The Role of American Domestic Medicine in the Nineteenth Century: Implications for Modern Populations with Low Access to Health Care

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THE ROLE OF AMERICAN DOMESTIC MEDICINE IN THE NINETEENTH CENTURY: IMPLICATIONS FOR MODERN POPULATIONS WITH LOW ACCESS TO HEALTH CARE

By

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Thesis Summary

Domestic medicine can be defined as medical treatment provided within the home or community that is administered by a member of that home or community who is not a physician, surgeon, or nurse. During the late nineteenth and early twentieth century, domestic medicine flourished as housewives began to take on the role of medical practitioner. This was an attempt to alleviate the stress of low healthcare access that plagued lower-income and rural communities. Among lower- and middle-class communities in present day, we continue to see disparities in access to quality health care. I will argue that telemedicine has transformed during the pandemic to become an effective, though not perfect, solution to healthcare disparities present in modern America, similar to domestic medicine’s solution to healthcare disparities in the nineteenth century.
Introduction

Low access to quality health care in America has resulted in poorer outcomes for minority populations across the country. In rural areas, there are a variety of barriers that prevent residents from accessing health care and maintaining appropriate health seeking behaviors. For example, lack of transportation, poor health literacy, and workforce shortages prevent individuals from accessing their primary health provider on a regular basis which results in poorer health outcomes in rural communities (MacKinney et al., 2014). These healthcare disparities are a product of poor healthcare infrastructure that began in the early nineteenth century. As industrialization pushed people into cities, healthcare practitioners also moved closer to cities. Transportation into rural communities failed to be prioritized and lower healthcare access resulted. During the late nineteenth and early twentieth century, domestic medicine flourished as housewives began to take on the role of medical practitioner. This was an attempt to alleviate the stress of low healthcare access that plagued lower-income and rural communities. Thus, healthcare became a nonprofessional trade among lower- and middle-class families but remained as effective, if not more so, than the health care provided by medical professionals.

Domestic medicine can be defined as medical treatment provided within the home or community that is administered by a member of that home or community who is not a physician, surgeon, or nurse. Throughout history, there are many different names for this type of medicine that are all referring to the same category of home medical care. In the nineteenth century, domestic medicine, natural medicine, and home remedies were common names to refer to home care. Domestic medicine became a popularized term in nineteenth century America with the publishing of William Buchan’s “Domestic Medicine.” William Buchan was a Scottish physician who wanted to distribute his medical knowledge to different homes in words that were easily
comprehensible (Dunn, 2000). This book was first published in 1796 and continued to edit new editions through 1913 which reflects public interest in the topic (Rosenberg, 1983). One reason domestic medicine was especially common in nineteenth century America was the incomplete and inefficient profession of medicine. The available treatments provided by medical professionals were no more effective than home remedies. Moreover, home remedies were better tolerated and less debilitating, than were the rigorous, aggressive, and harsh treatments provided by medical professionals. Thus, many Americans lacked trust in the professional medical community.

I will show in the first part of the paper that domestic medicine was widespread and important. It both complemented and substituted for a physician’s advice. More importantly, in the second part of the paper I will argue it can be used to significantly supplement medical care from a doctor. It could be particularly useful in areas where healthcare disparities are more prominent, income is low, and doctors are not easily available or affordable.

**History of American Medical Theory**

*Humoral Theory*

In very early colonial America, there were few, if any, medical professionals; domestic medicine was the only medicine that existed. The origin of domestic medicine would be the equivalent of the origin of medicine. It is unclear when medical professionals officially arrived but even so, they would have been in short supply, but certainly by the middle of the eighteenth century they began to arrive. Domestic medicine was the original form of medical delivery not only in America, but all the way back to ancient Greek and Roman societies. Public hospitals were officially established in 1736 in New York from the Almshouse, and this combined with technologies, developed later in the nineteenth century, sparked the beginning of the transition
away from domestic medicine delivered within the home and towards hospital care administered by doctors (History of Public Hospitals in the United States - America's Essential Hospitals, n.d.). In nineteenth-century America, hospitals were “charitable organizations primarily used by patients who did not have a family to take care of them” and visits were unusual compared to physician visits and surgical procedures that were typically performed within the patient’s home (Domestic Medicine | Contagion - CURIOUSity Digital Collections, n.d.). The transition towards hospital care was partly a result of the transition from the humoral theory of disease to the germ theory of disease.

The humoral theory of disease, developed by Hippocrates, asserted that four major humors within the body determined a person’s health as seen in Image 1 (ADMIN, 2011). Any sickness or ailment was a result of an unbalanced humor, and the resulting treatment would be to restore this balance. This was typically restored through procedures such as bloodletting or induced vomiting and sweating that would be performed within the home. Most of the disease transmission was attributed to miasma, or bad air, and not to contamination and transmission between individuals. As such, there was no harm to keeping a sick patient in the home with family and using household devices to induce bloodletting and then cook dinner.

Germ Theory

The germ theory of disease asserted that different microorganisms, or germs, caused different diseases and could be transmitted from an infected patient to another patient. At first,
this transition was not accepted within the medical community and was essentially rejected
among the public. Over time, this theory became the modern theory of disease throughout the
world. In America specifically, it was not until after 1880 that the germ theory of disease was
widely accepted (Richmond, 1954). In fact, Europe’s medical community was experiencing the
greatest activity with the theory between 1850 and 1880. This means that European scientists and
citizens were becoming accepting of and interested in the theory while Americans were still
rejecting it (Richmond, 1954). The hesitant acceptance of this theory of disease drove domestic
medicine to remain an essential piece of medical care delivery at this time as physicians
practicing humoral theory were still predominant.

Domestic Medicine

Definitions and Concepts

During the first half of the nineteenth century, domestic medicine primarily focused on
botanical treatments while the second half began focusing more on prepared treatments among
professional medical providers as well as among some domestic providers. Herbs such as
lavender, rosemary, wormwood, sage, foxglove, mint, and more were used to treat headaches,
dropsy, or stomach pains (Backus, 2021). There was also emphasis on miasma, or bad air, and
treatment included moving patients to the mountains or coast where the air was suspected to be
cleaner and would induce healing (Health & Medicine in the 19th Century - Victoria and Albert
Museum, n.d.). Botanical treatments were common in households because they was familiar and
because the rise in popularity and frequency of hospital visits was not until after the publication
of the Flexner Report in 1910. As noted in one review of the contents of domestic medical
chests, “heads of households were often reminded of the importance of having remedies
available in the home” (Creltin, 1979). These practices were passed down through generations
and recorded in various Domestic Guides that were published. Buchan, the British surgeon and apothecary whose book “Domestic Medicine” sold over 80,000 copies, believed in increasing access to medical knowledge and demystifying the medical profession through the dissemination of his book. He believed that disease prevention was just as important as treatment of the illness itself. Lay men would be able to protect themselves against the causes of disease. Thus, Buchan believed, that the actual incidence of disease itself would decrease (Dunn, 2000). Home medicine was the main form of care delivery and housewives were trained by their mothers in this area. Women’s trade was “household maintenance, childrearing, gardening, cooking, cleaning, and doctoring” and they were expected to keep any medical supplies in the home and be trained in how to use them appropriately according to the then currently accepted theory of disease (Apple, 1987).

J.K. Crellin was a British author and professor who ran the Newfoundland Journal that published various pieces on the importance of medicinal herbs and plants within a medical chest (Crellin, n.d.). Along with the discussing the contents of domestic medical chests in his journal, J.K. Crellin also noted that the medical care being administered by the housewives “upheld current, orthodox medical practice” and was truly replacing the care of a physician in early-nineteenth-century America (Crellin, 1979). There was a population that switched from domestic medicine to care from medical professionals at the turn of the century, but childbirth and infant care remained mostly domestic. While domestic, maternal care was also the common method of care delivered to infants, the care of infants and children has remained a household task more than other types of medical care. In the early nineteenth century, when the humoral theory of disease was prominent, expectant mothers and their infants were safer having a home birth with a midwife than in a hospital. While this has since changed, many women and families still choose
to give birth and nurture the infants at home instead of at the hospital (Schram, 2009). As shown in the graph, in modern America, women are beginning to choose to birth their children at home rather than in a birthing center in the hospital (Macdorman et al., 1990a). Moreover, in the early nineteenth century when there was no technology available in the hospital, the quality of care was no different at home than in the hospital and may have even been better. In 1900, almost all U.S. births occurred outside of the hospital, but this number fell to 44% by 1940 (Macdorman et al., 1990b). This was indicative of the high quality of care and comfort that could only be achieved in the household surrounded by family and close friends within the community in 1900. It only changed with truly modern hospital care in the mid-twentieth century.

Domestic medicine was an essential aspect of the healthcare system before the turn of the century. Many preferred botanical and herbal healing solutions simply because of the pain inflicted by their counterparts, bloodletting and purging. The efficacy of botanical and herbal solutions was probably not much different than the efficacy of professional medical care and medicines. Oliver Wendel Holmes Sr. in 1860 said “If the entire materia medica could be sunk to the bottom of the sea it would be all the better of mankind and all the worse for the fishes” showing how ineffective the medical profession and their treatments were at the time (Modell, 1963).
During the transition from herbal treatments at the beginning of the nineteenth century to prepared treatments during the second half of the nineteenth century, patent medicine became increasingly popular. These ‘medicines’ were created by nonmedical professionals and typically included things like opiates that were marketed towards the general public for having health benefits. They were readily available at local pharmacies without a doctor’s prescription and were not regulated by the government during the nineteenth century. However, these medicines were not highly effective. They were created during the Civil War in America and became more popular during the second half of the nineteenth century as a rival to heroic medicine. These medicines were not necessarily effective but they were less harsh than any treatment performed by a medical professional (National Museum of American History, n.d.). On the right are images of some of the more popular patent medicines that are still in circulation today (National Museum of American History, n.d.). Since most of the patent medicines were never officially patented, they were able to be remade by chemists and pharmacists after the twentieth century and now bode more efficacy.

Effectiveness and Necessity

Domestic medicine was the main component of health care delivery in the nineteenth century because in rural America and along the western frontier, trained physicians were in short supply and were usually attending to wealthy individuals who could afford the steep prices. As such, many of the domestic medicine guides kept in households were entitled, “Poor Man’s
Guide" or "Poor Mans's Physician" (Gevitz, 1990). A lack of communication and transportation contributed to physicians being unable to meet the needs of their patients (Gevitz, 1990). Thus, women and the clergy became the primary deliverers of care when someone was sick or injured. One author stated that domestic guides were written "specifically for the use of the clergy", a reminder that many clergy played a significant role in rural medical practice well into the nineteenth century (Crellin, 1979).

Physicians treated several categories of patients. On the one hand, they treated those without money or a family. However, their favorite populations were the wealthy, and they were not shy about charging exorbitant fees. Middle class patients with common ailments would have been taken care of by physicians but the cost prevented many from calling the physician until the disease was severe. These families were forced to consider the cost and would not willingly submit to the expensive fees of physicians until the disease had progressed substantially. These domestic guides to health were incredibly common in low to middle class families to save money on physician fees and reduce the risk of having a physician treat the family members (Gevitz, 1990).

Domestic medicine was a common household practice because it replaced the failing medical profession in the early nineteenth century. In the early nineteenth century, Daniel Drake noted that domestic medicine was "both a body of theory that adequately explained health or illness and a set of procedures adequate for the treatment of illness or the maintenance of health" (Shapiro, 1985). This harsh critique of the medical profession was all the more shocking as it came from Drake, an established physician and highly regarded educator, who would eventually establish the medical school in Cincinnati, Ohio (Daniel Drake, n.d.).
Cholera epidemics swept through America in the 1830’s and 1840’s. It killed many and sickened many more and the medical community had nothing to offer in terms of treatments as epidemics occurred, disappeared, and reappeared over the course of a few decades. This lack of knowledge and effective treatment emphasized the inadequacy of professional medicine and further pushed skeptics of the profession to denounce members of the medical community as “useless and wrong” (Shapiro, 1985). Hence, the combination of familiarity with the practice of domestic medicine and the skepticism surrounding the medical profession’s ineffectiveness produced the perfect environment for domestic medicine to thrive and become a leading mode of delivery for healthcare.

During the nineteenth century, American medicine had very little effective medications and surgeries that could be used to improve patient outcomes. One common practice was heroic medicine. This was a very extreme treatment that involved bloodletting, purgatives, blistering, medicinal mercury. It was uncomfortable unpleasant, and debilitating treatment or regimen. The reason for this was the lack of training for nearly all physicians. Most were trained via two-year apprenticeship, but few had a formal education. The humoral theory of illness was still present, so the main technique was bloodletting or providing the patient with a laxative which was at the heart of heroic medicine. Increasingly, the practice of heroic medicine resulted in a negative perception of professional medical treatment by a physician when the individual was not of the upper class. On the other hand, domestic medicine was “acceptable on a variety of grounds ranging from the view that the advice they gave was at least harmless (and perhaps tended to counteract the activities of quacks), or that is supported orthodox practice” (Crellin, 1979). Domestic medicine tended to be more gentle and was not associated with a negative outcome like death or increased symptoms. Later, in the twentieth century, when more effective
treatments were available, housewives were still expected to keep home remedies available in the home to administer in case of an emergency. The distrust of physicians was waning but in an emergent situation where a patient could die soon, home remedies administered by the family were chosen over a physician’s care (Crellin, 1979). The "very bad consequences" associated with ‘modern medicine’ were infiltrating all thoughts of danger and death in health care and most patients felt more comfortable being cared for by the mother or wife who has been trained for decades instead of a male physician who only trained for two years (Crellin, 1979).

Domestic medicine in rural areas was used to balance unequal access to care to which urban areas were not exposed. Quite unexpectedly, even though urban areas were overcrowded, poorly sanitized, and poverty-stricken areas, their disease death rate was still lower than rural areas because of a lack of healthcare access. This disparity can be seen in the “Report on Vital and Social Statistics in The United States at the Eleventh Census” in 1890 that collected death rates for a variety of diseases and stratified the data by geography, urban versus rural communities (Billings, 1896). This data combined with lack of healthcare access, suggests that the likely cause of higher death rates in rural areas was lack of access (Billings, 1896). This disparity was able to overcome other social determinants of health such as poor housing and lower income that typically result in higher-than-average death rates.

### Modern Social Issues

In modern America, medicine as a profession has advanced far beyond that of nineteenth century American medicine. The germ theory of disease has been solidified and accepted, medical technology is advancing far beyond what was expected, and the profession is highly

<table>
<thead>
<tr>
<th>Death Rates per 1,000 People</th>
<th>Rural</th>
<th>Urban</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whooping Cough</td>
<td>9.91</td>
<td>6.52</td>
</tr>
<tr>
<td>Malarial Fever</td>
<td>29.74</td>
<td>9.18</td>
</tr>
<tr>
<td>Respiratory Disease</td>
<td>172</td>
<td>163.88</td>
</tr>
</tbody>
</table>

Table 1.
respected and effective. However, there are still vulnerable populations within America that could benefit from the advantages of domestic medicine. Immigrant populations, rural areas, and low-income communities have less access to health care and are in need of alternative forms of healthcare to meet their medical needs. The high cost of health care is one reason that these vulnerable populations are not able to access health care and would benefit from domestic medicine. One study conducted on U.S. cancer survivors found that more than two million survivors did not get one or more needed medical services because of financial concerns and 7.8% of cancer survivors forwent a medical appointment because of the cost (Weaver et al., 2010). Populations struggling with low wages cannot afford the steep prices of care and prescription medications and are having to sacrifice their appointments. As mentioned earlier, one of the main beneficiaries of domestic medicine are those who cannot, or choose to not, afford standard medical care. Crellin opined that the purpose of having a domestic medicine chest was to “exercise the greatest benevolence by administering to the disease of the poor and indigent neighborhood” (Crellin, 1979).

Specifically within rural areas, there are plentiful barriers including “lack of transportation, insurance, or family support; the daunting complexity of the health care system; poverty; culture; poor patient-health care provider communications; race/ethnicity; and lack of health care professionals such as nurses and doctors with adequate geriatric preparation, or generalists who are undereducated in geriatrics” that prevent patients from accessing quality medical care (Horton & Johnson, 2010). Access to care in rural communities is one of the largest
barriers. As seen in the graph on the right, access to medical care, dental care, and mental health care is significantly lower in rural communities than non-rural communities (LaPointe, 2017). By addressing this barrier to accessible healthcare, patients can begin to receive better care and have better health outcomes.

Generally, patients in rural communities tend to be poorer, older, and less insured than patients in cities (Ricketts, 1999). The barriers to accessible and quality health care coupled with the pre-existing medical vulnerability of individuals in rural communities makes this population an idea candidate for domestic medicine. Health care that could rival the orthodox practices of modern medicine that could be provided within the home. Further, residents of rural communities tend to be more reluctant to seek health care from a physician both due to financial burden, scarcity of service, and cultural concerns (Douthit et al., 2015). Financial burden and ease of access are the main concerns that prevent patients in rural communities from accessing health care that is widely available in more urban areas.

Solutions

Domestic medicine can only remain a viable option for less severe illnesses and injuries. The development of modern medical treatments in the twentieth and twenty-first century has far surpassed that of the nineteenth century. Treatment for cancers, cardiovascular disease, broken bones, etc. in the hospital by a medical professional has been proven to be extremely effective. Technology has also advanced extremely far since the nineteenth century. For example, x-ray,
MRI, blood panel, and sterile surgery have all been developed and are an essential part of the modern medical diagnostic plan. The majority of these technologies are only available at a medical facility and cannot be substituted by domestic medicine or telehealth. Further, the assistance of a trained medical professional is also needed to help the patient understand what diagnostic tests, if any, are needed. However, there are some at-home diagnostic tests that are available for minor or common illnesses and injuries. For example, at-home COVID-19 self-tests are available for free through insurance and are extremely reliable and are a legitimate substitute for a COVID-19 test performed in office (CDC, 2022). First aid supplies for more minor injuries, like a sprained ankle or a small burn, can also be found at local pharmacies without the prescription of a physician.

Similarly, the pharmaceutical industry has made massive strides in their development of effective prescription medications. Thus, domestic medicine is not able to replace the entire modern medical practice in the same way that it could in the nineteenth century. So, how are low income and low access communities able to combine both domestic medicine and physician care comprehensibly and manageably? There are many options, from home hospital care to telehealth, that take advantage of the unique advantages of domestic medicine.

Home hospital care has been available in urban areas since the beginning of the twenty-first century and has typically been in the form of hospice care. More recently, it has expanded to include care for a variety of chronic illnesses such as diabetes and hypertension management. However, these services are typically unavailable in rural communities where, arguably, there is the greatest need. One study conducted interviews with patients in rural communities who stated that they were “open to receiving acute care” to reduce their need for constant readmission to the hospital in the city. However, the main barriers to these services are the availability of skilled
human resources and geographic accessibility (Levine et al., 2021). Once these barriers are overcome, home hospital care in rural areas would provide an excellent form of domestic medicine that allows a patient to be treated from their home.

Traditional domestic medicine was applied in the form of botanical treatments that could be applied externally or taken orally. Consuming specific herbs in order to better health can be applied to the modern understanding of healthy eating in order to reduce the incidence of multiple chronic illnesses. However, access to and education on healthy foods is not particularly high in lower income and marginalized communities. In order to increase awareness of the importance of healthy eating with respect to health, physicians should be trained in the importance of proper education on this topic. One study found that when physicians were aware of resources in their community that would provide inexpensive healthy foods, their patients were more likely to take advantage of that resource (Rosenbaum, 2021). This is an example of a term called ‘wrap-around services’ that provides social and medical resources to patients. In terms of modern domestic medicine, this is a concept that would provide home care and prevention through food without the need for additional medical visits and treatments.

A great modern-day solution is the addition of telemedicine. This system of virtual healthcare visits was developed in the twentieth century to satisfy the need of NASA to communicate with their astronauts as they journeyed to space. Since then, it has been revolutionized to become a substitute for a traditional doctors visit when a physical examination is not necessary. With the current COVID-19 pandemic, technology and physician advancements in this field have increased and developed telemedicine into its own unique field. Internet access has become more widespread, and the COVID-19 pandemic has increased insurance coverage of virtual visits (Mahtta et al., 2021). Telehealth has been shown to be a cost-effective system for
healthcare delivery and has even improved healthcare outcomes since its implementation at the beginning of the current pandemic (Mahtta et al., 2021).

This increases the area that a physician can cover from one practice and increases the medical access to members in low access communities. Further, domestic medicine is still able to replace many unnecessary doctor’s visits. For example, influenza, colds, headaches, sprained ankles, etc. can still be treated at home. In fact, many physicians do not prescribe any prescription grade medications for these ailments. Thus, by combining domestic medicine for minor illnesses and telemedicine for physician advice and treatment, members of low income and low access communities would begin to increase their overall health.

In one example, a virtual urgent care (VUC) was recently developed as a trial in North Carolina to offer telehealth services specifically to communities in poverty. This program was advertised through social media as well as through physician’s offices. The program was streamlined through one platform and did require the participant to have access to Internet. This program reached 18% of impoverished zip codes, 20% of predominantly African American zip codes, and 17% of predominantly American Indian zip codes within the first four quarters. This study has increased access to primary health services in the form of a cheaper, online healthcare service that was otherwise unavailable in many zip codes. This study commented on future studies closely monitoring the Internet requirements and evaluating how accessible free, or inexpensive, Internet access is in rural areas of minority populations (Khairat et al., 2019). While this is not an example of a flawless system, it shows that the current pandemic has opened the door for researchers to begin making adjustments to telehealth systems, targeting underserved populations such as minority groups and rural communities, and continuously molding programs to significantly reduce the gap in healthcare access and affordability.
During the COVID-19 pandemic, many aspects of health care access were altered. Various centers reduced hours to reflect a reduction in staff and others were moved online to reduce the spread of infection. One new tool to better measure health equity factors with respect to online medicine is the Digital Health Equity Framework. This framework was developed as a response to the World Health Organization’s 4-year strategy to build up the digital health care infrastructure to measure the social determinants of health that would interact with digital health care. This new framework is able to detect and measure how environmental factors such as internet access and housing will affect a patient’s access to affordable digital health care (Crawford & Serhal, 2020). This is especially important when considering a person’s access to online healthcare, online health information regarding COVID-19, and communication with others. During COVID-19, many practices have begun to disseminate health information primarily online, so it is important to assess what populations do not have access to this information in order to engage in alternative ways of spreading information.

Dr. Jenay Beer at the University of Georgia is working to develop a Cognitive Aging Research and Education (CARE) center that will be one of the first examples of a state-wide telehealth initiative that is truly accessible to all. This center is currently on a trial basis in four counties in Georgia with the goal of eventually being present in all counties across the state. It has a base in Athens, sponsored by the University, and extension centers in four other counties. It also provides training to physicians to recognize signs of both Alzheimer’s disease and other dementia’s as well as free health care to any older adult. Some services offered to patients include dementia assessment, treatment plan, and referrals. These extension centers are operating via telehealth to the main center and all of the technology and internet is provided at the center. The goal of this project is to allow free access to quality health care for older adults across the
state. The current trial counties are situated in rural areas with higher populations of low-income and minority racial and ethnic populations (Baggett, 2022). If successful, this program will be able to vastly reduce the disproportionate gap in healthcare access present in minority racial and ethnic groups in Georgia and potentially other states.

Telehealth is not limited to use by medical doctors. One study showed that patients who were seeing physical therapists and rehabilitation specialists through telehealth had success rates equivalent to in person visits for specific conditions and therapies. For example, patients with severe burns who sought telehealth for pain management visits were as successful with their prescription changes as those who used in person visits for the same request. Patients who have suffered from stroke or spinal cord injuries and are in need of supervision for their exercises were able to do so through telehealth. There are obvious limitations to this practice that prevent the therapist from performing a complete physical examination and developing a personal rapport with the patient; however, this was not shown to affect the patients outcome (Tenforde et al., 2017).

A modern interpretation and implementation of domestic medicine has many advantages that will serve to reduce the healthcare disparities present in rural and minority communities. Systems such as home hospital care and telemedicine serve to address a disparity in access to care. While today’s scientific medicine has advanced far beyond its nineteenth century practices that warranted the development of domestic medicine, there are many novel disparities that modern domestic medicine would better alleviate than does its twenty-first century professional counterpart.
Conclusion

Domestic medicine was an original form of medical care and remained a significant part of nineteenth-century American health care. Domestic medicine constituted numerous natural remedies and recipes made from herbs and botanicals that had been passed down through families for generations. With the popularity of William Buchan’s “Domestic Medicine” guide, household medical care became more organized and more recognized by the medical community. Housewives were expected to maintain their own medical chest with supplies and medicines for members of their family and community. The most common role of a physician in early nineteenth century was to treat the wealthy and the homeless. This was partly because the medical community was not respected or effective until the germ theory of disease was accepted, and the Flexner Report of 1910 was published. It was also due to the high cost of medical care and its relative inaccessibility in rural communities and in the western plains. Before the reform of the Flexner Report, individuals did not trust physicians and found more effective and harmless outcomes from domestic medicine rather than from surgical procedure and heroic medicine performed by a physician. In modern America, domestic medicine should be used to reduce the disparities in access to health care for vulnerable populations such as rural and low-income areas. These populations are experiencing similar struggles with the medical community that much of nineteenth century America experienced. Financial burdens, lack of access, and cultural differences all increase the reluctance to seek care in rural communities and prevent many of these individuals from receiving the treatment they need. Telehealth and other forms of domestic medicine have not yet been perfected, but neither has our current healthcare system. Domestic medicine was typically an effective solution in nineteenth-century America, and it can be an effective solution in modern America.
Appendix


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