more objective and focus-on-the-topic rhetorical strategies: «are increased [...] are drove back [...] constricted [...] being relaxed [...] are performed». Adverbial expressions concerning manner are reduced to a minimum and bound to the process explained: «with rapidity». What follows concludes the opening definition, which is a quotation attributed to Hoffman:

and when it [*fever-spasmodic affection*] operates, it drives the vital fluids from the outward parts to the heart and great vessels; and afterwards, when the systole of the heart and arteries are increased, they are drove back with rapidity and heat, through the constricted vessels, to the outward parts again, till the spasms being relaxed, the secretions are performed, and the fever vanishes. (*EB* s.v. Medicine)

*RCy* has a completely different focus: Rees continues the entry providing alternative definitions, ascribed to Sydenham, Quincy, and ‘others’. The outline of the various kinds of fevers and their categorisation follows, according to their causes, duration, and symptoms. Different proposals for classifica-

tion are attributed to different physicians. Verbs are mostly in the present tense and active voice. They simply ‘tell’-inform the reader of alternative approaches, strictly dependent to and identified with the physicians cited and their thoughts. The focus, thus, shifts from the topic *fever* to the physician-scholar, a kind of story-exposition of the *disease* by ensuing defining steps:

Sydenham defines a *fever*, a strenuous endeavour or effort of nature to throw off some morbid matter that greatly incommodes the body. Quincy defines it, an augmented velocity of the blood; others, a fermentation of the blood, accompanied with a quick pulse and excessive heat.

*Fevers* are of various kinds, denominated and distinguished from the particular causes that produce them; the time they continue; their accesses and returns; and their different symptoms.

Riverius reckons above thirty different kinds of *fevers*; and Sydenham has increased them to double that number; but certainly physicians have observed something common to all these diseases, which made them denominate *fevers*. [...] (RCy s.v. Fever)

Alternative definitions and perspectives are also introduced in Motherby’s *NMD* but, in this case, attribution is not included and the focus remains on *fever*. Expressions such as «It hath generally been said [...] and this is said to be [...] but, this does not appear to be the case» help depersonalise the whole paragraph, emphasising conceptual abstraction and rhetorical-stylistic elaboration. The prose is neat and the verbs used are, more often than not, linking verbs plus complement, «is an effort [...] is no other than [...] is the surest and most rational», non-finite verbs, «to remove or expel [...] to restore [...] abating [...] removing», or in the passive voice, «to be proved [...] it was caused». The *NMD* also reiterates the idea that *fever* is just a symptom of another disease:

It hath generally been said that a fever is an effort of nature to remove or expel some morbid matter from the blood, and so to restore health, and this is said to be proved by eruptive fevers abating when eruptions appear on the skin; but this does not appear to be the case, for the fever is no other than a symptom, which increases and protracts the disease; and an immediate extinction of the fever, if possible, is the surest and most rational method of removing the disorder by which it was caused. (*NMD* s.v. Febris)

The *MD* places instead its attention on the tricky nature of *fevers* and introduces a more evaluative and involved section, reflecting a complex flow of thoughts and complex situations to interpret and solve. Morpho-syntactic

features reflect this complexity since they are characterised by many turns, prepositional phrases (particularly post-modifying units embedded one into the other), subordinate clauses, sometimes in initial position, such as «As the Nature of [...] That such Errors may be avoided», and hypotactic and paratactic units, as well as digressions, within the same sentence. This syntactic structure slows reading down and makes it more difficult, since the text – and the message it carries – results in being less consistent, though ‘dense’ in ideational load. The appeal to cohesive and coherent elements is intermittent because of the changing focus of attention and the many secondary elements ‘scattered’ in it. Another interesting feature is the great amount of adverbial expressions of manner, emphasising the evaluative attitude and the more involved perspective in comparison with the preceding compilers. Thus, for example, expressions such as «an highly latent [...] the more carefully to guard [...] Errors are easily fallen into [...] is generally attended [...] duly discovered [...] maturely weighed», are common:

As the Nature of this Disorder is of an highly latent and concealed Kind, so we ought the more carefully to guard against Mistakes and Errors in investigating it.

But, in a Research of this kind, Errors are easily fallen into, in consequence of the large Train of Symptoms, with which this Disorder is generally attended, and without which, however, there may still be a Fever.

That such Errors may be avoided, it is necessary, from among numberless Symptoms, to select those Phenomena alone, which always accompany every Fever; from the Presence of which Physicians know, that a Fever is present; and from the Absence of which they conclude, that a Person is free from a Fever.

Then, from the Symptoms and Phenomena, duly discovered, are maturely weighed, the particular Nature of the Fever is to be found out. (*MD* s.v. *Pyretos*)

The text also reveals an argumentative nature, typical of debate: reasoning is disclosed, and logical passages are marked by junctions (coordination and subordination) and adverbials. These are *as ... so*, *but*, *in consequence of*, *and*, *however*, *then*: from the general assumption, «as [...] so», to the general consequence, «then».

The in-depth encyclopaedic treatment, and the more technical and detailed exposition of *fever(s)*, their classification, their signs and symptoms, their causes, their possible remedies, and their progress in time, are developed further on in the lexicographic entries (or monographic article for the *EB*). The next section will discuss (some of) these aspects as systematised in the four dictionaries.

#### 4.2. EXPANDING MEDICAL CONTENTS S.V. *FEVER* IN THE *EB*, *RCY*, *MD*, AND *NMD*

This section is devoted to the analysis of a selection of encyclopaedic contents included in the four dictionaries s.v. *Fever(s)*, *Febris*, *Pyretos*. Particularly relevant – and always present – are the symptomatology (the symptom complex of fevers) and the categorisation of fevers. Both aspects, symptomatology and categorisation, are treated and displayed in the dictionary entries in various ways. As regards symptoms, sometimes they are treated in general terms, sometimes divisions and subdivisions are included according to the many kinds of fevers. The sections devoted to symptoms and categorisation provide an overview of the lexicographic techniques (and practice), and of the textual strategies – rhetorical and stylistic – used by the compilers.

##### 4.2.1. *SYMPTOMOGRAPHY: LISTING, CLUSTERING, AND RECORDING SYMPTOMS*

The section on symptoms may be considered as an extension of definitional practices: actually, symptoms – also variously called signs or phenomena – help delimit the clinical manifestations of fevers and make them easily recognisable to the medical practitioners. This is the reason why most of these symptomatological sections follow the general definitions and concise expansions, which usually create the background for further information.

Before introducing the symptoms (symptomography, or symptomatological defining), the *EB* cohesively repeats, with some variation, the initial definition as a general cause: the «formal or fundamental cause of a fever consists in the spasmodic affection of the whole nervous and fibrous genus», immediately followed by the «usual phænomena» (to be read, the *usual symptoms*) attending it. Most of the symptoms listed point out a physiological state, «a pain [...] a coldness [...] a livid colour [...] a subsidence [...] a livid countenance [...] a sensation of» etc.; a more limited group, instead, highlights a physiological process going on, «a shivering, shaking, trembling [...] a yawning; a stretching; [...] a trembling and palpitating motion», all of them observable manifestations (phænomena and symptoms) of the *fever*, «spasmodic affection». These nominal groups, whose heads are nouns or nominalised verbs, may include further details: these are adverb phrases such as «more particularly about the loins» (pain), «especially of the extreme parts» (coldness) following the noun phrase, separated by a comma; whereas post-modifying prepositional phrases follow the head and are embedded within the noun phrase, such as «in the back», «of the nails», «of the vessels of the hands and feet», «of the heart», «of the præcordia», «of the blood about the heart», etc. This collection of symptoms, along with the accumulation and inflation of details by the use of adverb(ial) and prep-

ositional phrases, makes the sequence conceptually dense, within a simple sentence structure: the only verb is «appears» in the main (and only) clause.

*Of FEVERS in general.*

HOFFMAN defines a fever to be, [...]

The formal or fundamental cause of a fever consists in the spasmodic affection of the whole nervous and fibrous genus. This plainly appears from the usual phænomena of a fever, *viz.* a pain in the back, more particularly about the loins; a coldness, especially of the extreme parts; a shivering, shaking, trembling; a livid colour of the nails; a subsidence of the vessels of the hands and feet; a shrunk, dry skin; a yawning; a stretching; a pale, livid countenance; a trembling and palpitating motion of the heart; an anxiety of the præcordia, difficult breathing, inquietude, restlessness; a sensation of an ebullition of the blood about the heart; a contracted, weak, small pulse; a nausea, and an inclination to vomit; a suppression of perspiration; costiveness, with thin watery urine. (*EB* s.v. Medicine: 60)

This symptomatological definition – overlapping with the whole sentence-paragraph – is immediately followed by another section dealing with possible general causes of fevers: «Hence [...] whatever has the power to irritate and solicit the nervous and vascular system to spasms» (cfr. below), can generate fevers. Once again, in this introductory sentence, cohesion is established lexically, by repeating (with variation) the key terms or multiword expressions already used: «the nervous and vascular system to spasms» (cfr. «spasmodic affection of the whole nervous and vascular system», opening definition; «spasmodic affection of the whole nervous and fibrous genus», first definitional repetition, above, previous paragraph). A detailed list of possible causes is provided with the same strategies used for listing symptoms: noun phrases, pre- or post-modified, such as «violent passions of the mind», «a poisonous, subtle, caustic matter», «a stoppage of perspiration», «a suppression of critical sweats; eruptions», etc. follow each other, as before. Some nominal groups are more complex than others, this happens when noun phrases embed non-finite clauses (or, reduced relative clauses, here in italics) to post-modify the head: «caustic matter, either *bred* within the body, or *received* by infection», «an abundance of purulent ulcerous matter *adhering* to various parts», and «corrupt and bilious crudities *lodged* in the primæ viæ». The overall effect is one of conceptual density reflecting a complex and ever changing physiological condition:

Hence it naturally follows, that whatever has a power to irritate and solicit the nervous and vascular system to spasms, is most

likely to generate a fever. To this class belong violent passions of the mind, especially terror and anger; a poisonous, subtle, caustic matter, either bred within the body, or received by infection; a stoppage of perspiration; a suppression of critical sweats; eruptions driven back; an abundance of purulent ulcerous matter adhering to various parts; aliments too acrid and sharp; corrupt and bilious crudities lodged in the *primæ viæ*; excessive watching; a violent pain and tension of the nervous parts by sharp instruments; acrid and corrosive drugs; cold baths, and, on the contrary, those that are too hot or astringent. (*EB* s.v. *Medicine*: 60)

*RCy*, similarly to the *EB*, repeats with variation one of the aspects already introduced in the expansion to the definition proper. The expansion includes some considerations on the denomination and distinction of fevers, based on «the particular causes that produce them» (*RCy*, s.v. *Fever*, cfr. § 4.1. above). Here, the focus shifts «on every *fever* from an internal cause» whose characteristic – and always present – three general symptoms are «trembling, [...] heat and quick pulse». These «three chief observables» are framed into a temporal sequence, «first [...] and then», and thus presented as a process. Further explanation of the process follows, expanding the key features of fevers and their manifestation, «cold or shivering [...] pulse [...] quicker». What happens – the narrative process – is highlighted by dynamic verbs in the present tense, «begins [...] affords», or in the present participle, «growing». This section ends with an evaluative statement on the presumed function of fevers, «The health [...] seems to be the primary aim of»:

FEVER, FEBRIS, in *Medicine*, a disease, or rather class of diseases [...].

In every *fever* from an internal cause, the three chief observables are these: first, an universal trembling, and then an increased heat and quick pulse: a *fever* almost always begins with a cold or shivering; and soon after, the pulse growing quicker, affords the primary diagnostic of a *fever*. The health of the patient seems to be the primary aim of nature in *fevers*, though they often terminate in death. [...] (*RCy* s.v. *Fever*)

The detailed symptomatological section comes further on in the entry and is titled as «FEVERS, *signs of*»: this section may be further divided into sub-sections according to its contents and the way they are communicated to the reader (descriptive vs. narrative). It opens with a presentation and description of the most common *signs*, «accelerated progressive motion of the blood», «quickness of the pulse», «an increased heat in the body»: each

of them is pre- and post-modified by prepositional phrases, mostly introduced by «of the», «by the», «in the», or reduced relative clauses, «of the blood, distinguished by», to create complex and dense units of meaning. The progression from one *sign* to the other is guaranteed by the use of anaphoric demonstratives, linking together in a sequence the different steps «signs of. These are [...] quickness of the pulse; this is [...] increased heat [...] immediately after this the tonic motion of the parts [...]. This is seen», and is definitely summarised by the expression «these symptoms are succeeded by», introducing the long and more detailed list of symptoms, or symptomography:

FEVERS, *signs of*. These are an accelerated progressive motion of the blood, distinguished by the quickness of the pulse; this is succeeded by an increased heat in the body, and immediately after this the tonic motion of the parts is either constricted or relaxed. This is seen in the face: in the first case, it becomes red and bloated; in the latter, thin and pale: these symptoms are succeeded by an immoderate thirst, and a loathing of food of all kinds; an absence of sleep; and a peevishness or uneasiness in the temper, with an extreme sensibility of every thing, and a neglect of the common business of life: after this there is a great loss of strength, and an inaptitude to any motion; a sensation of pain in some part; a very uneasy and difficult respiration; a sweating more than usual; and finally, there is a change in the urine, its colour being usually very high, and its consistence thicker than that of persons in health. (RCy s.v. Fever)

Symptomatological defining (McConchie-Curzan 2011: 85-86) is here characterised by a series of noun phrases starting with «immoderate thirst» and closing with «in health», and is articulated into three phases: «these symptoms are succeeded», «after this there is», and «finally, there is», the temporal frame, delimiting the nominalised process is almost always present. Sometimes, these nominal groups are pre-modified, «immoderate thirst», «uneasy and difficult respiration», but, more often than not, they are post-modified by prepositional phrases, «loathing of food of all kinds, «absence of sleep», «uneasiness in the temper, with an extreme sensibility of every thing», «a neglect of the common business of life», or by non-finite clauses, «the urine, its colour being usually very high, and its consistence [ellipsis of the verb] thicker than». This section, as a whole, from «FEVERS» to «in health», is a descriptive one, characterised by the presence of linking verbs, «these are», «being», existential expressions, «there is», and the passive voice, «this is succeeded», «this

is seen», «is constricted or relaxed». Its complexity, thus, is due to its ideational load and distributed in the many nominal groups syntactically embedded one into the other. The immediately following sub-section, instead, introduces a change in perspective, since the focus is now placed on what fever does and how the patient may react to it. The shift is from description to narration, from a general – and more abstract – listing of symptoms to an apparently more contextualised experience. The fever and the patient interact, «the fever comes [...] the patient generally complains», the fever manifests itself gradually in different manners listed in a new sequence of symptoms from the patient's perspective, «the patient generally complains [...] languor, listlessness, soreness [...] heaviness, loss of appetite, sickness». Here, as in previous sections and sub-sections, the text is organised by means of time expressions delimiting the process: from «When [...] gradually», to «after some time», to close with «the fever attacks suddenly». The difference is one of emotional involvement in the action. It is first a gradual challenge for the patient, then a sudden attack to face, a kind of military combat against worse symptoms:

When the *fever* comes on gradually, the patient generally complains first of languor, listlessness, soreness of the flesh, or of the bones, as it is vulgarly expressed; heaviness of the head, loss of appetite, sickness, with clamminess of the mouth; after some time there succeed excessive heat, violent thirst, inability to sleep, &c. When the *fever* attacks suddenly, it always begins with an uneasy sensation of excessive cold, accompanied with debility and loss of appetite; the cold is frequently attended with shivering, oppression about the heart, and sickness of stomach, or vomiting. Buchan. (RCy s.v. Fever)

Most of the verbs used are dynamic ones, and in the present tense to highlight immediacy and action «comes [...] complains [...] there succeed [...] attacks [...] begins». A similar approach is exploited further on in the entry, in the section titled «FEVERS, *method of cure in*». Once again, the patient's perspective seems to be the organising principle of this narrative-descriptive paragraph. However, instead of just listing symptoms and possible remedies, both of them are displayed with further, contextualising explanations. This is the case with *heaviness*, «this symptom evinces the propriety of keeping him [the patient] easy, [...] in bed»; *in bed*, «lying in bed relaxes the spasms, abates the violence of [...] gives nature an opportunity [...]. The bed alone has often removed»; *food*, «should be light, and easy of digestion [...] given in small quantities [...] of the vegetable kind, as panada, roasted apples, gruel, and such like». These explanatory sequences also make an evaluative attitude emerge, modulating meaning in various ways (asides, lexical

choice, adverbs, modal verbs): «if possible», «gives nature an opportunity», «the bed alone has often removed», «should be light», «ought chiefly to be». The record of the individual patient's experience, essentially expressed in the present tense – «complains [...] evinces [...] relaxes [...] abates [...] gives», though not situation-dependent – helps the general reader to perceive it as a shared experience, close to everyday life:

FEVERS, *method of cure in*. At the beginning of a *fever*, the patient generally complains of great lassitude or heaviness; and this symptom evinces the propriety of keeping him easy, and, if possible, in bed: lying in bed relaxes the spasms, abates the violence of the circulation, and gives nature an opportunity of exerting all her force to overcome the disease. The bed alone has often removed an incipient *fever*. The food of the patient in a *fever* should be light, and easy of digestion, and given in small quantities: it ought chiefly to be of the vegetable kind, as panada, roasted apples, gruel, and such like. [...] Buchan's *Med.* chap. 13. (*RCy* s.v. *Fever*)

Small portions of texts thus reveal a great discourse complexity and a multilayered textual organisation, both of them reflecting the complexity – and the difficulty – of treating fevers in the real world. Furthermore, ascription to a well-known author and work of the period (Buchan's *Domestic medicine*, 1772, Ch. XIII, titled *Of Fevers in general*) adds (declared) intertextuality to intra-textual (sometimes cross-referred) medical discourse.

This is the state-of-the-art for the entry *fever* in the two universal dictionaries of arts and sciences (*EB* and *RCy*), whereas the two medical dictionaries organise their contents differently, according to their target readership and general aims.

James's *MD*, as previously said, includes a very long entry and symptomography covers more than just one section. Symptoms are disseminated throughout the entry when describing different kinds of fevers, their development, and their cures or remedies. However, there are many sections completely devoted to the systematic treatment of symptoms. They first appear organised in a list and labelled as «usual» in «an acute *Fever*»:

FEBRIS. A *Fever*. See the Articles CATHARTICA, DEPURATORIA, MILLIARIS, and PYRETOS.  
[...]  
PYRETOS, πυρετός. A *Fever*.  
[...]  
The usual Symptoms, accompanying an acute *Fever*, are, Cold, Tremors, Anxiety, Thirst, Nausea, Eructations, Vomiting, Weak-

ness, Heat, Exestuation, Dryness, Delirium, Coma, Watchings, Convulsions, Sweats, Diarrhœas, and inflammatory Pustules.

(*MD* s.v. Pyretos)

This general list is followed by an explanatory section and some evaluative comments, «it must be remarked», «always having due Regard to» on their meaning and treatment. Here, as at the very start of the entry, «a Fever is a very frequent Disorder, [...] the Cause not only of many Diseases», *fever* is considered the cause of (all) these symptoms «arising from, and caused by the Fever». This denotes a traditional outlook on the phenomenon if compared to the *EB* and the *NMD* (both issued in the 1770s, and considering fevers as a manifestation, an effect, symptoms themselves among others, of many diseases). However, some hints of a changing perspective may be recognised in the expression «Regard to the Cause and State of the original Distemper», closing the paragraph. This seems to suggest other possible causes than the fever itself. In any case, the discourse is rich in alternative hypotheses, even in a few lines. The complexity of reasoning is unfolded by post-modification, symptoms «arising from, and caused by», remedies «adapted to»; and subordination, «when that is removed», «provided they», «remarked that these», «which can», «if any of these»:

All these Symptoms arising from, and caused by the Fever, cease spontaneously, when that is removed: For this Reason, they require no particular Method of Cure, provided they can be supported without endangering Life, till the Termination of the Fever.

But it must be remarked, that these Symptoms frequently arise from an Attempt of the vital Powers to form a Crisis, and expel the critical Matter; and then they precede, accompany, and follow the Crisis; in which Cases, nothing must be done to moderate them, which can in any Degree interfere with the salutary Work carrying on.

But if any of these Symptoms are unseasonable, or too severe to be supported without the Hazard of Life; if so troublesome, as to render the Patient insupportably uneasy; or if there is Danger of their producing some more formidable Disorder; in such Cases they must be mitigated by Remedies adapted to them; always having due Regard to the Cause and State of the original Distemper. (*MD* s.v. Pyretos)

At the end of this general introduction, the *MD* has specific sections on each of the symptoms previously listed. These sections are titled and subdivided into clustered sub-sections concerning remedies, prognostics

in acute diseases, or in the parts of the body, etc. Each of them includes detailed contents, ascriptions, and quotations to highlight the complexity of medical reality and medical issues, according to alternative perspectives and approaches. Once again, the discourse tends to be exhaustive and scholarly, carrying a dense informational load, framed in a complex morpho-syntactic and textual structure. What follows are the opening paragraphs of the first symptom:

FEBRILE SYMPTOMS; and first of

FEBRILE COLD

Cold, in the Beginning of Acute Fevers, arises from a decreased Attrition of the Liquids with each other, and with their respective Vessels; a Diminution of the circulatory Motion; a Stagnation of the Liquids at the Extremities of the Vessels; a diminished Contraction of the Heart, and only a partial Evacuation of its Ventricles; and a less copious Influx of the Spirits conveyed from the Cerebellum.

This Cold, if of long Duration, causes polypose Concretions in the larger Vessels near the Heart; and in the small Vessels an Evacuation of the Fluids [...]; and in both these Cases many and severe Disorders are excited. (*MD s.v. Pyretos*)

The strategy is always the same: accumulation of causes of the symptom itself, «Attrition [...] Diminution [...] Stagnation [...] Contraction [...] Evacuation [...] Influx», all of them pre- and post-modified; and circumstances, «in the beginning», «if of long duration», «in both these cases».

Of the four dictionaries, the *NMD* is the most concise one. The section introducing symptoms is very short and focusses on the most general ones, always present: «heat and a disordered pulse». Interestingly, Motherby uses the term sign(s), that is what is actually an objective signal of a fever and belongs to it, and not the term symptom(s), which mainly represents many possible manifestations according to the patient(s) and changing circumstances. The linguistic choice thus lexicalises – and institutionalises – a conceptual difference: that is to say, what belongs to the personal and environmental perception («symptomatical»), and what, instead, strictly belongs to the nature of an *affection*, a *disorder*, *distemper*, *disease* («pathognomonic signs»). This is the kind of selection – and selective attitude – discussed by Motherby in his preface: a selection of contents and a selection concerning the way these contents are included, presented, and treated.

FEBRIS. A fever. A fever is when the natural heat of our bodies [...].

All fevers are symptomatical. And perhaps it is but the truth

to assert, that all fevers are but every fever differently circumstanced; or, that fever is one and the same disorder; but appearing differently, according to the various circumstances that it meets with in different constitutions. [...]

As to the diagnostics of fevers, they vary for the most part of them, in different patients, and in the same patient at different times; [...]. However, it is sufficient to know that the pathognomonic signs of a fever, that is, those signs that are present in every fever, and without which a fever cannot subsist, are heat, and a disordered pulse; these attend every fever, every degree, and every stage of it; and from these marks alone do we judge of the presence or absence of this disorder.

[...]

Every fever is a symptom of some disease, either manifest or latent; and as the secretions are diluted more as this symptom increases, the immediate suppression of it will at once appear the necessary aim. [...] (*NMD* s.v. *Febris*)

The section on symptoms, as compared with the preceding dictionaries, concludes by repeating that a fever is just a symptom of some other disease, and not a disease itself. This statement emphasises, once again, the innovative perspective of Motherby's dictionary. It reflects the claims and achievements of contemporary medical thought. Some other details on febrile symptoms are included later on in the entry, when Motherby introduces some remedies and cures to specific manifestations of fevers. Hence, for example, «Longings. [...] should be moderately gratified», «Hæmorrhage at the nose» should never be stopped, «Delirium» may need bleeding or cataplasms, «Hiccup» is a danger and should be cured by «julep, large doses of milk, and gentle cordial opiates», «Night sweats» are easily relieved by «a light but nourishing diet, moderate exercise in the air, [...] infusion of the bark», etc. Each symptom has thus its specific remedy.

#### 4.2.2. SYSTEMATISING FEVER(S)

The four dictionaries also include taxonomic sections on the different kinds of fevers, according to different degrees of detail and/or conciseness. The *EB* adopts and introduces Dr. Cullen's classification, and continues with Hoffman's explanation:

The doctor [*Cullen*] divides diseases into the four following classes, *viz.*

CLASS. I. PYREXIÆ, or Feverish Disorders.

[...]

The *first* class (PYREXIÆ) is subdivided into two sections. *viz.* 1. Intermittent; and, 2. Continued fevers.—The first section contains three genera, *viz.* 1. The Tertian fever; 2. The Quartan; 3. The Quotidian: —The second section likewise contains three genera, *viz.* 1. The Synocha; 2. The Typhus; 3. The Synochus.

[...]

*Of FEVERS in general.*

HOFFMAN defines a fever to be [...]

According to the different nature of these causes, and the various manner [sic] of affecting the nerves, arise fevers of divers kinds. Some are benign, other malignant; some are intermitting, others continual; some are simple, others compound; others regular or anomalous; eruptive, spotted, putrid, hectic, or slow. Some admit of an easy cure, others difficult; some soon terminate, others are protracted a long time; and many hurry the patient suddenly out of the world.

[...] (*EB s.v. Medicine*)

Fevers are an effect of a nervous internal cause whose external signs determine its clinical severity: a sense of urgency emerges from the accumulation of contrasting situations, «intermitting [...] continual», «easy cure [...] difficult», «soon terminate [...] are protracted a long time», and typologies, «benign [...] malignant», «simple [...] compound», «regular [...] anomalous», «eruptive, spotted, putrid, hectic [...] slow». This sense of urgency and dramatic development of certain dangerous fevers is definitely conceptualised and lexicalised as «hurry [...] suddenly out of the world», in the passage closing the paragraph. The move involves a shift from an informational sequence of linguistically neutral elements to an emotionally involved metaphorical passage. Here, the reader identifies with «the patient suddenly [*hurried*] out of the world». This introductory paragraph is systematically followed by titled sub-sections on the diversity of fevers which cover much of the treatise (pp. 60-83): «INTERMITTING FEVERS, or AGUES [...] CATARRHAL FEVER [...] SEMITERTIAN FEVER [...] NERVOUS FEVER [...] Epidemic, Catarrhal, Eruptive FEVERS [...] Malignant, Goal, and Spotted FEVERS [...] PESTILENTIAL FEVER [...] MILIARY FEVER [...] SCARLET FEVER [...] MEASLES [...] SMALL-POX [...] ERYSIPELAS, or ST ANTHONY'S FIRE [...] SYNOCHUS, or Continual FEVER [...] BILIOUS FEVER [...] CAUSUS, or BURNING FEVER [...] Burning Bilious FEVER, or YELLOW FEVER of the West Indies [...] SENEGAL FEVER».

RCy distinguishes fevers into two main categories – «*essential* and *symptomatic*» – according to their possible causes. This background section is extremely concise, starting from two moderately expanded definitions and closing with a list of 'symptomatic fevers':

FEVER, FEBRIS, in *Medicine*, a disease, or rather class of diseases [...]

The most general and genuine division of *fevers* is into *essential* and *symptomatic*.

FEVER, *essential*, is that whose primary cause is in the blood itself, and which does not arise as an effect or symptom from any other disease in the solids or other parts.

This is what we absolutely and properly call a *fever*.

FEVER, *symptomatic*, is that which arises as an accident or symptom of some other antecedent disorder; as an inflammation, phlegmon, erysipelas, imposthume, small-pox, pleurisy, &c.

Whence it is peculiarly denominated inflammatory, erysipelalous, purulent, variolous, or pleuritic *fever*. (RCy s.v. Fever)

Essential and symptomatic fevers are treated separately under specific sub-headwords such as «FEVER, *essential* [...] *symptomatic* [...] *continual* [...] *non putrid*, *continual* [...] *continual putrid* [...] *ardent* or *inflammatory* [...] *bilious* [...] *benign catarrhal* [...] *malignant catarrhal* [...] *choleric* [...] *colliquative* [...] *epidemic* [...] *eruptive* [...] *goal* [...] *hectic* [...] *inflammatory* [...] *intermitting*» etc. Some of these sub-headwords just cross-refer to other headwords, others are structured as any other entries, starting from a general definition and expanding contents with further explanations.

As regards the *MD*, the section – or, sub-sections – concerning the categorisation of fevers and their individual treatment is (significantly) concise for James's standards of expansion and detail of inclusion. Apparently, only three (macro) typologies are identified, titled and discussed: «CONTINUAL FEVER [...] CAUSUS, OR ARDENT FEVER [...] INTERMITTENT FEVERS». However, each of them includes sub-categories – or, sub-species – as run-ons:

PYRETOS, πυρετός. A Fever.

A Fever is [...].

A CONTINUAL FEVER. The most simple of continual Fevers, is an *Ephemera*, or Diary Fever, which goes through the different Stages, as the Beginning, Increase, State, and Declension, in the space of twenty-four Hours. It arises from [...]. If this species of Fever continues many Days, it is called *A continual but not putrid Fever*. The Causes, Signs, and Cures [...].

That species of Fever, which is called a *putrid Synochus*, arises from [...]. This Fever is distinguished by the Name *Homotonos*, when it preserves [...]: When it perpetually increases, it is called *Epacmastica*, or *Anabatica*: But when it continues to decline [...] *Paracmastica*.

A CAUSUS, OR ARDENT FEVER. Among these Fevers, we may just

reckon the *Causus*, or burning Fever, on account of its Frequency, Danger, and Difficulty to Cure. The primary Symptoms [...].  
 INTERMITTENT FEVERS. We have already given the Definition of an intermittent Fever, the Diagnostics of which are obvious, and its Distinction in various Classes easy, since these depend only on the Difference of Time. But 'tis to be observed, that intermittent Fevers, in general, are either vernal, [...]; or autumnal [...]; which Distinction is necessary on account of the various Conditions, Symptoms, Terminations, Durations, and Cures of different Intermittents: Besides, one intermittent Fever sometimes removes another. [...] (*MD s.v. Pyretos*)

The sub-section on intermittent fevers is the longest and most articulated one; however, all of them share a common structure (definition and expansions: emerging symptoms, progress, cure). The organisation of discourse reflects James's all-inclusive attitude in order to be as exhaustive as possible: that is to say, to add information in his texts, to disseminate and cluster details, and to hypothesise different situations.

The *NMD* is very concise in the categorisation of fevers, summarising what previous «writers» – as Motherby calls them – «have enumerated». Fevers are then reduced to three main groups, ardent, nervous, and putrid. The principal differences among them regard either their nature and signs, «blood is redundant [...] the heat [...] increased [...] the lymph is disordered [...] defect of the natural heat», or their progress, «symptoms proceed with rapidity [...] symptoms proceed more slowly»:

FEBRIS. A fever. A fever is [...].

[...]

Various are the divisions and subdivisions of fevers which different writers have enumerated, but they may be included in those of the ardent, nervous, and putrid; at least every acute fever is best managed by the methods required in one or other of the just named three kinds.

In ardent fevers the red blood is redundant, and the heat of the body increased beyond the medium of health. In the nervous kind, the lymph is disordered; and in the putrid sort, there is such a defect of the natural heat, as admits of a putrid quality taking place, and increasing in the blood.

An acute fever is when the pathognomonic symptoms proceed with rapidity, and danger to the patient. When these symptoms proceed more slowly, and with less danger, the fever is said to be chronic. (*NMD s.v. Febris*)

Nothing else is said in the entry about the classification of fevers. However, Motherby includes different fevers under specific headwords, to facilitate the finding of the term and the consultation of the entry ‘in haste’: that is to say, to facilitate distinction and selection, and to be to the point according to the practitioner’s immediate need(s). All erudition is avoided.

#### 4.3. FRAMING FEVER IN EIGHTEENTH-CENTURY HANDBOOKS: BASIC PATTERNS, ELABORATE DESCRIPTIONS, AND DISCURSIVE ISSUES

The objective of this section is the analysis and discussion of *fever* as treated and represented in medical handbooks. The topic is a relevant one in this kind of reference works. Some of them are completely devoted to it, such as Grant’s *An enquiry into the nature, rise, and progress of the fevers most common in London* (1771), and Clark’s *Observations on fevers, especially those of the continued type; and the scarlet fever* (1780). Some others include *fever* as one of the main affections of the period and, as such, one of the main topics of interest and description for the professionals and the lay readers. This is the case with Millar’s *Observations on the prevailing diseases in Great Britain* (1770), Buchan’s *Domestic medicine: or, a treatise on the prevention and cure of diseases by regimen and simple medicines* (1772), Sims’s *Observations on epidemical disorders, with remarks on nervous and malignant fevers* (1776), Black’s *Comparative view of the mortality of the human species* (1788), and Wallis’s *The art of preventing diseases, and restoring health, founded on rational principles, and adapted to persons of every capacity* (1793). All of them introduce *fever* in general terms and distinguish between manifestations common to every kind of fever, and specific symptoms belonging to specific fevers. The classification of fevers according to the *genus-differentia* pattern is a recurrent feature, and also reflects the structure of their works. Usually, the introductory sections provide general issues on any fevers, whereas sub-sections are devoted to particular fevers, their causes and manifestations. The similarities among fevers are organised in a symptomatological defining pattern. Symptomography is thus the main strategy to collect symptoms under the general denomination *fever*. The following extracts, taken from Clark (1780) and Black (1788), exemplify the approach:

PART I. OBSERVATIONS ON FEVERS, &c. SECT. I. CHARACTER OF FEVERS. FEVERS are known by beginning with chillness or shivering, succeeded by frequency of pulse, preternatural heat, and weakness of voluntary motion, without deriving their origin from Local Inflammation, Specific Eruptions, or other primary diseases which produce symptomatic fever.

[...]

When fevers are once confirmed, a very numerous train of symptoms arise: the nervous system is in general disordered, and all the functions of the body perverted: The mind is often affected with delirium: Want of appetite, thirst and inquietude generally prevail; and the salutary secretions and excretions cease to be regular. (Clark 1780: 3, 5)

and

We shall first trace the prominent features of the general febrile Class, descending progressively through the different Orders and Genera. In most fevers, of whatsoever genus, one or more of the following symptoms occur: shivering, chilliness, and heat of the skin alternating: the circulation of the blood, and consequently of the pulse, as felt at the wrist, accelerated more than in the natural state; [...] also general languor, lassitude and debility of the nerves and muscles; dryness of the mouth and tongue, thirst; little or no sleep, or disturbed and not refreshing, and generally headach: in most of the continued and remittent fevers, there is total suspension of appetite, sickness at the stomach, nausea and vomiting; increased heat of the skin, at least burning sensation; aversion to motion; the sick are mostly confined to bed, unable to walk, or frequently even to sit erect; and this is commonly the case, even in the intermittent genera during the febrile paroxysm: the remittent and continued have usually an evening or nocturnal febrile exacerbation: the voice and countenance frequently express condolence: and in the genera of topical inflammations, there is fixed pain in the different parts affected. (Black 1788: 77-78)

In the first example, Clark frames symptoms within a process developing in time, «by beginning with [...] succeeded by», and highlights similarities by the use of adjectives and adverbs, «When fevers are once confirmed [...] in general disordered [...] often affected [...] generally prevail [...] cease to be regular». The number of symptoms is limited to the most relevant ones, and the most widespread. In the second extract, Black takes a partially different approach to «trace the prominent features of the general febrile Class». The context and the structure is still one of symptomatological defining, but the number of symptoms increases, and they are mainly provided as a list, «shivering, chilliness, and heat of the skin alternating», «the circulation of the blood [...] accelerated», «general languor, lassitude and debility of the nerves and muscles», «dryness of the mouth and tongue, thirst»; generalisation is provided by the use of adjectives and adverbs, «whatsoever

[...] general [...] total» and «progressively [...] consequently [...] generally [...] at least [...] mostly [...] frequently [...] commonly [...] usually»; elaboration of ideas and a more abstract perspective, that is to say detachment from situation-dependent events placed in time and space, are signalled by the abundant use of nominalisations, «circulation of [...] debility of [...] dryness of [...] suspension of [...] sickness at [...] aversion to»; and non-finite verbs, «descending [...] alternating [...] accelerated [...] disturbed and not refreshing [...] increased».

Notions concerning the general issues on fevers may also be found in concluding sections, such as in Grant (1771). In his Recapitulation, the author sums up the general features discussed in previous chapters, thus providing the reader with further hints on the topic:

All fevers are, for some days, preceded by several little complaints, [...]. These are succeeded by a degree of rigour, which is the beginning of the *stated* fever, and marks the first day of it *in the journal*. The quick pulse, dry mouth, hot skin, and other febrile symptoms follow: these increase gradually for some days, and at length get into a regular train; so that something of the same sort happens every day nearly at the same hour, for some days, without any sensible alteration.

[...]

Every fever may be divided into the following periods: the harbingers, the beginning, the increase, the state, the decline, and the consequence; and each of these may have different degrees, both of violence and duration, according to the nature of the fever; for each species of fever has a nature peculiar to itself, in consequence of which, it goes through its periods with greater or less velocity than others: it is therefore necessary to acquire a particular knowledge of each species, so as to distinguish the fever in question from all others, and to determine the duration of its periods. (Grant 1771: 425-426)

Grant reduces the main symptoms of «All fevers» and «Every fever» to a concise list: «quick pulse, dry mouth, hot skin, and other febrile symptoms». His attention is instead focussed on the evolution and the manifestations of these symptoms: the process is emphasised by the use of verbs, «preceded by [...] succeeded by», and adverbial expressions «for some days [...] the first day [...] gradually [...] at length [...] every day nearly at the same hour [...] for some days» etc. The passing of time thus becomes the criterion to identify different states shared by every fever, independent of its nature and cause, «the harbingers, the beginning, the increase, the state, the decline, and the consequence»: symptoms are only relevant if considered in this context.

Another interesting, and worth quoting, introduction to fevers belongs to Wallis (1793). Under the heading «FEBRILE AFFECTIONS IN GENERAL», the main symptoms recur, «pulse [...] heat [...] chillness [...] languor [...] lassitude [...] weakness», in a very concise pattern:

CHAP. I. FEBRILE AFFECTIONS IN GENERAL. All those are so considered where there is an alteration respecting the pulse and the heat; for the most part, an increased quickness of the former, and the latter augmented in some degree;—many of the functions of the machine injured—particularly the strength of the limbs diminished; attended with chillness, languor, lassitude, and other marks of weakness, without any local primary disease. Under this head is comprehended all the fevers, of whatever nature, by which the human frame is afflicted; but, as they put on different appearances, they are divided under distinct heads, according to these appearances, as

1. CONTINUED, OR CONTINENT.
2. REMITTENT,
3. INTERMITTENT,
4. HECTIC, and
5. ERUPTIVE.

(Wallis 1793: 315-316)

However, since these general symptoms assume «many different appearances», Wallis distinguishes five sub-categories of fevers, according to their external manifestations, and their degree of severity. The same organising and categorising principles, based on the relationship *genus-differentia*, or *general-particular*, or *superordinate-hyponym*, is repeated in subsequent sections, that is to say for the classification of *continued*, *remittent*, *intermittent*, etc. *fevers*.

The classification of fevers is also present in other medical writings, but it is not identical across handbooks. The criteria used may overlap, particularly when expressing the need to identify similarities and distinguish differences, but the aspect to be highlighted for distinction may vary: symptoms (external manifestations or appearances), causes (inflammation, infection, contagion, other diseases), process (remittent, intermittent), severity (malignant, putrid, etc.). However, what generally emerges in all of them is the need to be clear and essential, and avoid useless sub-divisions and excessive variety in the denotation and description of febrile affections. Millar (1770) and Clark (1780) are determined in expressing this:

The division of fevers hath been so widely extended, and so many minute differences established, that if the knowledge of

these distinctions are really necessary, in order to their being successfully treated, it is in vain to pretend that any physician on earth can ever be duly qualified to undertake the cure of them. The very names by which they have been distinguished afford a subject for laborious study, and the multiplicity of minute circumstances, on which they are founded, is too intricate to be unraveled by the most unwearied and attentive observation. But if they are the offspring of fancy and invention, and not of an accurate attention to the progress of nature, it is highly expedient that they should be for ever discarded from the records of physic. (Millar 1770: 128)

and

SECT. II. OF THE DIFFERENCES OF FEVERS. Fevers have been divided into many genera, and various appellations have been given to them both by the ancients and moderns, derived from the time of their duration; from some remarkable predominant symptom; from the state of the fluids; and from other circumstances\*. But, unfortunately, the many names to be found amongst Authors, not only load the memory, perplex the unexperienced, but answer no real advantage in practice. After several years careful attention to the symptoms and nature of fevers, as they have occurred in different climates, I freely confess that I have never been able to follow authors through their numerous divisions and subdivisions. [...] fever is essentially the same, or, in other words, consists only of one *Genus*; and that the only species which can be well ascertained, are the following, viz. *Intermittent*, *Remittent*, and *Continued* Fevers. (Clark 1780: 5-6)

If handbooks are meant for practical usage, then useless subdivisions and the multiplication of perplexing names are to be avoided, or deleted: «minute differences [...] minute circumstances» (Millar), «many genera [...] numerous divisions and subdivisions» (Clark), «the very names» (Millar), «various appellations [...] the many names [...] load the memory, perplex the unexperienced, [...] no real advantage» (Clark).

In the following sections, some extracts on general and particular fevers are analysed in detail. The main pattern selected by authors to organise contents, and the main linguistic and textual features adopted by them, are highlighted and discussed.

## 4.3.1. LEXICAL DEFINITION: CATEGORISATION AND SHARED KNOWLEDGE

The first series of examples drawn from medical handbooks emphasises at least one major definition pattern, that is to say, the definition *per genus et differentiam*. In examples 1 and 2 the structure and the categorising function of this pattern at both lexical and content levels are highlighted:

**Example 1****CHAP. XIII. OF FEVERS IN GENERAL.**

A fever is the most general disease incident to mankind. It attacks every age, sex, and constitution, and affects every part of the body; nor is the mind itself free from its influence. A fever is known by a quick pulse, an increased heat, a general debility, and a difficulty in performing some of the vital or animal functions, as breathing, walking, &c.

FEVERS are divided into continual, remitting, and intermitting. By a continual fever is meant that which never leaves the patient [...]. A REMITTING fever differs from a continual only in degree. [...] Intermitting fevers, or agues, are those which, during the time that the patient may be said to be ill, have evident intervals or remissions of the symptoms. (Buchan <sup>2</sup>1772: 174-175)

**Example 2****NERVOUS FEVER.**

This is so named, because the *nervous system* appears to be the part most affected. It differs from the inflammatory fever in the part of the constitution attacked, and occurs in such as are dissimilar. Here the nervous system is defective, attended with little or no intensesness of vascular motion; the fluids are also poor and thin, and the nerves extremely incitable. This is also called the slow fever, because it is slow in its progress compared with other fevers, particularly the foregoing. (Wallis 1793: 335-336)

In example 1, the term *fever* is firstly defined as a ‘kind of’ disease (*genus*), that is the sense relation of hyponymy with the term *disease* is thus established. However, this is not simply a lexical definition, since it points at the real world of experience: stating that *fever* is a *disease* means to categorise medical knowledge. The second paragraph opens with the same sense relation of hyponymy, this time between «Fevers» (superordinate) and «*continual, remitting, and intermitting*» as hyponyms: once more, the usage of lexical definitions as a starting point to categorise extra-linguistic encyclopaedic knowledge oper-

ates. At a lexical level the *genus-differentia* pattern is obviously condensed in pre-modification, the *genus* being represented by the head *fevers*, the *differentia* by the pre-modifiers *continual*, *remitting*, and *intermitting*. However, the difference is not only performed along the vertical axis, that is to say between fever and ‘kind of’ fevers: «FEVERS are divided into continual, remitting, and intermitting», but also between co-hyponyms along the horizontal one (‘kind of’ fever 1 vs. ‘kind of’ fever 2). In this case, individual co-hyponym~co-disease features alternate with co-hyponym~co-disease difference(s), as in «a continual fever *is meant*»<sup>1</sup>, «intermitting fevers [...] *are*» vs. «a remitting fever *differs from* a continual only in degree». The same compare-contrast structure is also exploited in example 2, describing and discussing the nervous fever: the focus here is on co-hyponym~co-disease difference(s), introduced by the expressions «It *differs from* [...] and *occurs* in such as *are dissimilar*». To identify the characteristic features of a nervous fever, the reader must primarily infer ‘what nervous fever is not’. In both examples, 1 and 2, the ‘kind of’ fevers discussed are also identified by what they do as a ‘real disease’ in the real world of experience: dynamic verbs are emphasised in «it attacks [...] and affects» (example 1) and «constitution attacked [...] occurs» (example 2). A concise description enumerating the most relevant symptoms (example 1) or delineating the general condition (example 2) – but not overlapping with symptomography (cfr. § 0.2.1.) – follows: «a quick pulse, an increased heat, a general debility, a difficulty in [...]» (example 1) and «the nervous system is defective, [...] little or no intensesness of vascular motion; the fluids are also poor and thin, and the nerves extremely incitable» (example 2), most of them expressing nominalised (material) processes.

In example 3, the comparison with a well-known external phenomenon or situation is the main feature.

### Example 3

#### CHAP. XXI. OF THE MILIARY FEVER.

THIS fever takes its name from the small pustules or bladders which appear on the skin, resembling, in shape and size, the seeds of millet. The pustules are either red or white, and sometimes both are mixed together.

The whole body is sometimes covered with pustules; but they are generally more numerous where the sweat is most abundant, as on the breast, the back, &c. A gentle sweat, or moisture on the skin, greatly promotes the eruption; but, when the skin is dry, the eruption is both more painful and dangerous. (Buchan<sup>2</sup>1772: 257)

<sup>1</sup> In this quotation and in the following ones, italics highlights the expressions which introduce similarities and differences.

The definition of *miliary fever* firstly overlaps with the explanation of its denomination, «THIS fever takes its name from» (as it happened in ex. 2 above with nervous fever, «This is so named, because the nervous system»), and further on is expanded by the inclusion of shared knowledge. The connection with the real world helps thus the reader understand the use of the term(s): «the small pustules or bladders [...] resembling [...] the seeds of millet». The definition then expands to a concise description: «The whole body is sometimes covered with pustules [...] A gentle sweat [...] greatly promotes the eruption [...] the eruption is both». The disease is, once more, primarily identified by its most relevant clustering symptoms and their evolution in time.

Also glossing strategies may be variously exploited in medical writing, the following extract highlights the flexibility of this textual, stylistic and lexicographic device. In example 4, glossing corresponds to a long list of Latinate and English highly-descriptive denominations:

#### Example 4

##### [NERVOUS AND PUTRID FEVERS].

[...] Nervous and putrid fevers have been described under the following different names: slow nervous fevers, febricula, maligna lenta insidiosae mitis, nervous and putrid fevers, putrid remittents, typhus castrensis, jail, hospital, infectious, putrid, malignant, continued, putrid, spotted, purple, petechial fevers; yellow fever of the West Indies, or typhus Icterodes. (Black 1788: 92)

Apart from showing the abundance of medical terminology for analogous – if not identical – ‘disorders’, these denominations cannot be organised: this means that no hierarchical sense relations among them can be definitely established, whether (co-)synonyms, (co-)hyponyms, or superordinate vs. hyponyms, etc. In other words, no categorisation at both lexical and content levels is possible. Moreover, in this highly ambiguous context, the notion of equivalence becomes useless. Here uncertainty – and possibly overlapping – dominates. In this sequence, glossing probably simply corresponds to a series of loosely related expressions; in any case, its function is not clear.

#### 4.3.2. SYMPTOMOGRAPHY: LISTING AND CLUSTERING

This and the following section (§ 4.3.3.) exemplify longer and more elaborate descriptions of symptoms than the concise typologies just outlined in the previous sections. For practical reasons, the first extract has been schematised below (the original version is regularly structured into paragraphs) to highlight the various ‘symptomatological groups’ (italics mine):

Example 5

[NERVOUS AND PUTRID FEVERS]. [...]

The symptoms slight alternate

1. *chills* and *fugacious heats*,  
    especially in the evenings;
2. *heaviness*, *giddiness*, and *headach*,  
    particularly in the posterior and superior part,  
    and the *pain* often descending down the spine;
3. *great debility* and *prostration of strength*;  
    and in both *nervous* and *putrid*, the functions of the  
    brain, and of muscular motion, considerably weak-  
    ened, and interrupted;
4. also *depression of spirits*, *sighing*, *restlessness*, *very little sleep* and  
*not refreshing*;
5. *accelerated*, *weak*, and *small pulse*;
6. *nausea*, *total inappetency*;
7. *inconsiderable heat of the skin* or *thirst*;
8. *dry tongue*,  
    *a little yellow* at the sides;
9. *pale urine*,  
    and *without sediment*;
10. *irregular sweats*;
11. sometimes *pains*  
    resembling *rheumatick*.

After a few days,

12. the *fever*, *stupor*, *delirium*, and *headach* increase,
  - i. with *slow muttering delirium*,  
    chiefly during the nocturnal exacerbation,
  - ii. and with *noise in the ears*,
  - iii. and *universal debility of the corporeal* and *mental organs*.

The remissions are generally more distinct in the beginning,  
and, by degrees, more obscure. (Black 1788: 93-94)

As my synthesis makes clear, the definition is characterised by twelve juxtaposed symptomatological groups in which the individual symptoms are either listed (ex. 1-7, 10) or clustered (ex. 9, 12 i-iii). Some groups also include both details expressing ‘time when’ something usually happens (1, 11 and 12 i) and additional information concerning the course of illness (2-3). Most symptoms are identified by means of nouns without pre-modification, whereas others are pre-modified by adjectives emphasising clinical severity: «great debility» (3), «very little sleep» (4), «accelerated, weak, and small pulse» (5), «total inappetency» (6), «inconsiderable heat» (7), «irregu-

lar sweats» (10), «universal debility» (12). The prevailing feature in this extract is the accumulation of symptoms, either listed or clustered, whereas in other cases the framework is structurally more elaborate, as will be shown in the following section.

#### 4.3.3. SYMPTOMOGRAPHY: PROCESS AND DISCOURSE MARKERS

The paragraph excerpted here below is one in which not only symptomatological groups, but also discourse markers and other details in the course of illness are highlighted (*italics* and **bold mine**): that is to say, the network in which symptoms are embedded is more complex and tight than the one in the previous text. For the purpose of the present analysis, in the following excerpt, such structural and discursive complexity is marked in **bold**, whereas symptoms are in *italics*:

##### Example 6

**NERVOUS FEVER.** [...]

**DESCRIPTION.** This fever **makes it attack with** *dejection of spirits—loss of appetite—oppression—disturbed sleep, or restlessness—the patient *often sighs* and *groans involuntarily*—is frequently terrified, and affected with *uncommon lassitude* after exercise, though that should be slight, and **at the same time has cold and hot fits succeed, and alternate** with each other—he is troubled with *nausea, and a vomiting of insipid phlegm, which come on in a few days after the attack, with giddiness and pain of the head—extreme prostration of strength—no remarkable heat—no thirst—the pulse is frequent, weak, and sometimes* intermits—the *tongue continues moist, white, and is covered over with a viscid mucus—there is an oppression at the pit of the stomach, and the breathing difficult—the urine is pale, watery, and sometimes* like milk whey—the face red, and flushes, **at the same time** that *the feet are cold—the mind is slightly disturbed by ridiculous imaginations, which continues, but without any violent delirium—sometimes* immoderate sweats **break out, or colliquative, dissolving looseness comes on—the senses lose** their quickness, and **become dull and heavy**—with anxiety and *fainting attending.**

**Towards the close,** when nature appears almost worn out by the continuance of the disease; *the tongue trembles—the extremities grow cold—the nails livid—they lose the power of sight and hearing—the delirium is converted into stupor, and a lethargic disposition—the feces and urine pass away involuntarily—twitching of*

*the tendons come on—and generally convulsions close the scene, in death.* (Wallis 1793: 336-337)

The course of illness is delineated by dynamic verbs marking the subsequent steps in the process: the beginning «makes it attack», the evolution «sighs [...] groans [...] succeed [...] alternate [...] come on [...] intermits [...] flushes [...] disturbed [...] continues [...] break out [...] becomes [...] trembles [...] grow [...] pass away», and the conclusion «close». Adverbial expressions (both single-word and multi-word) usually mark time, frequency and manner, either by pre-modifying the verbs themselves, «often sighs», «groans involuntarily», «is frequently terrified», «slightly disturbed», «pass away involuntarily», or by introducing further developments «at the same time», «in a few days after», «sometimes», «towards the close». As regards symptomatological groups, more often than not they are noun phrases, whose head may be pre-modified by adjectives either intensifying the symptom itself, «uncommon lassitude», «cold and hot fits», «insipid phlegm», «extreme prostration», «no remarkable heat», «ridiculous imaginations», «violent delirium», «immoderate sweats», or categorising it, «viscid mucus», «colliquative, dissolving looseness», «lethargic disposition». Post-modification is mostly represented by prepositional phrases, «dejection of spirits», «loss of appetite», «vomiting of insipid phlegm», «pain of the head», «prostration of strength», «oppression at the pit of the stomach», «power of sight and hearing», «twitching of the tendons». In general terms, example 5 is descriptive in nature (accumulation of symptoms, mostly juxtaposed), example 6 is characterised by a more narrative approach which highlights the process underlying symptoms.

#### 4.4. CHAPTER SUMMARY

This chapter has introduced and discussed *fever* as a shared medical experience represented in eighteenth-century reference works. The analysis has highlighted both similarities and differences of treatment across genres (universal/medical dictionaries vs. handbooks) and within the same genres (universal/medical dictionaries or handbooks). In general, medical writers organise their materials in order to define, categorise, and unfold the complexity of their topic, and of their experience as practitioners. Their aim is the distinction, selection, classification of fevers, with the practical issue of curing them. However, the variety of febrile manifestations and their denominations are so numerous that the identification of specific fevers, and their diagnosis, is often problematic and uncertain.

Among the most relevant similarities across and within dictionaries and handbooks is the extensive use of symptomatological defining: the listing

and clustering of symptoms which strictly characterise every fever, or distinguish specific fevers. The expansion of symptomography depend on the general aims of the work under scrutiny. In any case, what is a lexicographic technique is systematically exploited by medical writers in their handbooks: symptomography establishes the background for text structure and discourse organisation.

As regards dictionaries, differences mainly concern the extension of lexicographic entries, the degree of detail included, internal or external references, and the focus of their discussion: on the one hand, contemporary medicine and case studies; on the other hand, contemporary perspectives alongside traditional approaches.

Handbooks may be completely devoted to fevers, or include fevers among other diseases: this may determine the extension and the detail in their description and treatment. Among the most relevant features across handbooks is the aim of avoiding excessive sub-divisions of fevers and their respective denominations: medical writers of handbooks have a strictly practical attitude, and theorising cannot be of any help. The omission – or reduction – of redundant details, the necessity to be clear and to the point, the systematisation of topics and sub-topics are reflected, as far as textual organisation is concerned, into titled sections for quick reference. Once again, symptomography plays a key role in the organisation of textual structure and topic development. The focus on contemporary approaches is sometimes supported by the presentation of more traditional cures and remedies.

## 5.

### CONCLUSIONS

The analysis of vernacular medical writing in reference works, such as universal dictionaries of arts and sciences, medical dictionaries, and handbooks testifies to the fact that medicine was a relevant topic both in genteel society, and within an emerging disciplinary community. On the one hand, medicine was general knowledge and shared experience; on the other hand, it was on the way to specialisation and professionalisation. The advancements in medicine, in the second half of the eighteenth century, favoured a gradual epistemological change, from medicine as scholarship and erudition to medicine as scientific, technical, and experimental knowledge. This implies a progressive shift from learning to science. This also stimulates a substantial expansion of medical writing at different levels, and for different users.

Universal dictionaries of arts and sciences were mainly addressed to a lay educated readership: they included medicine as part of a more general, comprehensive idea of knowledge. Medical terminology – and medical entries – in alphabetical order was a practical way to store, organise, and display medical information. Two works of this kind were examined and discussed: the *Encyclopaedia Britannica* (EB 1768-1771) and Abraham Rees's *Cyclopaedia* (RCy 1778-1788).

The *EB* includes three main treatises of medical content: Medicine, Surgery, and Midwifery. The most relevant and complex is the first, with many sections and sub-sections. The choice of collecting medical knowledge under specific treatises mirrors the general plan of the work, which aims at avoiding dispersion of information. Symptomatalogical defining is one of the strategies used by the compilers, it is embedded within the progress of the disease and signalled by time markers. Hypothesising is another discourse strategy meant to introduce different situations and individual cases (signalled by *if* and *when*). The single entries in alphabetical order are as short, essential, and concise as may be found in dictionaries of

the English language published in the same period. Entries generally consist of lexical definitions, usually followed by cross-references to the main treatises. Etymology is never included, whereas spelling variants and lexical variants are hardly ever listed. Almost always, one single form is provided. This method is typical of the *EB*, and distinguishes it from other contemporary universal dictionaries of arts and sciences, as *RCy*.

*RCy* organises its contents in alphabetical order, and no monographic treatises are included: if compared to the *EB*, *RCy* displays a different epistemological approach and lexicographic practice. Entries are usually long and complex, including such linguistic information as etymology, equivalents, spelling variants, and lexical definitions. In the description of diseases, symptomography is one of the key features in listing and clustering symptoms and signs of the diseases, and sometimes also their possible causes. The practice of identifying single topics as headwords (and vice versa) helps readers to focus on them as conceptual units (cross-references are reduced to a minimum to avoid dispersion).

In both the *EB* and *RCy*, medicine and medical headwords represent a major subject of interest and show extended treatment, though with different discourse strategies. The relevant presence of medical contents and terminology in both of them also testifies to their pervasiveness in society and everyday shared experience.

As regards more specialised reference works, two major medical dictionaries were analysed and discussed. James's *A medicinal dictionary* (*MD* 1743-45), and Motherby's *A new medical dictionary* (*NMD* 1775). They are organised in alphabetical order, and represent the effort to include, illustrate, and delimit the medical field through its terminology.

James's *MD* is a huge work which aims at extensive inclusion and detailed exposition: a scholarly collection of what is known about medicine, from past tradition to contemporary practice. Not unlike seventeenth-century works for educated readers, *MD* declares that its target audience is mankind in general. However, the length and complexity of its entries actually address a more restricted and specialised readership, of experts and semi-experts, such as physicians, practitioners, apprentices, students, surgical and apothecary trainees. The internal organisation of the entries, their sub-topics, their digressions, the description of diseases, and the inclusion of detailed case studies for practical reasons make this perspective quite evident. Actually, *MD* entries are monographic articles, in which the historical dimension is a key feature that is meant to background – and sometimes compare – contemporary medical issues. The density of details makes reading a demanding activity, which requires an expert perspective. Some sections are highly informative and expositive, others more argumentative (different perspectives are provided); sometimes, personal involvement emerges, particularly in reports of real medical events, highlighting prac-

tical and situation-dependent approaches, in time and place. *MD* may be considered as a kind of *summa* of medical knowledge, especially as learning.

The *NMD* is instead the result of a process of selection and specialisation of contents and vocabulary. The general aim of the *NMD* is to be useful to the practitioner ‘in haste’. This means that Motherby (de)limits the amount of details and internal cross-references: exhaustiveness and comprehensiveness are established by referring to more specific external sources. Motherby provides systematic intertextuality, when necessary. Entries generally consists of lexical definitions, regularly followed by descriptive, expository, or explanatory sections, which develop the topic-headword. They are well structured, and more coherent and cohesive at textual and discourse levels than the corresponding entries in the *MD*. Etymology is still perceived as an essential element to introduce the topic, whereas the number of lexical and spelling variants gradually decreases. Historical approaches and perspectives, as well as scholarly digressions are reduced to a minimum, since the attention is placed on contemporary medicine, and events strictly medical.

The third group of reference works analysed and discussed is composed of handbooks and *practica*. This kind of works highlights the expanding social interest in medical events, since their general aim was diffusing medical knowledge in society: at large, this socio-cultural interest is treated by such writers as Buchan, Fisher, and Wallis. However, besides the strong commitment of these works to public health, another fundamental goal was to share medical practice within the emerging disciplinary community. This is the reason why their readership was, once again, multilayered (as for universal and medical dictionaries). Different levels of education among the non-experts (or lay people) and different degrees of specialisation among the experts (physicians, practitioners, students, trainees) involved different registers and textual issues in medical writing. As a consequence, the works analysed show some similarities but also some differences as regards their structure, contents and their organisation, detail of treatment, language and register, etc. Some of them were focussed on specific affections (fevers, infectious diseases), others on many different diseases, as kinds of general repositories with very practical goals (cfr., for example, Fisher 1785). The tables of contents make the main topics and the internal organisation emerge. Clusters of specific diseases are usually ‘displayed’ under more comprehensive headings: these headings function as headwords and more specific diseases as sub-headwords (sub-topics, for example *inflammation of the lungs* vs. *pleurisy*). Diseases are usually introduced by recursive elements, such as etymology, equivalents (variant denominations), and lexical definitions. They are systematically followed by more complex paragraphs on symptoms (symptomatological defining), causes, specific manifestations (accounts based real circumstances), possible cures, and remedies. Sometimes, descriptive or expository sections are interspersed with more personal passages by the *physician-* or *practitioner-*writer comment-

ing on some situations: it is a way to provide further information related to personal experience.

*Fever* is the last topic-headword analysed and discussed in this study. It is both a term which pervades medical writing, and a widespread scaring experience in eighteenth-century society. *Fever*, and what is written about it, is here compared across reference works. This means that the analysis is carried out in universal dictionaries of arts and sciences, in medical dictionaries, and in handbooks at the same time. This makes some similarities vs. differences emerge more directly than in previous chapters, which were focussed on individual genres. The results of the comparison highlight that some major strategies and lexicographic techniques are systematically used across reference works, independent of their nature. These include: etymology, to introduce and provide a preliminary understanding of the topic; equivalence (variant denominations of medical events; different registers and degree of specialisation); lexical definition; symptomatological defining (listing and clustering of symptoms); use of hyponymy to categorise and organise contents (topics and sub-topics as headword and sub-headwords). In all the works analysed, medical discourse on *fever(s)* and its complexity at a conceptual level emerge as a multilayered textual organisation. Reference works, according to their specificity, are rich in details and digressions (particularly James's *MD*, and *RCy*). Explanatory and expository sections alternate with argumentative paragraphs, and some evaluative comments. The *NMD*, instead, among the four dictionaries is the most concise, essential, and focussed on the main characteristics of *fever*. This is in line with the original plan, which emphasises Motherby's practical issues, and systematically refers to external specialised works for thorough reading. As regards the treatment of *fever(s)* in handbooks, the most recurrent feature is the *genus-differentia* pattern, used to organise contents, text, and discourse. As said above, symptomatological defining is a major feature: it goes from concise typologies, to elaborate descriptions of symptoms (listing and clustering), to the structuring of the disease as a process, in this case along with time and space markers.

In the second half of the eighteenth century, the communication of medical knowledge both as science and as practice was a widespread and well-established activity, among expert writers (*MD*, *NMD*, and handbooks) and non-expert compilers (*EB* and *RCy*). The construction and the dissemination of medicine as an emerging science and shared disciplinary practice take advantage of recurrent discourse strategies and textual features across genres. In particular, the practice of classifying contents under individual topic-headwords – in both dictionaries and handbooks – gradually helped to delimit and to identify specific, technical topics for professionals rather than scholarly erudition and learning for mankind. Medicine was definitely on the way to becoming science.

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