The Medical World of Samuel Taylor Coleridge

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COLERIDGE LOVED TO RELATE HIS OWN CASE HISTORY. In 1800, at the age of 28, he lost his health for good. He recognised his symptoms from childhood as rheumatic fever. But rheumatic fever was not just a physical condition for Coleridge. It was embedded in what the psychoanalyst Melanie Klein might have called a whole constellation of object relationships.[1] These he described in loving detail to his friend Thomas Poole in five magnificent autobiographical letters written in 1797 and 1798. Coleridge believed that he first contracted the disease at the age of eight as a consequence of having spent an entire night sleeping beside a river. He had just attacked his brother Frank with a knife and he wanted everyone to believe that he had run away from home. He told Poole that in particular he wanted his mother to suffer. 'I very devoutly repeated [my prayers] thinking at the same time with inward and gloomy satisfaction how miserable my mother must be!'[2] So rheumatic fever was associated quite consciously in his mind with his own infantile violence. It was at school that the disease was first diagnosed as rheumatic fever. Richard Holmes, one of Coleridge's shrewdest biographers, has noted that Coleridge's early poetry is often at its most emotionally charged when referring to situations in which a sick child is being cared for.[3] Coleridge spent much of his adult life looking for people to nurse him. But behind or alongside this quest for a nurse is a sado-masochistic relationship between a mother and a child in which a child is punished with the symptoms of rheumatic fever for wanting to punish his mother for loving his brother more than she loved him. Rheumatic fever was thus associated in his mind with a lack of maternal love and perhaps too with a feeling that he was himself unlovable. (Coleridge told Poole that he was his mother's favourite (CL I 347). Perhaps he was; but I do not think he felt himself to be her favourite.) After his discovery of Frank's suicide it became a precious relic of his dead brother.

When his recurrence of rheumatic fever showed no sign of abating, he decided that it had been reinforced by what he called 'gout of the stomach'. This exotic condition was almost certainly rooted in his use of opium which wreaks havoc on the stomach and the digestive system. But Coleridge thought it had to do with a series of experiments he had carried out on his own senses. These experiments, for which he made the most grandiose claims, were undertaken on behalf of his patron and benefactor Tom Wedgwood. But as I have suggested elsewhere, they were also intended to launch him in a new career as a metaphysician, leaving poetry to Wordsworth. Thomas McFarland in his classic paper, 'The Symbiosis of Coleridge and Wordsworth', talks of Coleridge's turn to metaphysics as part and parcel of a 'masochistic

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[1] For an explanation of this concept see Melanie Klein, *The Psycho-Analysis of Children*, (London: The Hogarth Press, 1932), p. 175.

[2] Earl Leslie Griggs (ed) *The Collected Letters of Samuel Taylor Coleridge* (London: Oxford University Press, 1956-71), 6 vols, I, p. 353.

[3] Richard Holmes *Coleridge: Early Visions* (Harmondsworth: Penguin 1989), p. 15.

submission' to Wordsworth.[4] I agree with him. And I would go further in saying that his gout was both a gift to Wordsworth (and, in a different way, to Wedgwood) and a means of talking about what it had cost him to be rebuffed by Wordsworth. Six months later, he would assert that he had scrofula, a completely different disease but one he attributed to childhood unhappiness and malnourishment at his school (CL I 756). This was the first time he allowed the psychological context to constitute the cause of a physical disorder. But here care is needed; Coleridge imagined that his childhood unhappiness wreaked havoc on his body very slowly over a long period of time: ten years or more.

To twenty-first century readers, these suppositions might seem fanciful but they were thoroughly compatible with the medical theories of Coleridge's time. Coleridge told his first biographer James Gillman that he first began to think seriously about medicine at about the age of 11 while he was still a schoolboy at Christ's Hospital. In 1784, his brother Luke spent a year 'walking the wards' of the London Hospital Medical College which had been founded barely a year earlier in Whitechapel by Sir William Blizard. Coleridge used to visit his brother at the hospital. 'Every Saturday I could make or obtain leave, to the London Hospital trudged I,' he recalled. 'O the bliss if I was permitted to hold the plasters, or to attend to the dressings… I became wild to be apprenticed to a surgeon.'[5] It's a pleasing anecdote which places Coleridge in a very particular moment in eighteenth-century medical history.

Newcomers to the history of eighteenth-century medicine often take their bearings from Michael Foucault's *The Birth of the Clinic* (originally published in French in 1963 and translated into English in 1973).[6] The word 'clinic' in Foucault's title is an awkward translation of the French word 'clinique' which means both 'teaching hospital' and 'clinical doctrine'. Foucault believed not only that the mindsets of physicians were transformed during the eighteenth century as a result of the growing importance of teaching hospitals but also that medicine changed its function then as well. This was not a straightforward matter. It needs to be borne in mind that in Britain physicians were the elite practitioners of medicine who usually treated only the very rich. The less well-off would have seen itinerant healers of various sorts, apothecaries, surgeons and surgeon-apothecaries. As a result of the establishment of teaching hospitals on the Leyden model in Scotland, physicians actually began to touch their patients' bodies. They learned to read pulses, they rediscovered the art of percussion (tapping the surface of particular body parts to determine their underlying structure) and they began to relate symptoms and signs garnered at the bedside to *post-mortem* findings. Teaching hospitals offered free treatment to the poor on the understanding that the patient's body would be given to the medical school in the event of his or her death. Pathology and physiology

[4] Thomas McFarland 'The Symbiosis of Coleridge and Wordsworth', *Studies in Romanticism* 11 (4), pp. 263-303, p. 270.
[5] James Gillman, *The Life of Samuel Taylor Coleridge* (London: William Pickering, 1838), pp. 22-23.
[6] Michel Foucault, *Naissance de la clinique:* . (Paris: Presses universitaires de France, 1963) translated by Alan Sheridan Smith as *The Birth of the Clinic: An Archaeology of Medical Perception* (London: Tavistock Publications, 1973).

became progressively more integrated and as we shall see, a great many medical doctrines were turned inside out. At the same time, as Foucault emphasises, medicine became an instrument of the surveillance of the health of the nation. In *The Birth of the Clinic*, the patient in the teaching hospital is in a similar situation to the prisoner in the Panopticon who features in Foucault's fourth book, *Discipline and Punish*.

Foucault says remarkably little about British medicine in this early work. Many critics have pointed out that the establishment of teaching hospitals here did not go hand in hand with an augmentation of the power of the British state; but there is no doubt that the birth of the teaching hospital did bring about a revolution in medical thinking. The most prestigious medical school by far and a major driving force behind doctrinal change both in Britain and further afield was that in Edinburgh. Edinburgh Medical School set up what became the Royal Infirmary as a teaching hospital in 1727 and the other Scottish universities followed suit in the decades that followed. Medical students at Oxford and Cambridge were not offered any experience at the bedside and consequently many undertook a course of study in Scotland on completion of their degrees in England. The London medical schools—such as Bart's, St George's and the London—were opened by ambitious surgeons late in the century.

The education Luke received at the London would have focused heavily on the structural details of the human body—he was going to be a surgeon, after all, not a physician—but the London Hospital also copied the practice of clinical lectures that were first instituted in Edinburgh. In fact, many of the lecturers used lecture series from Edinburgh as the basis of their clinical courses. Christopher Lawrence has argued that Scottish medicine of the second half of the eighteenth century was distinguished by two central doctrines: first, it pictured the human frame as an integrated totality of mind and body, mediated by the nervous system; second, it was committed to the concept of the 'reactive organism', that is, of living entities functioning biologically by reacting to stimuli in the external world.[7] The originator of this vision was Robert Whytt. Whytt was one of the most important physicians in Europe and his ideas underpin a great deal of Scottish Enlightenment thought. In a paper read before the Philosophical Society in Edinburgh in 1745 or 1746, he postulated the existence of an immaterial 'sentient principle' operating most conspicuously through the nervous system but being 'diffused throughout the body'. The sentient principle was not an autonomous force in the body in the manner of the soul in Georg Stahl's animist medical theory; rather—and this is the most crucial point about it—it was *roused into activity* by external stimuli and stimuli arising within the body; and it operated within the constraints set by the body's mechanical action. Coleridge gives us a version of the sentient principle in 'The Eolian Harp':

[7] Christopher Lawrence, 'The Nervous System and Society in the Scottish Enlightenment' in *Natural Order: Historical Studies of Scientific Culture*, eds. Barry Barnes and Steven Shapin (Beverley Hills and London: Sage, 1979), pp.19-40.

> And what if all of animated nature
> Be but organic Harps diversely framed,
> That tremble into thought, as o'er them sweeps
> Plastic and vast, one intellectual breeze,
> At once the Soul of each, and God of all?
>
> (CPW I 109)

Whytt used the word 'soul' interchangeably with the sentient principle; he saw himself continuing in the tracks of the illustrious anatomists Thomas Willis, Archibald Pitcairne and George Cheyne in presenting a 'philosophical', i.e. a scientific, view of the soul. The sentient principle lay behind the actions of the mind but was more wide-ranging than the mind in that it was also responsible for *all* physiological activities of which we are usually unconscious, such as the motions of the heart. It was a kind of master-principle in the body, guaranteeing the functional integration of the latter; but its operations were circumscribed by its dependence on stimulation. In this model, health was redescribed in terms of the state of the sentient principle which in turn depended largely on the state of the nervous system. Sensibility, defined as the capacity of the body to transmit and implement the instructions of the sentient principle, was the most important factor underpinning health. The task of the physician was to guide the patient towards the right life style for his or her inborn level of sensibility. The sentient principle led Whytt to postulate further what he called a 'general principle of sympathy that prevails throughout the body'. This is perhaps Whytt's most famous theory. Adam Smith said it was the basis for the quasi-automatic moral sympathy which he described in *The Theory of the Moral Sentiments*. In Whytt's theory, the general principle of sympathy underpins the feeling of wholeness and bodily coherence that the healthy in body take for granted.[8] Nervous disorders such as hysteria and hypochondria arise when the principle of sympathy becomes vitiated in some way.

It will be apparent even from this brief summary that in Whytt's theory the boundary between the mental and the physical in eighteenth century was at best fuzzy. For if all of the operations of the mind and the body were under the control of the sentient principle, there would be no physical illness that did not have mental *sequelae* and no mental disturbance that was not accompanied by physical infirmity. And though it is often forgotten, this was the consensus in medicine until the turn of the century: the concept of mental illness independent of physical illness wouldn't have made sense to anyone. Whytt was far from alone. He spearheaded a whole climate of opinion which dominated British medical education until the 1810s.

Nor was the mind-body split the only fuzzy area in eighteenth-century medicine. The boundaries between disease entities also became blurred. It

[8] Julius Rocca, 'William Cullen and Robert Whytt on the Nervous System', in H. Whitaker, C. Smith, S. Finger (eds.), *Brain, Mind and Medicine: Essays in 18th Century Neuroscience* (New York: Springer Verlag, 2007), pp. 85-98.

became common to say that diseases were quantitatively rather than qualitatively different from one another, difference now residing in the extent to which disordered states were based on too much or too little bodily stimulation. The consequence was a new skepticism about the existence of local disease. Medicine was the art of treating disease. Doctors believed in disease, but their faith in diseases as real entities was shaken. Diseases were merely the appearances assumed by disease. New classifications were drawn up, in which illnesses were reduced down to a very small number of general physiological principles. This work of massive reduction and synthesis was to preoccupy the greatest minds in eighteenth century medicine. For Foucault, it was what defined the 'clinic'. Most of these classifications, or 'nosologies', were loosely based on Linnaeus's classification of plants in *Systema Naturae* (1735). Whytt's great antagonist Albrecht von Haller attempted a nosology based on two fundamental classes, diseases of the irritability, which arose when the body had difficulty producing life out of external stimuli, and diseases of the sensibility, which arose out of an excess of facility. In William Cullen's *Synopsis Nosologiæ Methodicæ* (1769) the number was expanded to four as it was in Erasmus Darwin's *Zoonomia; or the Laws of Animal Life* (1794-6). In his highly influential *Elementa Medicinae* (1780) Cullen's embittered pupil John Brown, the founder of the so-called 'Brunonian' system of medicine, reverted to Haller's notion that there were two basic kinds of illness, though he supplied a different basis for the distinction between them.[9] For Haller and his disciples, the first step in any treatment was to identify the class to which a disease belonged. In the eyes of these men, specific conditions were just so many points on the spectrum of health and disease: they all had a common underlying cause which gave them an affinity with one another. For this reason they saw disease entities as inherently unstable, which if not quickly checked tended to agglomerate into more complex and more lethal conditions—an assumption that can be seen to colour Coleridge's anxious prognostications of 1801 to 1803.

Coleridge had been surprisingly close to the heat of those putative discoveries. He had known Dr Thomas Beddoes, the Bristol Brunonian, since 1795 and was aware of his plans to set up a small research clinic in which members of the public would be treated for a variety of conditions by breathing in various specially-prepared gases. There can be no better example of a Foucauldian *clinique* than Thomas Beddoes' Pneumatic Institution; for here was something akin to a teaching hospital, albeit on a modest scale, that was set up to test and propound the doctrines of John Brown. As a patient of Beddoes, Coleridge's friend and co-patron Tom Wedgwood donated a thousand pounds towards the establishment of the Pneumatic Institution, so seriously did he take the possibility of its success. And in 1800, a few months after his return from Gottingen, Coleridge went to the Pneumatic Institution as

[9] William Cullen, *Synopsis Nosiologiae Methodicae* (Edinburgh: A. Kincaid and W. Creech, 1772); Erasmus Darwin, *Zoönomia; or, The Laws of Animal Life*, 2 vols (London: Joseph Johnson, 1796); *The Elements of Medicine of John Brown*, ed. by Thomas Beddoes (London: Joseph Johnson, 1795).

a research subject in what is surely the most misrepresented scientific experiment of the Romantic period. The experiment into the effects of nitrous oxide which Humphry Davy oversaw was an attempt to see whether that gas was the most powerful Brunonian 'exciting power' that had yet come to light—in effect, whether it was the elixir of life. Davy famously concluded that it was at best a weak stimulant. Biographer after biographer has represented this episode as if it were an investigation into the gas's psychotropic effects. It was much more wide-ranging than that; but to see how, you have to understand the febrile condition of neurological medicine at the turn of the nineteenth century.[10]

Davy became disillusioned with grand neurological schemes and gave up on them, turning the next year to the chemistry of tanning. But it was at this precise moment in time—late 1800—that neurology forced its attention on Coleridge as never before. He entered a period of severe, chronic illness that lasted in one form or another for almost 33 years until his death in 1834. And in line with the prescriptions of his medically-informed acquaintance, he sought to understand his condition in the light of modern nervous medicine.

I won't rehearse here all of the details I have laid out elsewhere concerning Coleridge's application of medical theory to his own case.[11] Suffice it to say that the diseases Coleridge diagnosed in himself set the course of his intellectual development for some years to come. I shall focus on just one aspect of his self-treatment, namely, the management of his increasingly disturbing psychological symptoms. Beginning towards the close of 1802, Coleridge began to be plagued by nightmares. As Molly Lefebure has pointed out, these were at first irregular in their visitation but by the spring of 1803 had become increasingly frequent.[12] Now Coleridge would not have looked on nightmares with Freudian eyes, as signs of anxiety alone. For him, as for Hartley, Darwin and Beddoes, nightmares indicated a disorder of the body. Darwin thought it was a sign that the physiological agency by which the brain issued commands to the body—the 'volition'—was under strain. To Coleridge it seemed as though a new phase in his disorder was unfolding, one in which the 'nervous' strand in his 'gout' was gaining the ascendant. He tried to cut out opiates altogether and in August of 1803 went on a walking tour of Scotland with William and Dorothy Wordsworth. There he tried to walk forty miles in a single day in bare feet in the hope that exercise would take the place of opium in stimulating his body. He quickly discovered he was subject to shaking, fainting fits and the most excruciating nightmares. The shaking—which we recognise as a classic symptom of withdrawal—he interpreted as a sign of epilepsy in its early stages. He was led to this deduction partly because of reading a small book by Thomas Beddoes entitled *An Essay on the Disorders*

[10] The best account of the work of the Pneumatic Institution is to be found in Mike Jay, *The Atmosphere of Heaven* (London and New Haven: Yale University Press, 2009).
[11] See my *Coleridge and the Doctors* (Oxford: Clarendon Press, 2004).
[12] Molly Lefebure, *Samuel Taylor Coleridge: The Bondage of Opium* (London: Gollancz), p. 374.

commonly called Nervous.[13] This essay takes epilepsy as representative of all nervous disorders. At its heart is the case history of Karl Wilhelm Ludwig von Drais (1755-1830), a high-ranking civil servant in the Grand Duchy of Badenein großherzoglicher, badischer Geheimrat, who in 1798 published (anonymously) an account of his struggle with epilepsy, *Diaetophilus, physische und psychologische Geschichte seiner siebenjahrigen Epilepsie*. Beddoes said of this account that it gives 'a clearer representation of the ebbs and flows and eddies of the mind in epilepsy than all the writings of medical men put together'.[14] Most of von Drais's book takes the form of a journal which he kept with the aid of his wife. A clue to his approach can be glimpsed through his pseudonym. *Diaeta* in medical terminology means 'ordinary or prescribed course of life' (*OED*). By implication, we might think that the cure for epilepsy is to be found in regular, wholesome habits. I do not have time here to summarise the whole of Beddoes' readings of von Drais's book. It can be said, however, that one of the most powerful causes of von Drais's epilepsy was his habit of suppressing thoughts of a sexual nature. These then dominated his sleep leading him to masturbate and to have nocturnal emissions which in turn gave him epilepsy. But note the radical psychologism of Beddoes' view: he was saying that epilepsy was psychically caused.

I have suggested in *Coleridge and the Doctors* that Diaetophilus's case had a profound influence on Coleridge's view of his own infirmities. He came to believe that his nervous symptoms, especially those he had previously attributed to his gout, were psychically caused. His consciousness, as he told Sir George and Lady Beaumont, was taken up with 'Love, and Pleasure and General Thought' (CL II 1049). In more expansive mode, it also encompassed 'vivid Ideas drawn from Nature & Books' and was 'habitually applied to the purposes of Generalization.' But he was unable to make 'Grief & Trouble' or 'all the Feelings which particularly affect myself, AS myself' the 'objects of a distinct attention'. In consequence, thoughts falling into these categories '[connected & combined] with [his] bodily sensations, especially the trains of motion in the digestive Organs'. 'Grief and trouble' were to Coleridge what sexual ideas were to Diaetophilus. This account of his infirmities dominated Coleridge's stay in Malta and well beyond it. 'My stomach indeed is very weak', he wrote to his wife on 5 July 1804, 'the mesenteric Glands are certainly affected by the habit of suppressed painful Thought—yet still I live in Hope that gradually I shall bring myself around' (CL II 1143). And in line with this prescription, he spent the next several years minutely examining his consciousness for signs of the suppression of painful thought, detailing the

[13] Thomas Beddoes, *Hygëia: or, Essays Moral and Medical On the Causes Affecting the Personal State of Our Middling and Affluent Classes*. 3 vols (Bristol: Bulgin and Rosser, 1802-3).

[14] For an account of the impact of Von Drais's work see Gerhard Sauder, 'Nosce te ipsum! Diaetophilus, Krankentagebuch und Geschichte der Selbstheilung von siebenjähriger Epilepsie (C.W.L. Freiherr von Drais von Sauerbronn)' in Dietrich von Engelhardt, Hansjörg Schneble und Peter Wolf (eds.), *Das ist eine alte Krankheit: Epilepsie in der Literatur.* (Stuttgart: F. K. Schattauer Verlag, 2000), pp. 237-250.

results in Notebooks, in the hope of 'bringing himself around'.[15]

In a very fine article in this journal, Kenneth Boyd suggested that Coleridge's efforts late in his life to 'unify the interior with the exterior, the I AM with the it is' originated in his attempts to get to grips with illness early in the 1800s.[16] I agree with him. I have described Coleridge's involvement in medicine in terms of medical theories and treatments. But I could with equal justice have described the same events in philosophical terms which happen to have been the terms he himself often used. For not only did Coleridge treat himself in a manner consistent with 'advanced' eighteenth-century neurology, he also sought to use the experience of illness to clarify and extend its research programme, especially in relation to the interaction of the mind and body. Up until 1810 at least, a large share of his intellectual energy was directed at laying the groundwork for a new field that would encompass neurology, the psycho-physiology of perception and aesthetic and religious experience. In attempting such a synthesis, he was of course carrying on the work of men such as Haller, Cullen and Brown attempting in their different ways to make medicine consistent with Newtonian physics. There is a similar speculative breadth and a similar sense that world-historical breakthroughs lie just out of reach.

The first sketch of this new field emerges in the letters Coleridge wrote during the Spring and Summer of 1801 in which he oscillates between hypochondriac certainty that he is about to die and euphoria that his debility has slowed down his perceptual processes to such an extent that he can observe them in ways that a healthy person could not. In this latter mood he often suggests that he has gained directly, *from first-hand experience*, insights that have eluded most philosophers of perception because they had had to proceed more dogmatically.

It was this megalomaniac side of Coleridge's relation to medicine that most excited me when I carried out the research for *Coleridge and the Doctors*, no doubt in part because it resonated with megalomaniac aspects of my own character. I was passionately interested then, as I am now, in how people's intellectual development interacts with their affective life. Coleridge's illnesses fascinated me because they transformed his relationships—notably with his wife and with Wordsworth but fundamentally with everybody—and at the same time set the course for his intellectual evolution for ten years at least. I believed that I could see an unconscious dimension in Coleridge's relationship with medical ideas. To give one example: it seemed to me that one of the things that brought him close to Tom Wedgwood was a determination to use Wedgwood's illness as a kind of template for his own. Wedgwood told everybody that he'd been made ill by too much speculating. Coleridge's 'dejection' was borne out of unconscious identification with this broken-down, brilliant figure. Though I was careful not to use any psychoanalytic language in

[15] I have argued elsewhere that this understanding of the relationship between his bodily and psychological infirmities strongly influenced his Shakespeare criticism, especially his lectures on *Hamlet*, and underpins his slow espousal of a metaphysics related to Kant's transcendental idealism. See my 'Coleridge and the idea of 'Psychological' Criticism', *British Journal of Eighteenth-Century Studies* 2007 30 (2), 261-278.

[16] Kenneth Boyd, 'Medical Research and Metaphysical Imagination', *Coleridge Bulletin* (NS) 33, 2009.

the book (in my own name at least), I was and am proud of what a Freudian work it is. It was only thanks to a series of tacit psychoanalytic assumptions that I was able to weave together medicine, philosophy, and human relationships like strands of a rope to produce a 'thick description' of what it was like to *be* Coleridge.

Even as I was setting my conjectures down, I was conscious that there was another way of constructing Coleridge's relation to medicine that was less personal: by placing him in relation to the emergence of modern medical disciplines. This 'other way' was Foucault's. By way of a conclusion I would like to acknowledge some of what I missed when I neglected this great thinker.

Throughout his *oeuvre* Foucault argued that in the late eighteenth-century the emerging human sciences were characterized by ever-greater privatization of individual responsibility and a corresponding need for greater scrutiny of individual subjectivity. Thus, in *Madness and Civilization* we read that that paragon of humility and compassion Samuel Tuke (the founder of the York Retreat) 'created an asylum where he substituted for the free terror of madness the stifling anguish of responsibility; fear no longer reigned on the other side of the prison gates, it now raged under the seals of conscience'.[17] In like fashion, the prisoner in Jeremy Bentham's Panopticon had to learn to police his own behaviour because someone might be looking at him at any moment. As Foucault put it in *Discipline and Punish* (1976), 'The Panopticon is a privileged place for experiments on men, and for analysing with complete certainty the transformations that may be obtained from them. The Panopticon may even provide an apparatus for supervising its own mechanisms.'[18]

Some of this internalisation of the burden of modern sickness can be seen in Coleridge's case too. As I showed earlier on, he came to believe that he could control his physical symptoms by monitoring his consciousness minutely. I did not mention the further detail that he told almost nobody about this mode of treatment: his wife, his employer Sir Alexander Ball and Stuart—but almost no one else.

Foucault held that modern subjectivity was predicated on the rise of various disciplines, each of which would prove its worth by contributing to a new, 'scientific' understanding of humanity. Those who practised the disciplines were legitimising certain ways of talking about people, and to these ways of talking Foucault gave the name *discourses*. In *The History of Madness* he charts how the discourse on madness which eventually assumed the name of psychiatry emerged dialogically out of a distinctly modern view of 'unreason' (*déraison*). Psychiatry eventually became a kind of 'knowledge with a lower-case k' which Foucault would have called a *connaissance*, distinct from *savoir*. In writings by or about Foucault, 'savoir' is sometimes translated as 'depth-knowledge'. *Savoir* refers to the set of deep assumptions which enabled the

[17] Michel Foucault, The History of Madness, edited by Jean Khalfa and translated by Jonathan Murphy (London:Routledge, 2006), p. 485.

[18] Michel Foucault, *Discipline and Punish: the Birth of the Prison* translated by Alan Sheridan Smith. (London: Allen Lane, 1977, repr. 1996), p. 204.

knowledge-claims peculiar to particular discourses to count as meaningful. The things that were said about the nervous system in 1780 would have made little sense in 1680—not just because different things were known about the brain in 1780 but more fundamentally because the conceptual weight of the 'nervous system' in a range of discourses had changed almost beyond recognition. For Foucault, these tectonic shifts in the meanings of concepts are always the result of complex, trans-discursive, socio-political changes in *savoir*. The task of the historian is to undertake 'archaeological' research into the conceptual ruins created by *savoir* on which discourses take their rise. Conceptual archaeology enables us to piece together a picture of 'man' in all his historic mutability. (Foucault described himself as an 'anti-humanist' concerned to undermine the idea of a trans-historical stable human nature.)

It's a very powerful paradigm and historians and sociologists continue to apply it creatively to our own culture. The philosopher Ian Hacking, a sometime Foucauldian, has written movingly about the problem of what he calls 'Making People Up'.[19] A century ago, psychiatrists discovered mental dissociation and conjectured that some people had 'multiple personalities'. The condition more or less disappeared as a result of the institutional triumph of Freudian psychology over Pierre Janet's theory of *désaggregation psychique* and Breuer's 'hypnoid states'. Then in the early 1970s, with the decline of psychoanalysis, psychiatrists in the United States revived the conjecture. First, a person had two or three personalities. Within a decade the average number was 17. In Hacking's words '[having a multiple personality disorder] became a way to be a person.'

When we bear in mind the rich socio-psychological, religious and philosophical hinterlands involved in diagnosing oneself with 'irregular atonic scrophulous gout' it becomes possible to see how those medical conditions also offered Coleridge a way of being a person in 1801. More than this, Foucault's methodology helps us to see how Coleridge the medical student was unusual in being focused pretty consistently on *savoir*. I often think that the only defect of British medical historians of the eighteenth century is that they are so alive to the comicality and the preposterousness of eighteenth-century medicine that they occasionally overlook its more serious ramifications. It is easy, in retrospect, to patronize Coleridge as a hypochondriac. Gout was never just gout for him just as epilepsy was never just epilepsy. Those conditions were facets of human life with points of anchorage extending well beyond medicine into our experience of the godhead, and of imagination; they shaped our relations with others; and they shaped others' relations with us. It is this complex groundwork that Coleridge's reflections on his own condition attempt to throw into relief. If Coleridge took too much on trust from his learned medical contemporaries, it was partly because his intellectual energies were always directed at this more fundamental level—the level of *savoir*. This is what gives his medical studies an abiding interest and dignity.

[19] Ian Hacking, 'Making People Up', *London Review of Books* 28 (16), 17 August 2006. Available online here: http://www.lrb.co.uk/v28/n16/ian-hacking/making-up-people