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Introduction

The Kingdom of Naples, 1704. Domenica Jurlaro's mother is very worried. For a long time, her daughter has been suffering "pains in her genitals." Domenica has been treated by the city's physician and bled three times by a surgeon, yet nothing seems to help and her mother's anxiety grows day by day. While washing her clothes by a well, she confides her cares to another woman, Onofria Bufalo. Onofria is more than a mere chance acquaintance; she is a well-known "wise woman" or local healer. She promises a cure and offers her assistance, for a substantial fee. Onofria prepares a medicine sweetened with honey and administers an enema of rue and sage. Alas, Domenica's condition continues to worsen. The distraught mother and daughter now begin to suspect Onofria of having cast a spell on the young woman. They turn to a parish priest and request his blessing to lift or counteract Onofria's evil magic.[1]

This marvelous story, related in greater detail by David Gentilecore, illustrates many aspects of healing in early modern times. Some parts seem familiar to us, or appear nothing out of the ordinary. A woman suffering from a distressing complaint consults a physician (or her mother does). But then the story becomes more textured, mixing what seems commonplace (distress at the failure of a treatment to work, a search for another "opinion") with what seems considerably stranger (the decision to consult a wise woman met by chance and asking a priest to lift a curse). Yet none of this would have appeared anything out of the ordinary in early modern Europe. The temporal proximity of a succession of healers – a physician, a surgeon, a wise woman, and a priest – characterizes the range of medical choices available to early modern people.

Domenica's story was not "typical"; but it does illustrate how much has changed since then. What we today view mostly as different realms, such as medicine and religion, or how we distinguish between popular ("superstitious") and academic ("scientific") medicines, licensed and "illicit" medicines then interacted, entwined, and caused thereby no

[1] David Gentilcore, *Healers and Healing in Early Modern Italy* (Manchester, 1998), 1–2.

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cognitive discomfort. To a large extent, these seeming polarities were by no means separate, or separated, in the minds of those seeking alleviation of their ills and cure of their ailments. In this world, legitimate medical practitioners and legitimate medicine nested in many places. Religious cures (relics, supplications to saints, blessings, and exorcisms) and the use of supernatural or folk remedies were not regarded as "alternative" forms of healing, but ran concurrently with all other sorts of medical practice. They were, moreover, not "second-best" cures, sought out only in desperation or by the ignorant and impoverished. They were the everyday face of medicine and medical practice. The wealthy Cologne city councilor Hermann Weinsberg used surgeons, empirics, and wise women and the Reverend Ralph Josselin chose a variety of healers for himself and his household, although he rarely consulted a physician. Astrological cures enjoyed immense popularity in court circles but also among the local gentry, landowners, artisans, and tradespeople in the rural parish of Great Linford, Buckinghamshire. Folk healers everywhere did a brisk trade in herbal concoctions, amulets, and common remedies such as poultices and salves.

The story that Gentilcore used to introduce his book on healing in early modern Italy also provides an excellent introduction to how medical history has come to be written over the last thirty years. Since the 1970s, it has been deeply influenced by social history and several other disciplines, especially anthropology, and more recently by the perspectives of the new cultural history and gender studies. This work reveals medicine and healing as fully imbricated in the larger contexts of the early modern world. Thus, in order to understand medicine, to comprehend healing, and to perceive what people thought about health, we must deeply immerse ourselves in the contexts of their lives. While one might want to regard the healing described above as a pattern, not everyone made the same choices as Domenica, Weinsberg, or Josselin did. Nor were the possibilities of what one might choose the same; temporal and local differences accounted for much variation.

These factors condition how this book is written and what choices were made. Two points deserve emphasis. First, this volume weights equally the two halves of its title: medicine and society. The primary goal has been to reflect the ways in which medical history has become part of a broader historical mainstream. Mainstreaming takes a historical subspeciality, like the history of medicine, lifts it out of the confining limits of a disciplinary channel and refloats it in broader historical currents. But this endeavor should not suggest that medical history is enriched merely by being contextualized. Influences flow in both directions and medical history forms an integral part of bigger histories and, perhaps even more

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critically, understanding medical history is essential for anyone interested in gaining a sophisticated and deep comprehension of the early modern world more generally. No longer, therefore, is it sufficient to write medical history as an epic or romantic story of spectacular breakthroughs and embattled pioneers. Medical history must rather account for all the greater social, cultural, and economic forces affecting Europeans from roughly 1500 to 1800.

The approach taken here is deliberately historiographic and argumentative. *Medicine and Society* resolutely rejects, and rejects telling, a story of progress. Instead, it presents interpretations up front and deals with scholarly controversies head on: this is the true "stuff" of history, not facts *per se* nor, for that matter, polemic. Good history never merely praises or blames. Thus, this volume sedulously avoids a version of history that postulates a single and relatively straightforward passage into the modern world leading from the dark ages of ignorance, superstition, and suffering into a brighter world of knowledge, science, and abundance. This "things-are-getting-better-all-the-time" school has been rightly condemned for its hindsight, although it would be equally foolish for us to deny the undoubted benefits of modern medicine (if we also recognize its failings).

Finally, this history reflects the revisionist stance of much medical historical writing over the last few decades. To track the variations in how medical history was written in the middle of the twentieth century to how it is written now, more than fifty years later, is to trace a major evolution. Domenica's story might have once been used to illustrate ignorance and superstition or as an example of the stubborn persistence of religious over secular or scientific explanations. Today, medical historians would take the story on its own terms, seeking to comprehend why certain decisions were made and explain what the participants in these medical encounters hoped to achieve. Yet although this "new" history of medicine differs from its older sibling in several ways and we, its practitioners, tend to assume its superiority, it is prudent to bear in mind that each age remains a prisoner of its own prejudices. If twenty-first-century scholars are less willing to accept uncritically an explanation for change based on a march-of-progress analysis, perhaps our successors will find our certainties equally dubious.

How then have historians transformed the writing of the history over the past forty to fifty years? Predictably, the influences did not always come from within the historical profession or medicine alone.[2] For a

[2] For some perspectives on the history of medical history, see John C. Burnham, *What is Medical History?* (Cambridge, 2005); Burnham, *How the Idea of Profession Changed*

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long time, one might have termed the history of medicine *iatrocentric*. That is, physicians (*iatro*- pertains to medicine) wrote medical history as a hobby and followed well-trodden paths, concentrating on biographies, bibliographies, medical theory, and the practice of physicians. These histories were essentially what is often called *internalist*. At its worst, such writing produced exultant chronicles of medical progress, equally celebratory or even hagiographic biographies of famous medical men, and sneering condemnations of superstition and ignorance. Yet not all this history was bad; far from it. Many early studies were carefully done and meticulously researched. Moreover, they amassed a store of knowledge upon which we all still draw. Nor did all those laboring in medical history's old regime satisfy themselves with a rosy view of the present compared to a ghastly past.

Still, one can chart a sea-change beginning in the 1960s and 1970s that, not surprisingly, linked up with the tumultuous character of those decades in the western world, when much received wisdom and many venerable institutions attracted withering criticism. Those who wanted to change the world often also harnessed history to the wagon of social and political justice. New ideas as well as fresh faces entered the field and eventually reoriented it. George Rosen (an MD and a PhD) bridged the two eras. As early as the late 1940s, he began to think along new lines. In his 1967 presidential address to the annual meeting of the American Association for the History of Medicine, Rosen called upon scholars to redefine the "matter and manner of medical history." He proposed an agenda for research into the social context of medicine, into demography, into the history of emotions, and into responses to disease. Above all, he insisted that "the patient deserves a more prominent place in the history of medicine."[3] Rosen was not solely responsible for the shifts that came, of course, but his program traced out the direction in which it went.

More radical questioning attacked several pillars of modern society including science and medicine, as well as criticizing the prevalent sexism and racism of western life. Disenchantment with mid- to late twentieth-century health care profoundly affected the course of medical history. Critics of modern, technocratic medicine assailed the prerogatives of a professional, authority-claiming medical elite and likewise abhorred the

the Writing of Medical History (London, 1998); Roger Cooter, "After Death/After-'Life': The Social History of Medicine in Post-Modernity," *Social History of Medicine* 20 (2007): 441–64.

[3] George Rosen, "Levels of Integration in Medical Historiography," *Journal of the History of Medicine and Allied Sciences* (1949): 460–67; Rosen, "People, Disease, and Emotion: Some Newer Problems for Research in Medical History," *Bulletin of the History of Medicine* 41 (1967): 8.

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dehumanized, and dehumanizing, authority of modern medical treatment and hospital care. As early as 1963, Ivan Illich (1926–2002) stressed the *Limits to Medicine*. Other observers, such as the physician and eminent sociologist, Thomas McKeown (1912–88), argued that improvements in nutrition, rather than advances in medical science or public health, best account for the general decline of western mortality rates since the eighteenth century. Others suggested that people learned methods of avoiding disease in a world where medicine had few if any cures. Doubts about modern medicine multiplied, and many deplored the manipulative character of a medicine physicians dominated. Psychiatry often bore the brunt of such assaults. Thomas Szasz (b. 1920), for one, launched bitter jeremiads against the abuses of modern psychiatry and psychiatric institutions, arguing that the diagnosis of "mental illness" was just another way of imposing a bourgeois mentality and code of behavior on people viewed as "deviants." The French philosopher Michel Foucault (1926–84) battled on a broader front, presenting a basically pessimistic view of several changes occurring in the eighteenth century that were often associated with the Enlightenment and billed as "humanitarian reforms," including the abolition of torture and corporal punishments. Foucault insisted, however, that these "improvements" significantly increased surveillance over individuals, limited their freedoms, and vastly increased the power of regulatory mechanisms (such as the state). The "birth of the clinic" – the rise of scientific medicine around 1800 – was one of these pseudo-reforms.[4]

A whole generation or more of medical historians have pursued these insights, often with excellent results. If many historians of medicine were not quite as censorious, or polemical, as the culture critics, they certainly doubted facile stories of scientific progress and of the "great men in white" narrative presented earlier. They increasingly focused, moreover, on persons and practices that older medical historiography had slighted or scorned. In the closing decades of the twentieth century, feminist historians, post-colonialist scholars, medical anthropologists, and queer theorists contributed their own perspectives fructifying the field by urging historians to look again at what they "knew" about the medical past.

[4] Ivan Illich, *Limits to Medicine: The Expropriation of Health* (Hammondsworth, 1977); Thomas McKeown, *The Role of Medicine: Dream, Mirage, or Nemesis?* (Princeton, N.J., 1979); McKeown, *The Modern Rise of Population* (London, 1976); James C. Riley, *The Eighteenth-Century Campaign to Avoid Disease* (New York, 1987); Thomas S. Szasz, *The Myth of Mental Illness: Foundations of a Theory of Personal Conduct* (London, 1972); Szasz, *The Manufacture of Madness* (New York, 1970); Michel Foucault, *Discipline and Punish: The Birth of the Prison* (New York, 1977); Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception* (New York, 1973).

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The study of women in medicine, the non-European medical experience, questions of deviance, the relationship of broader belief systems (such as religion) to medicine, and the activities of folk healers all dramatically expanded the historian's purview. Scholars began situating European experiences within global or transnational frameworks and have simultaneously eschewed a tendency to speak only in terms of the European "impact" on the rest of the world.

Still, and despite the undeniable influence of these newer perspectives, I think it is fair to say that in many ways social history (and increasingly cultural history) and professional historians continue to dominate the field, albeit with an ever-greater openness to the perspectives of other disciplines. These perspectives have won recognition in the major scholarly journals devoted to the field. (For a list of the major medical historical journals, see the list of Further reading at the end of this book.)

Despite this expansion of the field in many directions at once, some empty spots remain as well as a series of desiderata. Much medical history remains focused on the western European and, especially, the English past. That blinkeredness has diminished considerably over the last twenty years, but the tyranny of Anglo-Saxon models that once forced questionable comparisons to a paradigmatic England remain. Admittedly, for certain periods, the focus always lay elsewhere; on Italy, for instance, in discussing anatomy or early public health measures, or on Germany for the development of a more intense relationship between state and medical care, or on France for the genesis of clinical medicine. At the beginning of the twenty-first century, we find more studies of developments elsewhere in western Europe, including considerable work on the Iberian peninsula and the Scandinavian countries. Patchier remains the treatment of eastern and southern Europe, Russia, and the Ottoman world; the last, after all, controlled large parts of European lands well into the nineteenth or even twentieth century. We are still, moreover, afflicted by a western-oriented, rather traditional periodization, although newer scholarly work seeks to erase or at least blur the boundaries and deny the ruptures between the medieval, early modern, and modern worlds. This book, on "early modern Europe," pleads guilty to sustaining the artificiality of such a division at least in part, although it emphasizes many continuities between the medieval and early modern experiences on one end and, if to a lesser degree, the early modern and modern on the other. Moreover, even the "new" history of medicine is rather Eurocentric not only in its location but also in the questions it poses. Africa, Latin America, and Asia remain relatively neglected, but these areas are no longer ignored. Indeed, historians increasingly realize that the newfound lands and, later, colonies significantly shaped life in the mother

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country. Extremely good work on Islamic, Arabic, and Jewish medicine exists and a growing number of scholars focus on China, Japan, and India. Chronologically, coverage has concentrated on the nineteenth and twentieth centuries, reflecting a broader historical favoritism for the modern period more generally. Much of what we know about early modern Europe would never have been discovered or would have been misunderstood without the excellent work being done by the medievalists and, increasingly, by classical scholars as well.

In composing the present volume, some basic organizational and conceptual problems had to be addressed. Unquestionably the subject was "medicine," but the text was also intended to appeal to those interested in early modern history more generally. But the most basic, and basically intractable, problem was how to define "medicine" in a work that explicitly accepts that medicine by no means exists isolated from the multiple contexts in which it is embedded and which powerfully affect it. Part of the problem, therefore, lay in establishing borders and deciding what to include and what to leave out of a subject with myriad ties to other disciplines and subjects. How can, for instance, a history of medicine not deal with famine and poverty and yet also not go astray in the territory of the demographers and family historians? The solution followed in these pages has not been a very rigorous one. Like many of my historical colleagues, I have not hesitated to trespass on the "turf" of other scholars. Indeed, I have done so frequently because such encroachment seems a splendid and appropriate way to demonstrate the centrality of medicine to larger themes in European history. Likewise, I have stretched the prescribed chronological limits especially in my decision to say quite a bit about ancient and medieval developments.

A strong accent on social and cultural history characterizes *Medicine and Society*, not only because those are the fields in which I feel most comfortable, but also because that orientation reflects much of the historical work being done today. (And, even though some observers have announced the death, or at least the increasing analytic irrelevance of the social history of medicine in the wake of post-modernism, the corpse seems to have quite a bit of life still in it.)[5] These preferences, however, in no way dictate the slighting of other subjects such as medical theory and medical education. Still, the book pursues themes that most frequently attract medical historians today and which are found in many popular medical historical textbooks (see Further reading); these topics often differ from the concerns of more traditional surveys. This volume, therefore, devotes as much attention to patients as practitioners; to

[5] Cooter, "After Death/After-'Life'."

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"general" practitioners as to physicians; to all forms of medical education and not just university instruction; to the importance of other systems, such as religion and its impact on medicine; and, finally, to the cultural and societal significance of medicine as well as to its scientific development.

A critical sub-problem in this complex of issues is how to define and understand disease. Perhaps surprisingly, disease is a very slippery concept; "feeling ill" is not equal to "having a disease" as personal experience often testifies. One can take an essentially positivist approach and argue, along with the *Oxford Concise Medical Dictionary*, that "disease is a disorder with a specific cause and recognizable signs and symptoms." That seems clear enough until we start to think about afflictions that have no discernible cause and the signs and symptoms of which fluctuate, sometimes radically. Contemporary physicians often diagnose chronic fatigue syndrome, for example, as a "real disease" (*myalgic encephalomyelitis*) and sometimes dismiss it as "yuppie flu." On the other side, even though the origins of alcoholism, obesity, hysteria, and autism remained unclear, they are increasingly labeled as "diseases" or spoken of as occurring "epidemically" as, for instance, in describing the spread of obesity in early twenty-first-century America as an "epidemic." Clearly one cannot deny that these diseases are to a large extent *socially constructed*; that is, their explanations, indeed their very reality and existence, shift with changing social and cultural expectations. A classic example is the disappearance in 1974 of homosexuality as a "disease" from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II) after being accepted as a "disease entity" earlier. Thus, " 'disease' is an elusive entity." It is more (or perhaps less?) than a biological thing and "in some ways disease does not exist until we have agreed that it does, by perceiving, naming, and responding to it."[6]

Much recommends the view that disease is itself a historical construction; protean not fixed, and respondent to social forces and human perceptions. Most historians nowadays certainly accept that knowledge is relative: what people "knew" in the past was "true" whether we believe it or not now. Whereas we might search for the "germ" that causes syphilis, people of the sixteenth century constructed a disease in their minds and from their experiences that they recognized and perceived as the "Great Pox" or the "French Disease." Obviously, early modern peoples held attitudes toward, and drew meanings from, various afflictions, or the

[6] Charles E. Rosenberg, "Framing Disease: Illness, Society, and History," in Rosenberg and Janet Golden, eds., *Framing Disease: Studies in Cultural History* (New Brunswick, N.J., 1997), xiii–xv.

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experience of illness altogether, that differ from ours. We shun pain, for instance, while early modern people could find meaning in it as a mark of God's favor or his displeasure. This divergent awareness, however, did not make them less intelligent or less perceptive than we are.

Yet, not everything is socially or culturally constructed and it is hard to accept a radical version that "reality does not exist"; that it is merely constructed. Much value adheres to Margaret Pelling's hard-headed observation that the social construction of disease "cannot be applied universally . . . [because] some diseases are more socially constructed than others." Pelling quite astutely points out that social constructivism when carried to an extreme actually hinders a subtle understanding of others by suggesting that only people in their own time and place can have accurate perceptions of "their" illnesses.[7] This book, while avoiding a Whiggish, positivist stance that elevates current views over previous wisdom and ways of knowing, also accepts that "real things exist" and that we occasionally share the perceptions of our ancestors. Smallpox is a good case in point. Early modern peoples sometimes misdiagnosed smallpox but they generally understood it (and plague as well) as a specific disease spread by what we would term "contagion," that is, person-to-person contact. Thus, Chapter 2 speaks rather confidently of the "diseases" of smallpox and plague while it also warns of the dangers of confidently diagnosing diseases in the past – *retrospective* or *retrodiagnosis* – as if we possess some superior insight. Medical historians are divided on this issue, admittedly, so a middle path seems to reflect current approaches most accurately.

Medicine and Society concentrates on the three centuries between 1500 and 1800. The general layout is topical; each chapter addresses a group of related issues. Within chapters, chronological confines exhibit considerable elasticity. It is, for instance, absurd to discuss the early modern experience of pestilence without beginning in the mid fourteenth century. This temporal pliancy holds true for other subjects, especially for public health, medical education, and hospitals, where I pick up the story in the middle ages.

No volume of this size (or any other, for that matter) can be comprehensive or fully reflect the richness and texture of medical history. Descriptive deficiencies or analytical weaknesses generally reflect lacunae in research. Geographically, the book tries to be as evenhanded as possible, but the secondary literature available is simply more voluminous for certain periods, topics, and approaches than others. Many gaps

[7] Margaret Pelling, *The Common Lot: Sickness, Medical Occupations and the Urban Poor in Early Modern England* (London and New York, 1998), 6–7.

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cannot be closed here, but a sincere effort is made to indicate them and suggest why they exist.

Note on the second edition

Ten years have elapsed since the first edition of *Medicine and Society* appeared. This second edition takes into account the literature published since then. I have also tried to respond to the criticisms raised by friendly commentators who suggested more coverage of certain topics or a different emphasis. I will not have, I am sure, satisfied all of them, but I have appreciated their points of view. Some chapters have been significantly rewritten and reorganized as well as expanded to devote additional coverage to topics, such as the colonial experience, that the original volume touched on only briefly. In the first edition, I tried to maintain a generally historiographical approach, emphasizing how arguments evolve, where debate lies, how opinions change, interpretations are revised, and, especially, how new perspectives influence the writing of history. I have preserved and, I hope, even enhanced that approach by directing the reader's attention to why and how historians differ and by insisting that such divergence of thought is altogether a good thing and productive of good history. Finally, the rewriting of this book has been intensely influenced by my experiences teaching "Medicine and Society" at the University of Miami. The explanations I present here are often ones I developed in teaching that course and that I found worked well with students at the undergraduate and graduate levels.

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