2024

VOL. 36 / N. 1

MEDICINA *NEI* SECOLI

FOUR-MONTHLY
NEW SERIES

Journal of History of Medicine and Medical Humanities

University Press

Sapienza Università Editrice

2024

VOL. 36 / N. 1

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Journal of History of Medicine and Medical Humanities

Founded by Luigi Stroppiana

SAPIENZA
UNIVERSITÀ EDITRICE

MEDICINA nei SECOLI

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Dipartimento di Medicina Molecolare - Unità di Storia della Medicina e Bioetica
Viale dell'Università 34/a - 00185 Roma, Italia - Tel. +39 06 49914033
email: medicinaneisecoli@uniroma1.it

Journal property of Sapienza University of Rome, published with the contribution of the University

Journal registered at the Civil Court of Rome at n. 391/88
Record at National Register of President of Cabinet n. 2488/88
ISSN 0394/9001
E-ISSN 2531-7288

Indexed by:
EBSCO, Historical Abstract
http://ebscohost.com/
EBSCO, Publishing, Inc.
INDEX COPERNICUS INTERNATIONAL
SCOPUS

Sapienza Università Editrice
Piazzale Aldo Moro 5 – 00185 Roma - www.editricesapienza.it - editrice.sapienza@uniroma1.it
Registry of Communication Workers registration n. 11420

Published and printed in April 2024 by Sapienza Università Editrice
https://rosa.uniroma1.it/
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Cover figure from: Le imagini de i dei de gli Antichi di Vincenzo Cartari, Venezia, 1556

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SAPIENZA
UNIVERSITÀ DI ROMA

Introduction
Medieval Medicine in Medieval Society

Tommaso Duranti
Alma Mater Studiorum - University of Bologna

© Author(s)
E-ISSN 2531-7288
ISSN 0394/9001

MEDICINA NEI SECOLI
Journal of History of Medicine
and Medical Humanities
36/1 (2024) 5-8

Received: 11.10.2023
Accepted: 15.12.2023
DOI: 10.13133/2531-7288/2883

Corresponding Author:
tommaso.duranti@unibo.it

This issue focuses on the history of medieval medicine in Western and Latin Europe, but the ensemble may appear lacking on several topics. In fact, none of the authors directly addresses diseases and therapies, nor do they, in some way, center their studies on the medical thinking produced by the great authorities of the past.

This absence is the result of a conscious effort to broaden our perspectives, moving away from rigid schemes of a teleological history of medicine – a history of the discipline constructed, willingly or not, as a progressive path towards modern biomedicine. This process is often perceived as a civilizing journey from darkness to light, from primitive to modern, depicted with almost ethnographic colours, and sometimes used to reassure ourselves about our modern medical experience. At other times, these details are uncritically exploited to create controversies about biomedicine and its practitioners (controversies often devoid of any knowledge of the past in the public discourse). In this perspective, the Middle Ages generally occupied – and continues to do so – a 'negative' place par excellence, a gap between Greco-Roman Antiquity – understood in this context as the dawn of civilization[1] – and the Modern Era, which supposedly introduced the scientific method and, therefore, modernity, considering everything that came before it as childish, obscure, and superstitious.

The history of medicine, as conceived between the end of the 19th and the first half of the 20th centuries, focused

on inquiries aimed at reconstructing its own past: namely, the past of an academic discipline profoundly transformed in this period by technical and scientific progress, giving rise to what we now define as biomedicine. Influenced by the strength of positivism in historiography, this approach created a 'strong' paradigm that somehow transposed an 'absolute' model of the hard sciences into the investigation of the past. The second half of the 20th century radically challenged this perspective: contributions from the social sciences and increasingly from medical anthropology shattered this understanding, highlighting the kaleidoscope of theories and medical practices, as well as the social and natural roots of ideas about health and disease, power struggles, beliefs, coping strategies, and so on.

Today, we are aware that in order to understand a certain aspect of the past – especially if it dates back to the Middle Ages – it is necessary to immerse ourselves in that context. This requires the challenging and inherently partial effort of setting aside our modern knowledge and our individual and collective 'beliefs'. In short, it is necessary to try to understand the medieval medicine that men and women of the Middle Ages theorized, knew, and practised: a period so vast and varied in its chronological changes that offering a *reductio ad unum* to a single perspective is extremely difficult. The inequality in the state of sources from different parts of the period amplifies this difficulty, necessitating diverse approaches and methodologies for the Early, High and Late Middle Ages.

There is now a consensus that health and disease are also cultural concepts– challenging to define[2] – but the same cannot be said about the concept of medicine. Not everyone fully acknowledges that medicine is also a cultural construct, subject to changes over time and space, and as such, it should and must be examined[3]. From a historical perspective, medicine cannot be understood solely by identifying those 'pieces' that sometimes only appear to recall previous phases of the modern discipline. In short, it is more accurate to consider all 'forms' of medicine, not necessarily understood as harbingers of modernity, regardless of the history of a university discipline that gave rise to biomedicine.

At this point, specialized historiography focusing on medicine, health, and disease[4] already shares this perspective but still struggles to eliminate commonplaces, especially concerning the 'Dark' Middle Ages, in popular and even non-specialized historiography.

Undoubtedly, one of the main contributions of the history of medieval medicine produced in recent decades is shedding light on the existence of a dynamic medical medieval thought. A way of thinking, certainly developed by healers and intellectuals, but also shaped in the encounter/conflict with other fields of intellectual knowledge (theology, law) and other practices related to health and disease, yet quite foreign to this environment[5]. Another contribution of this more recent historiography is the

insistence on the clear necessity of inquiries not based on the duality of body/soul, a completely anachronistic division for the Middle Ages[6].

Both medical thought, on one hand, and practices related to disease and health, on the other, should be understood as expressions of a particular society, in which numerous actors – individual or collective – played a role. Therefore, both should be examined with broader, specialised but not compartmentalised approaches to understand how societies constructed the idea (or rather, ideas) of medicine (and of health, disease, recovery, pain….) and also how these ideas influenced these societies themselves. Using historiographical categories, one could say this involves applying the methodology of social and cultural history to the history of medicine, bearing in mind, however, that these are historiographical tools and the object of inquiry is much more complex and intricate[7].

Therefore, as mentioned earlier, it is an issue in which disease, treatments, and the medical thought (at least as traditionally and rigidly understood) are absent. Certainly, it is only an apparent absence, as these elements underlie and emerge from the topics studied by the different authors. The perspective offered by this issue, however, is broader, providing a concise and naturally partial image of how the history of medieval medicine is predominantly understood and written by specialized historiography today. The essays delve into cultural aspects in the technical and broader sense of the term. For instance, they explore the vibrant relationship between religion and medicine, a topic studied in detail by Chiara Crisciani. They also examine actors and practices that go beyond our rigid and typical modern classification of medical treatments, as highlighted in the contributions of Guy Geltner, Francesco Bianchi and Tommaso Duranti. Additionally, there are inquiries into sources not exclusively related to the medical context, as discussed by Alessandra Foscati, and reflections on the relationship between the reception of written production and the development of practices and cultures as analysed by Marilyn Nicoud and Lluís Cifuentes i Comamala. Thanks to these contributions, a deeper understanding can be gained of what that civilization considered as disease, recovery, and health. The historical perspective shifts again from the Middle Ages to the present in Francesca Roversi Monaco's article on medieval medicine through the lens of medievalism, a field that investigates the continuous 're-creation' of the medieval era in contemporary society.

It is our hope that this issue will offer readers a more insightful perspective on the complexity of the topics investigated in the history of medicine, especially concerning a period of European history that continues to suffer from simplistic readings and instrumental uses.

On behalf of the other authors, I would like to thank Valentina Gazzaniga for providing a space in the journal *Medicina nei Secoli* dedicated to the perspectives and contributions of medieval historiography to the history of medicine.

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1. Cf. Green MH, Integrative Medicine: Incorporating Medicine and Health into the Canon of Medieval European History. Hist Compass 2009;7(4):1218-45, pp. 1223-4.
2. Corbellini G, Storia e teorie della salute e della malattia. Roma: Carocci; 2014; Amoretti MC, Filosofia e medicina. Pensare la salute e la malattia. Roma: Carocci; 2015.
3. Besides being one of the most relevant outcomes of the medical anthropology, this topic is widely shared in historiography: see, for example, Corbellini G, ref. 2, and what proposes the Harvard Medical School: https://ghsm.hms.harvard.edu/research/history-medicine. Also see the recent debate promoted by the Society for the Social History of Medicine: McKay RA, Why Do We Do What We Do? The Values of the Social History of Medicine. Soc Hist Med 2019;33(1):3-17.
4. Especially in the British and English-speaking context: among the most persistent experiences in this regard, one can mention the Society for the Social History of Medicine (https://sshm.org), which published a journal of the same name, and the book series *The History of Medicine in Context* edited by Andrew Cunningham and Ole Peter Grell (https://www.routledge.com/The-History-of-Medicine-in-Context/book-series/HMC). In Italy, however, in comparison with the European context, the history of medicine (especially of medieval medicine) struggles to find space as an autonomous specialised field of historiography.
5. Grmek MD (ed.), Storia del pensiero medico occidentale. Antichità e Medioevo. Roma-Bari: Laterza; 1993. Jacquart D, Cinquante ans de recherches sur la médecine des XIIIe-XVe siècles: les contours d'un nouvel objet pour l'historien. In: La medicina nel Basso Medioevo. Tradizioni e conflitti. Atti del LV Convegno storico internazionale, Todi, 14-16 ottobre 2018. Spoleto: Centro Italiano di Studi sull'Alto Medioevo; 2019. pp. 1-24.
6. For this reason, "on doit parler de dualité et non de dualism" (Jacquart D, ref. 6, p. 20); Besides, even in biomedicine today the rigidly somatic perspective that influenced the middle of the 20th century, influenced by the technological enthusiasm, is outdated.
7. See Green MH, ref. 1.

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Medicine e Religiosity: Exchanges and Interactions

Chiara Crisciani
University of Pavia

© Author(s)
E-ISSN 2531-7288
ISSN 0394/9001

4.0 INTERNATIONAL

MEDICINA NEI SECOLI
Journal of History of Medicine
and Medical Humanities
36/1 (2024) 9-26

Received: Settembre 2023
Accepted: Novembre 2023
DOI: 10.13133/2531-7288/2893

Corresponding Author:
chiara.crisciani@gmail.com

ABSTRACT
The medicine/religion relationship in the Middle Ages is based on the in the degradation/redemption polarity and on the bond between soul and body: this provides the opportunity of establishing a relationship of analogy and correlation between health (of the body) and salvation (of the soul) and of different forms of 'spiritual medicine', also chronologically marked in the long time of the Latin Middle Ages. This 'spiritual medicine', which accompanies the development of secular medicine step by step, is therefore essential to understanding the relationship between health, illness, and medicine in the Christian Middle Ages.

Key words: Religion - Spiritual Medicine - *Infirmitas* - Theologians

1. Medicine of the body and of the soul

There are a great number of relationships between medicine and religiosity[1] that anthropology and the history of ideas have progressively brought to light. In the case of the Christian context, these links are not dependent solely on the correlation between soul and body, between inside and outside, between consciousness and physiology which, in its various forms, are familiar to all times and cultures. This is perhaps a closer and certainly a special relationship, rooted in the salvific nature of the Christian religion itself, in the degradation/redemption polarity. Indeed, when seen against this background, the soul of man – now set in time and history - appears to be constitutionally tainted, invalidated by Original Sin and his body is constitutionally infirm and mortal because through this Sin, he has lost his likeness to God. In the face of human beings stained by the Original Sin and other sins, Christ redeemed all humankind by His love, becoming incarnate and sacrificing Himself in His passion and death. He has also shown us a path that can lead each of us out of degradation and result in our renewal and salvation; moreover, He promises and guarantees, through His resurrection, even the resurrection of individual bodies at the end of all days. For a Christian, the bond between body and soul is thus structured against this background and in the development of this path: this context then reveal the possibility of establishing an analogical relationship, a correlation between (bodily) health and salvation (of the soul)[2] .Therefore, various forms of 'spiritual medicine' are to be found, chronologically spaced throughout the long duration of the Latin Middle Ages.

2. *Infirmitas*, miracles and patience

In the early Middle Ages – when secular medicine was confined to humble peripheral schools and only had a few meagre tenets and compendia at its disposal - a conception focused on the direct and immediate relationship between *infirmus*[3] and God, and between the *infirmus* and his neighbour predominated. While sickness is primarily interpreted here as a divine punishment for the sins of an individual or a community, it should also be evident that, despite harming the body, it is symptomatic of a disorder of the soul. At the same time, it serves as the best remedy for this very soul, as it allows people to atone for their sins and avoid committing worse ones. On the other hand, God strikes with his scourges only those whom he loves the most. Therefore, the sicks are encouraged to be patient, silent and grateful (the *Admonitiones ad egros* by Gregory the Great provide examples in this regard). Indeed, it was commonly accepted how much "molestia corporalis sit salus anime", and that suffering, in addition to punishing the afflicted for their sins and healing the soul, brought them closer to Christ in His Passion: the sick patient could become His replica, a constantly recurring image of Christ in history and everyday life. Consequently, a persistent 'pedagogy of suffering' developed, according to which bodily ailments should be accepted with

gratitude. Indeed, some argued that ailments were to be sought after, as they healed the soul of the sinner: in themselves, they were 'spiritual medicine'. On the other hand, the afflicted, as they received alms, solicitous attention, and compassionate care from the healthy people surrounding them (who should see in them the mutilated Christ, who suffered so much for us), are themselves an effective 'remedy' for the souls of their fellows who, following the commandment of charity, give them aid and thus imitate the acts of Christ towards the sick and infirm.

The God who punishes and corrects is, however, also a merciful God who, when invoked through prayers, acts of devotion or penance, can instantly cure the sick individual or the community afflicted by an epidemic through freely given, immediate and direct miracles. The chronicles and hagiographic texts provide detailed descriptions of these healings, highlighting, on the one hand, the powerlessness of secular medicine (to which the sick person had sometimes turned in vain) and, on the other hand, the therapeutic omnipotence of God (and of those closest to him, such as saints and clergy, who serves as instruments of His will). As it is declared in *Exodus* 15.26: "I am the Lord, who heals you". Furthermore, since the times of Augustine, images of Christ as the greatest physician frequently occur (He, "*medicus noster, sanabit omnem languorem*", as Ivo of Chartres declares). Hence the therapeutic value of relics of saints and their burial places or other sites linked to the sacred places[4], visited by pilgrims: both the healthy (who could fall ill), the sick (who hoped for recovery) and the devout (who were concerned about their own salvation) gathered along the road to the shrine. During the path to these places managed by monks, relief was offered whether it be of a physical or spiritual nature, in the form of benevolent refreshment –food, accommodation, solace and some potions - but no medical aid, let alone medical treatments for specific ailments.

From these considerations, a particular connection emerges between medicine (in this case, specifically, illness/*infirmitas*) and religion, between the sick body and the soul. First and foremost, a spatial and temporal interrelationship between the healthy and the sick can be noted. These mingled at the fairs and along the roads leading to a shrine or in the distress of an epidemic, seldom separated by the fragile boundary between health and sickness, considering how thin this line was in a precarious and harsh ecosystem: just a poor harvest, a cold winter or an overly strenuous walk would be enough for people to switch from one condition to the other - the devout pilgrim could easily become a sick pilgrim, in the generalized uncertainty that characterized the journey of the Christian *viator* on earth. Nor were there any theories or practices specifically regarding sickness itself, as it was intertwined with *paupertas* in the more comprehensive state of *infirmitas* which (in a reality as harsh as in religious anthropology) constitutes the 'normal' condition of fallen man; and charitable acts towards *infirmi* were likewise undifferentiated. Moreover, the symbolic complex that develops around the figure of Christ– who is both a sick man, a physician, and a medicine- is the

image around which the relationships of the *infirmi* with themselves, God and neihgbor are shaped. Above all, a direct and immediate connection could be found between sin and illness, between miracles and healing –in other words, between soul and body, between God and man. The result is a 'spiritual' medicine that was basically called a 'pedagogy of suffering': ailments were valued because they were a remedy for the soul of those who suffered and, at the same time, the sick provided a remedy for the souls of those who charitably comforted and helped them.

3. Spiritual medicine in the 12th century

Since these were the conditions that characterized the spheres of material life, generic aid and spirituality in charitable and pastoral care, this background provided a context for the early types of 'spiritual medicine', viewed from a doctrinal and textual perspective. In the first place, the doctrines of physical medicine had to be employed to better interpret the numerous scriptural passages that speak of the human body or miracles performed upon it: Augustine and Jean Gerson remind readers of this essential aid for proper exegesis and recommend its use. Immediately and intuitively, a close analogy– based on the relationship between soul and body - between their respective forms of healing, that is, between salvation and health, comes to mind. This has given rise to metaphors that connect the two types of health: from early times, analogies and metaphors drawn from medicine are very commonly found when discussing the care of souls. In fact, beginning with Augustine, Gregory and Jerome, we find metaphors concerning Christ as physician[5], sins as *vulnera*[6], cardinal sins as leprosy, heretics seen as lepers with the various forms of this affliction, the ointments of prayer and penance, the Church as an *apotheca medicaminum*. More generally, we should "ad usos nostros convertere"[7] medical knowledge – argues Rabanus Maurus. As an example of these "usi", the medical metaphorization is omnipresent in Hugo of Saint Victor's *De quinque septenis* (a theological text on the definition of the gifts of the Holy Ghost) and it embodies the health-giving benefits of the gifts of the Holy Ghost. In this text, the Holy Ghost takes on the role of both physician and medicine[8]; the *languores* of the sick soul result from the capital sins - *vulnera interioris hominis*; the *medicus* is God, the *dona Sancti spiritus* are an *antidotum*, the *virtutes* are *sanitas*. There are plentiful, ingenious metaphors strewn throughout, but these are extremely generic, and they will remain so, as cliches and fixed semantic bundles, until the time of Luther[9] and beyond. They became more specific and structured only starting from the 12th century. In fact, it was only during the so-called '12th century Renaissance' that Western medicine, previously confined to a few schematic compendia and humble peripheral schools[10], experienced significant growth, as did every cultural and non-cultural field related to it[11]. One could mention the translations of medical texts from Arabic in Montecassino; the flourishing school of medicine in Salerno in the

twelfth century[12], the early years of the school of medicine in Montpellier[13], the naturalistic studies at the canonical school of Chartres[14]. Moreover – in a developing and self-differentiating society - the health care market began to take shape. Alongside physician-monks, healers who wandered from fair to fair, sanctuaries producing wondrous miracles with the aid of their relics, and village wisewomen (with their limited and often superstitious remedies), the learned professional physician emerged, a new and specific figure produced by the Middle Ages. The last-mentioned had the opportunity to study at the foremost Western medical schools and possessed a thorough and precise doctrinal knowledge, recently conveyed to us through translated text. At the same time, in the 12th c., pastoral care also underwent an innovative development: especially preaching and confession – which, metaphorically speaking, have and will always be seen respectively as prevention and treatment for the soul infected by sin - adjusted to suit the needs of a society that had become far more complex and structured. Preachings *ad status* thus began to be prepared. These were not intended for all Christians without distinction, but specifically for a particular social group or for members of certain professions; the preacher had to carefully select and analyse his audience, considering its characteristics and predispositions to produce suitable and genuinely exhortative teachings[15]. In brief, confession – given the establishment of an ethical code based rather on the intentions of the sinner than on the objective nature of the sin – had to pay attention to the mindset and lifestyle of each and every sinner. This reached the point that, at the beginning of the 13th c., the Fourth Lateran Council (1215) prescribed it for every Christian at least once a year. From then on, the confessor was in direct and periodic contact with each sinner/*infirmus*[16], and was meant to care for each soul. Against this scenario, the metaphorization of 'spiritual medicine' became more precise and specific in its choice of borrowings from the doctrines of physical medicine, which now had many more texts and theories at its disposal, as can be seen from two interesting cases.

In his work "*De medicina animae*", written for the prelates to guide them in understanding the causes and remedies for moral deviations in the monasteries, the Augustinian Hugh of Fouilloy[17] analyses life in the monastic settings in terms of the polarity between body and soul, sicknesses, and cures. Just as we can prevent physical ailments by considering the physical constitution (*complexio*)[18] of a person, the same defence-recovery mechanisms can be applied to the soul, bearing in mind the spiritual constitution. Thus, it involves adapting concepts related to humours and *complexio*, sicknesses and material treatments, to the context of monastery and the monk's soul, making secular knowledge fully useable for spiritual purposes. What Hugh uses as a basis for the analogy he constructs is the theoretical medicine, which was, by then, more complex, and specific; Hugh puts that complexity to competent use in the pharmacological part of his treatise as well, to classify spiritual ailments and therapies for them following the schema *a capite usque ad calcem*, which can be found in contem-

porary nosological medical writings. The task of the Father Superior's certainly had always been to take care of his *subditi*, as required by Benedetto's *Regula.* Then, it became his responsibility, as a *spiritualis medicus*, to make more precise diagnoses and administer specific treatments for the souls of his subordinates, using his medical knowledge. Hugh had a decent understanding of the naturalistic-medical theories of his times: indeed, extensive, and specific borrowings from the theories of the *Schola Salernitana* and some titles of medical texts can be found also in his treatise.
In the *Liber poenitentialis*[19] by Alain de Lille – whose naturalistic interests are well known[20] - dedicated to the clergy of his times to urge them to become proficient at taking confession, many elements considered above simultaneously come into play: the persistent metaphorization taken from medical treatment for the body applied to care for the soul, the new subjective ethics of individual consent, the changes in pastoral care. Alain explores two aspects of physical medicine. Firstly, the confessor should know how and to what extent the body, along with its humours and *complexion*, influences each person's soul: this means that gluttony could be considered less serious in those who are sanguine and robust, more inclined to eat heartily, rather than those who can easily fast[21]. On the other hand, the confessor should also understand the physiological reactions of the human organism to certain stimuli, and precisely why, naturally and neutrally, some sins – such as gluttony or lust, for example- appear one after the other: this will make it easier for the penitent to avoid them. It will also be helpful if the confessor knows that certain vices – again, gluttony and lust- also have dangerous physical effects, causing diseases in the organism, aside from the soul. When reminded of these, the penitent may be induced to mend his ways. In this case, therefore, the body, its natural predispositions, and humours, belong to the realm of the confessor. They are no longer just a basis for generic analogies and metaphors, but a component of specific causal links between the soul and the organism that the priest must understand. But, above all, Alain, faced with a class of clergy he judges so incompetent that often priests - both when preaching and confessing- "*quos debent sanare profundius vulnerant*", resorts to the behaviour of the educated professional physician and presents it as a model to emulate: thus, the priest "*debet gerere statum materialis fisici vel medici*". All the knowledge of the latter, his actions, his professional ethics, the organization of his diagnostic questions, his affability, combined with his rigorous treatment and his attention to the specifics of each individual patient, should be imitated by the priest. The body is no longer related by analogy to the disorders of the soul, and the physician's overall knowledge and behaviour of bodies becomes a regulatory and pedagogical ideal. Alain may have appreciated this either during his preaching period in Montpellier, presumably in students and medical professionals, or perhaps because he had read or heard about the Salernitan treatises on medical profession, which at that very time were devoted to the manners and behaviours of the skilled and watchful professional: the best known of all was the conduct

manual *De adventu medici ad egrotum,* attributed to Arcimatteo da Salerno. These two cases demonstrate that medicine was no longer the *vana curiositas* criticized and despised by Fathers and monks, and that the *schola Hippocratis* was no longer obliged to make way for the *schola Salvatoris*, the sole dispenser of true well-being: Christian ministers should dedicate some time to this aspect and know how to adapt it to their specific goals in spiritual treatment.

4. Physicians and theologians in the 13th century

At this point, a stable understanding of secular, scientific medicine had been reached, together with its projection into 'spiritual medicine' which, in its various senses[22], became usual in the following centuries. Therefore, in the 13th c. we find texts written by theologians (Albertus Magnus, for instance), which pay attention to what *dicunt medici*[23]. However, the analysis of the various instances of the use of medical knowledge found in their texts lies beyond the scope of this paper[24]. It is equally impossible to briefly summarize the interweaving of religious zeal and medicine on which much of the later writings of a famous physician –Arnaldo da Villanova- are based. Arnaldo was a lecturer in Montpellier and the court physician of various popes and sovereigns, an advocate of the Spirituals of Provence, an apocalyptic prophet[25]. A less famous yet equally zealous Christian physician was Galvano da Levanto[26], who translated key moments and fundamental aspects of Christian religiosity into a wide range of meticulous medical metaphors. In his texts, Galvano divides his topic into two parts: the medical analysis, for example, of epilepsy and subsequently its re-evaluation in terms of 'spiritual medicine'. The writings of these two physicians, not by chance called *theologizantes,* should be considered alongside the *Liber de exemplis*, from the same period: this is an encyclopaedia written for homiletic purposes by the Dominican Giovanni di San Gimignano[27]. A special chapter in this book suggests the use of *exempla* (that is, analogies) based on medical doctrine and cases to make a sermon particularly appealing and vivid. The text provides a vast selection of *exempla* that the preacher could use. This is demonstrated, amongst the many other preachings we could cite, in the sermons (and the *quodlibeta*) by Remigio de' Girolami, in those of Jordan of Pisa, and in *Lo specchio di vera penitenza* by Jacopo Passavanti.

Two thinkers of the 13th c. – a period rich in intersections between medicine and religious ideas – stand out as particularly interesting in this context: Nicholas of Ockham, a Franciscan theologian and lecturer at Oxford; and Humbert of Romans, the fifth General of the Dominican Order.

Nicholas, in the prologue to his commentary on the *Sentences*[28], addresses the common question about the nature of theology. Nicholas views theology as the union of the theoretical and the practical (as in the case of medicine); its *subiectum* is not God – as the Dominicans would have it - but the *genus humanum reparabile*. In support of this

definition, Nicholas quotes from Avicenna's *Canon*, where he defines the *subiectum* of medicine as the human organism *ex parte qua sanatur*[29], that is, human beings in their bodily form with the addition of a specific difference: they can be cured. Nicholas concludes that "*Est enim theologia supernaturalis medicina*". Thus, in theology, God is discussed not insomuch as He is God, but because he is *reparans*, capable of curing humankind, both through the ancient mosaic *mandata* and the new law of love in the Gospel. On other theological topics, such as the nature of Adam in the earthly Paradise[30], Nicholas demonstrates his medical expertise and provides unusual medical references partly due to the naturalism permeating theological thought during the century. The opinion of Ziegler, who discerns a 'medicalization'[31] of theological thought, especially in the second half of the 13th c., and the considerations of Paravicini Bagliani on the nature of a 'theology of the body' for the same period[32], appear appropriate and persuasive. I would like to point out here two works by Humbert of Romans, *De eruditione praedicatorum* (a collection of outlines for sermons *ad status* that provide a sort of sociology of preaching[33]), and *Expositio regulae sancti Augustini*[34]. In the latter, as confirmation that the *schola Hippocratis* is no longer despised, Humbert harshly criticises those brothers who, proud of their extreme ascetism, refuse medical treatment when sick, thus considering themselves to be more faithful and saintlier. However, the General admonishes that the body is a useful tool through which the preacher can act, as he should, in the world, and the cleric is obliged to take great care of it: the vainglorious ascetics should therefore bow with humility and gratitude when receiving any treatment from physicians[35]. In *De eruditione predicatorum* there are several plans of sermons dealing with medicine, the sick and treatment: for lepers in leproseries, for caregivers, for hospital orders, for the sick, and finally, one to address physicians, or rather, students in medicine. Here, Humbert presents a panegyric of spiritual medicine[36], which he considers one of the greatest glories that secular medicine can boast. Here are his words: "Indeed, there are three results that the science of medicine allows one to achieve: first and foremost, a knowledge of one's corporeal nature: it is medicine which teaches us how wretched and fragile the human body is. The second result consists in the act of mercy: by means of medicine many charitable acts may be carried out to benefit the sick, who are burdened with great misery. The third result is spiritual healing for souls: indeed, from art and medical sciences several guidelines concerning spiritual medicine can be found"[37].
We have thus come to define a true discipline for the well-being of the soul: 'spiritual medicine', which was fully recognised as such.

5. The 15th century

At the beginning of the 15th c., the chancellor of the University of Paris, Jean Gerson, dedicated a speech to this 'spiritual medicine'[38] to graduating students in medicine. Gerson emphasizes the excellence of secular medicine, but also its limitation, and

ends precisely with a list of the duties of spiritual medicine and the indispensable support that it receives from physical medicine. He reminds his audience that, through medical knowledge, we are able to understand more accurately the "*morbos corporales de quibus in Scriptura frequenter mentio est"*; above all, he emphasizes that "*utilem esse cogitationem humani corporis et accidentium suorum ut animae natura suorumque actuum et passionum intrinsecarum manifestatio facilius habetur*": the investigation into the passions, indispensable for the preacher, will benefit greatly. In addition, medical science allows transferring the causes of diseases and the methods of treating the body to the spiritual, or rather moral sphere (*ad aedificationem morum*), adapting them to the maladies of the soul. The theories of secular medicine thus enable interpreting the whole set of *morbus spiritualis* according to the effects of the *infirmitas corporalis*, which are more evident and convincing for the listeners. It also allows thinking of spiritual medicine as a repetition of the various parts of secular medicine (*praeparativa, purgativa, preservativa, reparativa*). Therefore, it is like a book "*a cuius lectione facilis est transitus ad scribendum librum conscientiae, transferendo naturales res ad morales intellectus*".

However, also several late medieval physicians were aware of the spiritual elevation that secular medicine could provide[39] – for example, Tommaso del Garbo and Jacopo da Forlì. In the rhetoric of their graduation speeches, they emphasize that medicine more than any other field of knowledge brings one closer to God ("*inter artes maxime appropinquat scientie divine*"): in fact, it allows a thorough knowledge of one of His most complex and secret creations – the human organism. When studying and treating the body, the physician, on the one hand, come closer than others to *res sacre* (medicine "*manuducit ad elevationem mentis in causam primam*", say both Gerson and Jacopo da Forlì); on the other hand, he performs one of the most fundamental and compelling acts of mercy, since a sick body can neither think nor act properly. Therefore, as the surgeon Henri de Mondeville reminds students and colleagues "*ex scientia vestra potestis salvare animas vestras*".

Finally, I would like to mention the *Tractatus moralis predicandus in civitate pestilentiata hiis qui de civitate recedere non possunt*[40] (Ferrara, 1424) by the city's Dominican inquisitor Bartolomeo da Ferrara[41], which is notable for its breadth, considering the series of other writings on this topic[42]. In fact, this is not just a sermon (like those of other contemporary preachers on the subject), but a truly wide-ranging *Tractatus*, with considerations on how to act to promote the well-being of the soul in a plague-ridden city. In this case, preaching would be the most fruitful- or the only thing to do - but, more generally, a range of considerations (from the causes of the plague to actions to prevent it, encouraging the processions and promoting an appropriate 'diet' for the soul) should be transposed into the spiritual, biblical and theological realm. A sort of interpretation of the plague in theological-religious terms is proposed, which could become a guide for preachings *de peste* to be used by other potential preachers,

at a time when the plague was endemic in the cities of Europe and Italy. The index of the *Tractatus* is similar to that of medical texts on the plague (treatises, *consilia*, prescriptions), many of which were written from the mid-14th onwards and throughout the 15th c. Their structure is almost identical, describing the real causes, signs, and remedies for the plague. However, in Bartolomeo's work, the key to interpreting the deadly disease and its remedies is entirely religious: the aim of the text is to save the soul and it takes the form of a *tractatus moralis*, although it dedicates significant space to naturalistic and medical concepts. Therefore, we have here a surprising case of 'spiritual medicine' - a real *Pestschrift moralis* - at a time when secular medicine was doubted and discredited, as it did not yet know how to deal with the malady[43]. Bartolomeo borrows the organization of the material related to the plague from the physicians and incorporates numerous medical concepts and theories about the plague and its treatment.

It might be interesting to compare Bartolomeo's *Tractatus* with the vernacular treatise on the plague written by the court physician Michele Savonarola in the 1440s, in Ferrara, to assist all his fellow citizens, *richi, poveri e mezani*[44] as a *medico humano*[45]. The physician Michele – whose deep-seated and heartfelt Christian devotion allowed him on various occasions to provide moral and even religious counsel, besides dietetic and medical advice - obviously provides details on the remedies for the plague but also emphasizes precautions that the confessor should adopt in the presence of plague victims. He stresses the moral duty not to infect those around him, reminds readers of the charitable and pious services given by the bishop in the plague-ridden city and the sermons on the streets urging people to repent. Finally, he suggests saying special prayers to the patron saints[46]. The complementary roles that physician and priest – if they are well prepared and competent - have towards the sick are thus confirmed, along with the beneficial interweaving of their knowledge and aims. As highlighted by the physician Arcimatteo di Salerno in his *De adventu medici ad egrotum* two centuries earlier, in the house of a sick person, "the physician and the priest hold the place of honour". In fact, they both cherish the health of man, which consists of the union of body and soul. It could be said that 'spiritual medicine' in Christian thought and pastoral care closely intersects and follows the doctrinal and professional events and the phases of development of secular medicine: its marginality in the early Middle Ages; its revival in the 12th c.; its success as a science and university discipline in the 13th and 14th centuries; its confusion and doubts in the 15th century. In the context of the medieval West, characterized to a greater or lesser extent by 'religious overdetermination', I think it might be useful, in addition to the study of the increasingly elaborate doctrines followed by physicians, to examine the projection of the image of medicine that the soul healers appropriated for their purposes. This could lead to a better understanding of both forms of therapy[47].

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Non-ISO4 abbreviations
AFP = *Archivum fratrum praedicatorum*
Es Filos = Esercizi filosofici
PL = Migne JP (ed.), Patrologia Latina cursus completus..., Series Latina. 221 voll. Parisiis: J. P. Migne /Garnier; 1844-

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3. Strictly speaking, *infirmus* refers to a person without security: the poor, the sick, the pilgrims.
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SAPIENZA
UNIVERSITÀ DI ROMA

Public Health in Preindustrial Europe: Urban and Rural Practices

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E-ISSN 2531-7288
ISSN 0394/9001

G. Geltner

Monash University - Melbourne

MEDICINA NEI SECOLI
Journal of History of Medicine
and Medical Humanities
36/1 (2024) 27-38

Received: Settembre 2023
Accepted: Novembre 2023
DOI: 10.13133/2531-7288/2895

Corresponding Author:
guy.geltner@monash.edu

ABSTRACT

Recent revisions to the medical history of western Europe between the twelfth and sixteenth century established that public health far predates Euro-American modernity and straddles the urban/rural divide and diverse occupational groups. Like numerous past societies, this civilization too monitored behaviors and manipulated environments in order to improve health outcomes by combining a culturally specific common sense with a prevalent natural-philosophical paradigm, in this case Galenism. The present review explains some of the preventative programs that urban and rural communities in Europe devised at the time, and their scientific and spiritual underpinnings. Beyond disputing these groups' longstanding reputation for hygienic apathy and ignorance, the broadened historical perspective shows that practicing public health can mean different things in different contexts.

Keywords: Public health - Europe - Periodization - Cities - Rural society - Galenism

Introduction

During the recent pandemic, large swathes of the so-called developed world witnessed the resurgence of low-tech, community-based prophylactics to the forefront of medical practice. The visible shift, from complex procedures and expensive drugs administered by trained professionals, to physical distancing, mask wearing and community support, evinced biomedicine's limitations when it comes to epidemic disease control. These changes in the perception and focus of public health interrogated an ameliorist ("newer is better") view of the field as well as its origin myth as a response to the Industrial Revolution and the culmination of advanced

science, secularism, the nation state and global capitalism[1]. As such, it vindicated numerous historical, archaeological and anthropological studies concerning different regions and eras, which have long challenged the teleology underpinning much of public health history as a by-product of European modernity. In addition, it underscored the importance, in a deeply unequal world, of accepting that community health always faces huge obstacles and that it can follow different paths and mean different things to different people[2]. Completing and solidifying this shift in both execution and perception, however, relies on adopting a culturally and spatially sensitive approach, one that rejects the accepted and often normative cesura between 'premodern' and 'modern' prophylactics, and moreover de-centers cities as the latter's main locus. The present essay accordingly lays out some of the ways in which public health historians have begun to collapse traditional geographical, locational and environmental divides. And although it focuses on western Europe between the twelfth and sixteenth century, there is excellent work to similar effect on earlier eras and different regions as well[3].

Urban prevention

For nearly a century medical historians and archaeologists have refuted deep-seated, modernist and Eurocentric views of earlier civilizations as unhygienic. By honing emic (bottom-up, culturally specific) perspectives, including through bio- and landscape archaeology, linguistics and oral history, scholars of health and hygiene in different world regions have shown that neither neglect nor ignorance characterised past societies' approaches to their own wellbeing as groups[4]. Nor did they lack a natural philosophy to inform their efforts. Across much of Africa, Europe and Asia, for instance, tens of millions of people shared the medical paradigm of humoralism, also known as Galenism or Hippocratic medicine[5]. The system was developed in ancient Greece, Rome and the eastern Mediterranean, and spread widely by Islamic merchants, settlers and conquerors centuries before it regained prominence in western Europe. Broadly speaking, Galenism identified three major vectors of disease transmission (person-to-person, mental contagion and miasma) and consistently privileged prevention over cure at both the individual and group level. Its practitioners, from Dublin to Delhi, strove to maintain a dynamic balance between people's humors (yellow bile, black bile, blood and phlegm) in the context of specific surroundings, activities and behaviors[6]. It was this set of principles that we can sometimes detect as underlying diverse preventative measures and applied to different circumstances.

Limiting ourselves to Galenic cultures in western Europe, recent studies of diets, labor, exercise, reproduction, town planning and governance have variously identified medical principles and programs purporting to promote community health[7]. Often the natural-philosophical inspiration is implicit, although on occasion extant documents and artefacts lay bare a policy's health-promoting intentions. In Italy, for example, city

councils and rulers promulgated by-laws *pro maiori sanitate hominum* and developed offices to enforce them within the city walls and in outlying areas[8]. Significantly, such efforts rarely distinguished between mental and physical health or indeed between the latter and communities' morality and piety. The fusion between moral and physical health reflects how in much of Christian Europe (and among Jews and throughout the Islamic world) medical practitioners and religious scholars regularly overlapped. Moreover, such experts had major inputs into government policies with regards to food provision and storage, war and diplomacy, and in preparation for or response to environmental disasters. They often sought, not only to address, but also to predict the latter by observing stellar conjunctions and other natural indicators which were integral to the study of medicine at the time[9]. In sum, the pursuit of health was both culturally authoritative and embedded in numerous power structures.

Most research on early community prophylactics has focused so far on preindustrial urban Europe. From Scandinavia to Iberia, and from the British Isles to the Adriatic coast, students of urban culture and government have unearthed a rich array of preventative policies as well as evidence for their enforcement, be it during crises such as wars, floods, famines and the Black Death (1346-1353), or in quieter periods. Sometimes building on Greek and Roman practices, interventions included the maintenance of hygienic infrastructures such as roads, bridges, wells, fountains, drains and canals, which were crucial nodes in supplying food and water as well as fighting fire and removing waste. As such, they were also strategic sites for promoting urban rulers' biopolitical agendas. In addition, municipalities were eager to attract, certify and monitor medical practitioners, from midwives, barber-surgeons and herbalists, to apothecaries and physicians, although the latter by no means exhaust the list of medical authorities people turned to. Arguably the best documented (but often overlooked) biopolitical intervention in cities concerned assuring quality of produce brought to markets, including medicinal herbs and compounds, through the strict regulation of markets and industries.

As an expressly "public" endeavor, the prerogative of promoting community health fell to different jurisdictions and organs. For instance, both city governments and craft guilds promulgated and implemented labor safety regulations to protect workers at all levels. In conjunction with ecclesiastical institutions, cities routinely modified burial practices to reduce fear and contagion, often citing Galenic principles. And both urban and ecclesiastical authorities founded leprosaria, hospitals and almshouses to protect vulnerable populations and the population at large, and curbed the bearing of arms, alcohol consumption, gambling and other morally unhygienic activities. Public health, but also public *authority*, was seen to benefit from periodically ridding cities of "unwanted" groups, such as religious minorities, the able-bodied poor, heretics and prostitutes, all of whom were easy to construe as polluting cities and disturbing communities' moral and physical balance. Most famously, perhaps, in times of crisis

urban leaders established quarantine facilities, sanitary corridors and dedicated information networks, and installed health boards to advise and monitor population health. In times of peace, in addition to regulating food supply and waste disposal, as mentioned, they also upheld building and planning norms to reduce the risks of collapse, flood, fire and pollution from industrial activities.

Cities certainly differed in terms of resources and their mobilization, and the latter's impact could be limited even with the best of intentions. Nor was the application of such programs even or their development linear. Yet evidence for the holistic and deliberate integration of preventative theory, policy and practice, often rooted in Galenic medicine, is by now too overwhelming to ignore as an exception[10]. However, the wealth and consistency of evidence for urban Europe in this period runs the risk of positioning the region as exceptional, a precocious forerunner to the hygienic triumph of later centuries. That is decidedly not the case, although retracing group prophylactics in other regions often requires more tools than archival methods due to the disappearance, destruction or non-existence of relevant documents. Linguistics, religious studies, anthropology, ethno-architecture, literature as well as the variety of (bio)archaeological approaches are in this sense instrumental for achieving a detailed and comprehensive view of these communities' hygienic pasts[11]. Moreover, developments in archaeological, art and architectural studies have shed much new light on the scale and achievement of providing for large populations in the Americas[12], and how numerous Asian and African cities likewise developed their own preventative programs, in response to different and changing threats, and based on a variety of medical, religious and natural-philosophical insights. These traditions live on, despite the globalization of biomedicine[13].

Rural prevention

City dwellers were a minority in many pre-industrial societies, and a focus on their group prophylactics can therefore be misleading or easy to dismiss as untypical. However, a similar methodological openness used to trace preventative programs in non-European cities provides insights into rural practices, too. Preindustrial miners and armies are a case in point, as they tended to be based in the countryside. Typically, these communities faced, in addition to their hard labor, food scarcity and exposure to the natural elements, several risks stemming from their (underground) work environments. For miners, these could include collapsing rock, flooding, dampness, darkness, fire, poor ventilation and poisoning[14]. Hundreds if not thousands of "underground cathedrals," as well as dwellings, art and documents miners left behind, allow us to assess miners' awareness and readiness to fight such hazards. Collectively these sources paint a rich picture of deliberate interventions in space, social organization and behavior designed to promote health and fight injury and disease at the community level. Some of these were unique to extractive activities in specific topographies, geologies and climates, while others reflect stresses common to rural life.

Miners' preventative programs were not necessarily and fully successful, but they certainly demonstrate that, as in cities, so in the countryside, people were proactive about preserving their health. Preventative interventions included, underground, the wearing of protective gear, including boots, legging, gloves, leather aprons and hats as well as face masks meant to save them from miasmatic vapors that Galenic physicians thought issued forth from exposed seams. Miners also designed guidance systems from ropes and leather straps to return them to safety or aid their rescue if they lost their way or consciousness. Tunnel supports, lamps, drains and ventilation shafts, moreover, were commonly used to increase safety at work, as did an organization into shifts of 6-8 hours, spread reasonably throughout the work week. Finally, the fostering of certain pious behaviors, including the use of crosses, prayers, charms and votives was meant to curry favor with god, relevant patrons such as Saint Barbara, as well as demons, which many miners believed occupied underground tunnels.

Above the ground miners strove to promote their health and fight disease in additional ways. In particular, other than encouraging the aforementioned pious behaviors, they built and decorated chapels, invited priests and followed the annual cycle of feasts. Mining communities also had access to relatively abundant diets thought by medical authorities specifically to counter the impact on their humoral balance by harmful vapors and working in cold, damp places. Nutritious diets were also achieved, given miners' commonly remote location, by adapting their environments for pasture, foraging and cultivation of grains, fruits and vegetables. A final and major example of preventative measures was zoning. The layout of mining villages was common and reflects an awareness (Galenic, not biomedical) to the importance of reducing the risk of breathing, drinking or consuming matter exposed to pollutants coming out of shafts or produced by metalworks or other industrial processes[15]. If zoning was a regular prophylactic technique in the era's towns and cities, it benefited rural miners as well.

Community prophylactics' impact can also be recovered, albeit more sporadically, through archaeological and paleo-scientific studies[16]. For instance, the near absence of cranial trauma and low rates of major fractures in arms and legs suggest that miners actually used and benefitted from protective gear. Proximate data for nutrition, demographics, height and life expectancy at birth matches those of regional urban *comparanda*, showing how miners compensated for their harsh conditions effectively. However, skeletal remains also exhibit stress markers in ligaments and bones associated with squatting, heavy lifting and strenuous physical activity, and soil deposits capture rather high concentrations of lead particles and other toxins, suggesting the limits of spatial interventions such as zoning. At any rate, collectively the evidence underscores how rural dwellers such as miners strove to maintain their health, and in doing so drew on a combination of common sense and the era's medical principles, as presumably did other extra-urban communities across the preindustrial world.

If miners tended to be sedentary communities, preindustrial society also included many groups that moved routinely between landscapes, seasons, settlements and cultural contexts, and thus faced changing health hazards. Merchants, pilgrims, armies and princely courts were among such groups, which could intersect, and are relatively well documented as compared with peasants. Among these the most numerous, socio-economically diverse and physically mobile groups were armies[17]. Before World War II, armies were demographic black holes, in that most soldiers died as a result of hunger and disease, not in combat or even from battle-inflicted wounds. Yet the political elites who led them hardly accepted this as a matter of course. Indeed, they developed a heightened awareness, if not a modern, biomedical understanding, of the threats soldiers faced, in the camp and on the march. The tactical guides they composed and consulted accordingly paid regular attention to the changing environmental circumstances an army had to contend with, and advised generals on the situation and organization of camps, length of exercises and marches, appropriate diets and rest[18]. For instance, the most influential military manual for all of Latin Europe, Vegetius' *De re militari* (late fourth or fifth century), stressed concerning a military camp that its "situation should be strong by nature" and that "[i]f the army is to continue in it any considerable time, attention must be had to the salubriousness of the place"[19]. Establishing the what a healthy place is relied in turn on Galenic medical principles; namely it:

> *[D]epends on the choice of situation and water, on the season of the year, medicine and exercise. As to the situation, the army should never continue in the neighborhood of unwholesome marshes any length of time, or on dry plains or eminences without some sort of shade or shelter. In the summer, the troops should never encamp without tents. And their marches, in that season of the year when the heat is excessive, should begin by break of day so that they may arrive at the place of destination in good time. Otherwise they will contract diseases from the heat of the weather and the fatigue of the march. In severe winter they should never march in the night in frost and snow, or be exposed to want of wood or clothes. A soldier, starved with cold, can neither be healthy nor fit for service. The water must be wholesome and not marshy. Bad water is a kind of poison and the cause of epidemic distempers*[20].

Archaeological and other sources suggest that armies applied and modified such advice in specific contexts to benefit and promote their wellbeing[21]. Armies, like miners and other non-urban groups, thus hardly had to wait for modern science and technology in order to develop preventative practices. In doing so, they routinely took their rural and ambient environments into careful consideration and sought to apply Galenic principles to reduce their harm.

Conclusion

All past societies, be they rural or urban, mobile or sedentary, were sensitive to how people and their changing environments mingled, with diverse impacts on their health. The measures they developed far predate environmentalism, biomedicine and the sup-

posed birth of the public health movement in Euro-American modernity, and they drew on culturally specific medical, religious and natural-philosophical principles. Moreover, as we have recently experienced, some of these allegedly low-tech measures remain relevant and are practiced today, and even if their efficacy is differently explained, communities around the globe relate positively to them. Medical history (and the history of science more broadly) showcases the wealth, diversity and contingency of cultural production across space and time, and not merely the "success" or "superiority" of certain measures, ideas or procedures. From this angle, public health in and beyond preindustrial Europe offers an exciting prism through which to view the human past. And it may also offer some inspiration on how to imagine our future.

Acknowledgements:
Funding was provided by the Australian Research Council, grant number DP220102914. I am grateful to Sarah May for their help in formatting this contribution.

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Non-ISO4 abbreviations
AHAMed = Acta historica et archaeologica mediaevalia (Barcelona)

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Guy Geltner Orcid identifiers: https://orcid.org/0000-0001-7827-1298

Sapienza Università di Roma

Healers: Lexicon, Functions and Roles of Medieval *Medici*

Tommaso Duranti

Alma Mater Studiorum - University of Bologna

© Author(s)

E-ISSN 2531-7288
ISSN 0394/9001

4.0 INTERNATIONAL

MEDICINA NEI SECOLI
Journal of History of Medicine and Medical Humanities
36/1 (2024) 39-62

Received: Settembre 2023
Accepted: Novembre 2023
DOI: 10.13133/2531-7288/2896

Corresponding Author:
tommaso.duranti@unibo.it

Abstract

The article presents the latest historiographical guidelines, aimed at providing a comprehensive understanding of individuals involved in healthcare activities during the Middle Ages. If one approaches medieval care without adopting a modern professional standpoint, the picture is much broader, more complicated, and less rigid than commonly portrayed. The use of this non-teleological approach also allows overcoming some traditional divisions, such as those between sacred and profane, between the early and late Middle Ages, and between learned and empirical physicians. The therapeutic journey that a patient can undertake becomes enriched.

Keywords: Healers - Practitioners - Professionalisation - Healthcare Occupations

1. A syncretic view of medieval syncretism

Traditional approaches on medieval practitioners – a generic term, that has only recently acquired a professional connotation[1] - have been built on the transposition of rigid professional categories and of the irreconcilable coexistence of sacred and profane, typical of a culture dominated by biomedicine, to a time where these two categories did not exist. These interpretations mainly descend from two integrated causes:

1. A history of medicine, particularly when authored by physicians consciously or unconsciously engaged in reconstructing historical progress, aimed, on one hand, to emphasize the abyssal difference between the contemporary medicine and the pre-modern 'primitive' world. On the other hand, it sought to present a consequent teleological interpretation of the evolution of the discipline, wherein biomedicine constituted the inevitable realization of 'medicine *tout court*', as if it were a universal and natural phenomenon[2].
2. A positivist interpretation of sources, especially those considered 'official', from the late Middle Ages, a period taken as a model and indicator of the entire millennium. In this sense, the public documentation utilized by historians to trace the origins of modern professions resulted in the construction of a rigid hierarchical – and equally rigid value-based – model of healthcare activities, interpreted as anticipations of the modern subdivision of healthcare professions.

The latter aspect – which is supported by historical evidence, but still requires a critical interpretation – has a counterpart in a medieval *querelle*: the debate over whether medicine was an *ars* or a *scientia* aimed at transforming it into a discipline rooted in reason, thus worthy of university recognition. However, this process has led to an attempt to disqualify – or at least subdue – all those healers not trained in the same curricula and methods[3]. Historiographical narratives have therefore established a rigid taxonomy of medieval health professions, consisting of physicians, surgeons, and barbers. Other actors, if considered at all, belonged to the nebulous and 'archaic' realm of religion, belief, folklore, and magic. The scholastic debate on medicine as *scientia rationalis* provided strong justification for this classification, but only if one ignores the doctrinal and normative nature of this production.

For some decades now, specialized historiography has abandoned the proposal of such a monolithic interpretation. Historians now collectively acknowledge that each medical system possesses its own rationality, and the question of rationality itself is not significantly crucial[4]. Qualitative and prosopographical research on medieval healthcare activities – if we refrain from labelling them as professions – has demonstrated that from the high Middle Ages, professional taxonomy does not withstand the transition from the discourse of authority to social reality[5]. The preponderance of

university-educated physicians in the period is unsustainable for numerical reasons, and professional antagonism should not be overstated: the image of an erudite medicine in conflict with all other healthcare practitioners is accurate but only partial and holds mostly theoretical value.

Thanks to the significant contributions of medical anthropology to medieval and general historiography, these rigid interpretations have now given way to a more plural and nuanced perspective, which does not aim to validate modern concepts in the past (or rather, it does not seek to confirm *a single* modern cultural system). These contributions have thus created an entirely different scenario.

The clear separation between medicine (or science), religion, and magic, based on a natural idea of rationality as mentioned earlier, is now universally acknowledged as outdated. These three systems are interconnected and frequently intersect to such an extent that they should not be perceived as merely coexisting independent facets, but rather as three different aspects of a syncretic attitude[6].

The historiographical paradigm shift, which has prioritized studies considering the 'point of view of the sick'[7], has led to a significant alteration. From this perspective, to understand the healthcare strategies employed in the Middle Ages, it is crucial to consider all the individuals that a sick person (along with their family and associates) could, at least theoretically, turn to when dealing with disease, sickness, and illness. This assumes that they exhibited a syncretic behaviour in their choices, where the motivation for such decisions is not always clear within the framework of learned categories[8].

The techniques employed during this period are not conducive to establish rigid categories. The principles of Galenic medicine permeated different social environments, at times undergoing simplification or misinterpretation, and treatments often exhibited overlap. The separation between pharmaceutical and dietary practices on one hand, and surgical practices on the other, frequently lacked practical significance. The resort to religious rituals (such as prayers and miracles) was not solely a prerogative of the clergy, and lay physicians often made equal use of them, even when they had a university training. Likewise, the recourse to what we define as a magical practice was not the exclusive domain of a single category: spells, invocations, amulets, astrological images were all part of the arsenal of priests, academic physicians, improvised healers, elderly villagers and so forth. Even miracles, to some extent, were not exclusive to saints (or their relics or even to God): consider the well-known case of thaumaturgic kings[9]. Some authors discuss natural medicine or the use of herbs, but this aspect does not require in-depth analysis, given that medieval pharmacology was entirely natural. Therefore, it does not function as a determining factor when considering the different categories of practitioners.

Gender studies and women's history have offered, and continue to offer, significant methodological value beyond their specific research scopes, particularly in the recon-

struction of therapeutical pluralism[10]. The notable scarcity of female healers in historical sources raised the question of whether this underrepresentation is a by-product of historians' perspectives. When searching for traces of women defined by the traditional professional labels, such instances appear in such a small percentage that it becomes almost absurd when considering all the evidence suggesting substantial female involvement in healthcare and caregiving across various civilization[11]. Furthermore, this approach reiterates the discourse of authority that, especially after the late Middle Ages, sought to marginalize women professionally. Up until the 14th century, terms used to denote healthcare professionals carried both feminine and masculine inflections. However, gradually, their female counterparts ceased to appear in normative documents, as the omission of names is a form of erasure (or a deliberate attempt to erase) of a reality[12]. Consequently, more recent research has sought to privilege approaches not focused on professional nomenclature, but rather on the conception of medicine as technologies of the body, recreating and attributing new meanings to the lexicon, drawing from diverse sources. It can be argued that this approach unveiled the hidden realms of female universe[13]. In my opinion, this methodology also offers valuable insights for more fruitful analysis of 'non-professional' male agents active in the field.

Furthermore, the domestic sphere played a primary role in the therapeutic journey of medieval patients towards recovery, both in terms of chronology (initial healing attempts were made at home before exploring other strategies) and quality (the majority of treatments occurred within the domestic context). In this regard, medieval Europe does not differ from other historical periods and cultural environments[14]. Women dominated the domestic space, not necessarily due to an assumed natural inclination for caregiving, but mainly because they were increasingly confined to it. The home represents an unavoidable location, a private domain much more challenging to investigate than the official realms of public power and occupations. It is within this space that self-care - a cornerstone of medieval (as well as ancient) attitudes towards illness - took place. The concept of domestic self-care included the understanding that the sick did not autonomously determine their actions and therapeutic strategies, but rather there was a collective reliance to strategies that did not require the intervention of a professional healer (be it an officially recognised physician or someone who primarily practiced this activity). This recourse to more private solutions was collective in nature, involving and mobilizing family members, friends, neighbours, colleagues, and many other individuals directly connected to the sick person[15].

This approach also blurs the differences between the early and the late Middle Ages, which were previously based on the absence, in the former of these two periods, of strong institutions responsible for creating therapeutic categories (specifically, public institutions and Universities, in this instance). If, instead of considering categories and professional vocabulary, one considers the possibilities available to the sick, it becomes

clear that the plurality of practitioners and therapeutic strategies characterises both macro-periods. Certainly, there are some differences: Katharine Park recently wrote a synthesis on medieval medical practice, establishing a chronology divided into four parts. The first, roughly concluded by the mid-11th century, marked by a considerable scarcity of sources; the second from 1050 to 1200, sharing similar features with the previous one but with more evidence. The third encompasses the turning point determined by the urbanisation and commercialization of European society, including the "creation" of a medicine transformed into *doctrina* taught in universities (1200-1350); finally, the last part, from the mid-14th to the 15th century, is marked by the emergence of medical institutions[16]. This framework, well-founded and widely accepted, should not overestimate differences in the period, as Park herself highlighted. For the sake of synthesis and in an effort to soften interpretative paradigms associated with traditional periodization, in this paper, however, I maintain the usual bipartition of the Middle Ages, considering the 13th century as a turning point. It is this century that witnesses the foundation of medical universities[17], as well as the first organisational entities of healthcare professions[18], a process closely connected to the emergence of diversified healthcare functions and the creation of a structural 'occupational' lexicon. While this did not standardize the situation, it marked a shift. In the13th century, at least from an official perspective, the Church also began to distance itself from the active role the clergy had in healthcare practice: a very slow process with numerous exceptions, even among the highest levels of the ecclesiastical hierarchy[19]. This distancing is more due to a moralisation of the clergy's behaviour and the separation between ecclesiastical and lay worlds than to a hypothetical aversion the Church expressed towards a medicine of bodies. This notion is one of the many commonplaces concerning the Middle Ages that, despite everything, continues to endure[20].

This aspect still generates many misunderstandings, which, despite historiographical efforts, seems to persist in defining the history of healers in the early Middle Ages. The confusion is rooted in the assumption of a distinction between religious medicine and secular medicine, not to mention the difference between medicine of the soul and medicine of the body. While these are indeed two distinct spheres, they are highly intermixed and juxtaposed throughout the entire period under consideration, and beyond[21].

2. The *medici*-monks of the early Middle Ages

Early medieval medicine is frequently still labelled as 'monastic medicine', suggesting that healers during this period were exclusively or primarily individuals affiliated with monastic communties. However, this definition requires further clarification: the monastic nature of this medicine relies on the type of sources available. Nearly all our knowledge about medicine, particularly as a discipline, in the first centuries of the Middle Ages is derived from copied texts, produced, and preserved within monastic

institutions. The monastic monopoly on medicine, therefore, is a textual monopoly and does not exclusively pertain to medical practice[22].
Indeed, the monastery, primarily conceived as a place of study and preservation, also served a more strictly therapeutic function. The ideal model, represented by the renowned St Gall plan, reveals a specific attention to healthcare concerns and practises: infirmaries, specific halls and kitchens, baths, vegetable and herbal gardens were designed for the members of the religious community wherein *medici,* who were not necessarily monks, operated. These practitioners often extended their services to outsiders and laypeople, offering care, assistance, as well as advice and guidance[23]. In the English context, there is evidence of monks visiting the homes of the sick[24]. Their role derived from practical and/or theoretical experience, their notions of medicine and, above all, of healthcare, to which the aspect of spiritual care, always connected to that of the body, cannot be separated. The term *medicus* was used to describe the monk providing these services, not because he practised a profession, nor necessarily because he was an 'expert' in medicine, according to professional and/or juridical criteria[25]. Meanwhile, central and northern Italy were characterised by the absence of monk-*medici*, with a majority of lay healers or even secular cleric practitioners[26].
Healthcare services that explicitly intersected body and soul were offered in sanctuaries[27]. These places, often pilgrimage sites due to the preservation of relics, provided spaces where physical healing, not necessarily understood as pathological, could also be sought. In these sanctuaries, a holistic healing process, highly valued in medical anthropology, was practiced: for example, morally and/or socially negative and harmful behaviours, defined as sins in a Christian context, were identified, and their correction was considered as equally important or even more significant than the disappearance of physical symptoms[28]. The effectiveness and, more importantly, the enduring success of resorting to these therapeutic strategies, which did not cease with the end of the Middle Ages (nor with the emergence of biomedicine), should be assessed in terms of symbolic efficacy and expectations. Hagiographies portray saints employing both secular medical procedures and mysterious interventions. In short, these sources depict not an opposition between medical systems (spiritual and corporal), but rather their integration, especially from the perspective of the sick[29].
The ecclesiastical monopoly on early medieval culture has thus granted us a powerful and exclusively religious perspective on the medicine practiced in that period, significantly shaping our comprehension. It is not that there are no traces of lay pratictioners, even in secular documents. Instead, their limited presence is the result of a lower cultural and social significance attributed to their activities, which were considered 'not worthy' of written record. These agents, often referred to with generic terms (mostly designated as *medicus*, a term that in the early Middle Ages held a generic and inclusive meaning) appear in 'indirect' documents. In these cases, their mention is not due to their professional functions, but rather their involvement in activities such as sell-

ing and buying goods, witnessing contracts, or in generic terms, appearing in normative texts[30]. Therefore, there are few elements that allow us to draw a clearer picture: certainly, we can imagine them possessing varying levels of education, mainly trained through experience or self-taught, practicing both medicine and surgery, especially considering the prevailing interest of early medieval medicine in therapeutic practice. Classifying these actors using dichotomies between learned and popular or scientific and magical is challenging – misleading connotations, as previously noted, when assessing different forms of treatment.

3. The healthcare professions of the late Middle Ages

The scholarly discourses elaborated by the medical doctrine that emerged after the experience of the *Schola Salernitana*, and later, in the core of medieval universities[31], dignified the discipline and gradually increased the number of educated physicians. However, these discourses also resulted in a lexical mutation that should not be interpreted as a faithful reflection of reality. Around the 13th century, a different society was being built; urbanisation and rapid economic growth led to a rapid separation of various work activities, as well as a progressive use of 'professional' categories as a means of individual identification, shaping social-image, administration and taxation[32]. The habits of a more secularized society gave rise to new demands for healthcare and prevention in the Europe of the time[33]. All these aspects collectively contributed to create what is considered – though not without debate – the first medicalization of society[34]. Concerning therapeutic options, the plurality of healers did not undergo a radical transformation: treatments provided by clergymen and miraculous cures did not disappear; instead, they witnessed additional incentives, albeit under more regulated conditions. Firstly, this occurred due to the urbanisation of religious houses and an increasing affinity between spiritual and bodily needs, including the proliferation and establishment of hospitals[35]. Secondly, it was a result of the progressive regulation of practices associated with miracles, their validation, and the increase of vows (the practice of penitence or pilgrimage followed by the fulfilment of the requested outcome)[36].

Scholarly reflection and the organisation of work, especially in urban environments, resulted into an initial classification of healthcare activities. Firstly, with the scholarly division of treatments into diet, pharmacopoeia and surgery, a distinction aroused between *physici* (dedicated to the first two) and surgeons. This disciplinary fragmentation also gave rise to a hierarchy: despite the variety of contexts, the *physica* and its practitioners held a more prestigious role, both intellectually and socially. However, this hierarchy should not be transposed to the perception of users, where the practical application of techniques made a tangible difference[37]. Authorities focused their progressive interventions towards these specific aspects, aiming to organise therapeutic functions: what, in terms not universally agreed upon, can be defined as the emergence

of professionalisation[38]. This process primarily manifested through the gradual issuance of licenses, granted by political authorities or universities, ensuring a monopoly over all (secular) healthcare activities, and providing greater guarantees to the sick. References to the common good should not be dismissed as mere functional rhetoric aimed solely at imposing norms from above: many studies suggest that the professionalisation process occurred rather 'from the bottom'[39]. Judicial consequences, which played a significant role in historiography, should not be overstated and should be considered in the light of professional closure, that is, the practise of medicine as a predominant and remunerated activity, thereby socially 'identifying'[40].
The theoretically rigid categories resulted in a theoretical crystallization of nomenclature. The performative aspect of these discourses may have had a more limited impact on the medieval marketplace than the historiographical investigations. 'Believing' in the taxonomy used in the official sources – more easily accessible and more functional to a preconceived thesis – narrowed the range of healers to those terms, excluding individuals not fitting into these categories or labels and, particularly those whose titles are not easily aligned with contemporary healthcare classifications. In some ways, this was the main consequence of medieval professionalisation[41].
It is precisely those who are excluded and marginalised in our perspective, however, who unveil a diverse world that the process of professionalisation has only partially managed to hinder: a world composed of those healers, who, in the lexicon of the time, can be collectively categorized under the umbrella category of empiricists. Their terminology, once again, derived from an authoritative discourse, in this specific case, from doctrine: it denoted individuals who had trained and practised only through everyday experience, in sharp opposition to the idea of a *scientia medica* built on the study, assimilation and commentary of authority texts[42]. It was therefore learned physicians from academic environments who coined the label of empiricist (*empiricus*), supported by public authorities. Within this large group, the variety of technical, social and cultural types was extreme, and being considered an empiricist (usually not a self-determined label[43]) did not necessarily mean not having a license to practice. The case of barbers is relevant in this sense. While they did not use the label of *medicus*, they still held the title of healthcare operators, engaging in both prevention and treatment. Consequently, they were sought after by private citizens, convents, royal, princely and ecclesiastical courts, and enrolled by the city and public power[44]. Barbers often organised into guilds, fully integrating into the urban labor market, and many of them identified themselves as barber-surgeons, emphasizing which activity was – or wanted to be – prevalent, creating a sort of oxymoron for us[45]. Furthermore, many surgeons were empiricist, trained, as in most medieval cases and professions, through apprenticeship. It is challenging to argue that the majority of *physici* were not empiricist; while the number of university-educated physicians certainly increased, they always represented the great minority[46].

To summarize, it is evident that the late medieval 'professionalisation' process did not create impervious categories but rather attempted, albeit unsuccessfully in the mid-period, to establish a rigid socio-economic hierarchy. In reality, these different categories often collaborated and worked in synergy over the period. The terminology itself, therefore, always contingent, artificial and in need of historicization[47], should be approached with caution: for instance, the Florentine Giovanni Battista appears in 1468 defined in hospital documents as a barber, perhaps a barber-surgeon ("medico della barba"), but also as a "medico cierusicho, e quando bisognia per fisicha"[48]. This is just one of a myriad of examples.

From the perspective of the sick, these categories have long been regarded as part of a set of options to be alternated or used simultaneously, not perceived as mutually exclusive, despite the growing reliance on, if not erudite, at least controlled and 'sanctioned' medicine[49]. Moreover, the search for professional healers included other actors, with pharmacists being notably relevant. Whereas in the early Middle Ages the *medicus* was responsible for the preparation and sale of drugs, pharmacists at this point were primarily merchants, authorized, however, to prepare drugs under the guidance of licensed physicians, with whom they could not establish economic agreements[50]. Practice, however, reveals the existence of societies of *medici* and pharmacists, as well as many cases in which the sick followed treatments devised by pharmacists: a way of shortening the duration of the healing process, avoiding excessive intervention in one's lifestyle habits, and seeking a solution for the symptoms rather than the healing of the causes (something much disputed by empiricists)[51]. The practice also reveals the existence of men and women who offered their services, voluntary or for a fee, in the institutions of care - hospitals that should be understood as comprehensive healthcare entities, regardless of whether or not there are medical 'professionals'[52] within them–; the appeal to the clergy and to the sacred, and most importantly, the practice of self-care and homecare, a *longue-durée* structure in the field.

4. Conclusions

Studies on healthcare practitioners confirm the existence of pluralism in every medical system, except, perhaps, that of biomedicine. Each healer – whether officially recognised or not according to norms, professional or occasional, theoretically trained or through apprenticeship; lay or ecclesiastic: male or female; even human or supernatural – should be considered a *medicus*. This perspective takes into account their specific social, cultural and technical profile, viewing them as "mediators of healing"[53] and agents of body technologies.

Similarly, the narrative of medieval healers should broaden the scope of inquiries and methodologies, avoiding uncritically adhering to the 'terms' that resonate, sometimes

illusively, with contemporary healthcare professions and their classificatory *ratio*. The transition between the early and late Middle Ages, in this sense, can be understood as a process of terminological differentiation, which did not imply, at least not exclusively, a therapeutic differentiation. Focusing solely on practitioners recognised by authorities (civic, academic), or university *doctores* allow us to investigate some fundamental aspects, especially regarding doctrinal and normative discourses, but it may obscure the senses for those who wish to explore the therapeutic resources available in these societies.
Scholars should identify these resources, sometimes making a deliberate effort to distance themselves, aiming to keep their focus on the various medical spheres (popular, professional, and folk[54]), much like, perhaps, a sick person would have done in the Middle Ages.

Bibliography and notes

Acknowledgements: translated by Edward Loss

Non-ISO4 abbreviations
AM = AM. Rivista della Società italiana di antropologia medica
BECh = Bibliothèque de l'École des Chartes
CIAN = Cuadernos del Instituto Antonio de Nebrija de estudios sobre la Universidad
Dynamis = Dynamis. Acta hispanica ad medicinae scientiarumque historiam illustrandam
Hist Med S = Histoire, médecine et santé
Q St UniPd = Quaderni per la storia dell'Università di Padova

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1. See McVaugh MR, Medicine before the plague. Practictioners and their patients in the Crown of Aragona, 1285-1345. Cambridge: Cambridge University Press; 2002, p. 40; Pilsworth C, Could you just sign this for me John? Doctors, charters and occupational identity in early medieval northern and central Italy. Early Mediev Eur 2009;17(4):363-88, pp. 369-72; Perez S, Histoire des Médecins. Artisans et artistes de la santé de l'Antiquité à nos jours. Paris: Perrin; 2015. p. 11; Duranti T, *Doctores* e dottori: laurea in medicina e professioni mediche nel Medioevo. In: Guerrini MT, Lupi R, Malatesta M (eds), Un monopolio imperfetto. Titoli di studio, professioni, università (secc. XIV-XXI). Bologna: Clueb; 2016. pp. 1-13, p. 1.
2. This 'teleological path' generally begins in the ancient classical age, which, from a humanistic perspective, is regarded as the distinguished origin (Green MH, Integrative Medicine: Incorporating Medicine and Health into the Canon of Medieval European History. Hist Compass 2009;7(4):1218-45, pp. 1223-4): once again, then, the Middle Ages appear as an interruption in the path of civilisation.
3. On the debate about medicine as *ars* or *scientia*, see Agrimi J, Crisciani C, *Edocere medicos.* Medicina scolastica nei secoli XIII-XV. Milano-Napoli: Guerini - Istituto italiano per gli studi filosofici; 1988, esp. chap. 1; Jacquart D, La scolastica medica. In: Grmek MD (ed.), Storia del pensiero medico occidentale. Antichità e Medioevo. Roma-Bari: Laterza; 1993. pp. 261-322.
4. About the argument of 'rationality' (and its opposite of 'irrationality') in medical thought systems - in addition to the discussions of Scholasticism (see ref. 3) - cf. Pizza G, Antropologia medica. Roma: Carocci; 2005, p. 196; Stengers I, Le médicin et le charlatan. In: Nathan T, Stengers I, Médecins et sorciers. Paris: Editions du Seuil; 2004. pp. 115-61. Nowadays, even within biomedicine, the rationality/irrationality pair seems to have lost explanatory value: cf. Corbellini G, Storia e teorie della salute e della malattia. Roma: Carocci; 2014. p. 44.
5. E.g.: Talbot CH, Hammond EA, The Medicals Practitioners in Medieval England: A Biographical Register. London: Wellcome Historical Medical Library; 1965; Wickersheimer E, Dictionnaire biographique des médecins en France au Moyen Âge, Jacquart D (ed.), Genève: Librairie Droz; 1979; Jacquart D, Le milieu medical en France du XIIe au XVe siècle. Genève: Librairie Droz; 1981; Naso I, Medici e strutture sanitarie nella società tardo-medievale: il Piemonte dei secoli XIV e XV. Milano: FrancoAngeli; 1982; Park K, Doctors and medicine in early Renaissance Florence. Princeton: Princeton University Press; 1985; Shatzmiller J, Jews, medicine, and medieval society. Berkeley: University of California Press; 1994; Rawcliffe C, Medicine and society in later medieval

England. Stroud: Alan Sutton Pub.; 1995. Getz F, Medicine in the English Middle Ages. Princeton: Princeton University Press; 1998. esp. pp. 5-8; Ead., Medical Practitioners in Medieval England. Soc Hist Med 1990;3:245-83; Siraisi NG, Medieval & Early Renaissance Medicine. An Introduction to Knowledge and Practice. Chicago and London: The University of Chicago Press; 1990; Moulinier-Brogi L, Les médecins dans le Centre-Ouest au Moyen Âge (XIIIe-XVe siècle). In: Laurioux B, Moulinier-Brogi L (eds), Scrivere il Medio evo. Lo spazio, la santità, il cibo. Roma: Viella; 2001. pp. 405-29; McVaugh MR, ref. 1; Picot J, Le milieu médical à Montferrand au Moyen Âge. Essai de répertoire prosopographique (milieu XIIIe-milieu XVIe siècle). Bull Auvergne 2014;CXV:99-154. Chandelier J, Nicoud M, Entre droit et médecine. Les origines de la médecine légale en Italie (XIIIe-XVe siècles). In: Chandelier J, Robert A (eds), Frontières des savoirs en Italie à l'époque des premières universités (XIIIe-XVe siècles). Roma: École française de Rome; 2015. pp. 233-93.

6. In sum, there is no such thing as magic that opposes, or at least is autonomous concerning religion and science, nor vice versa: studies on these topics have by now unanimously overcome the idea of the coexistence of different spheres that are monopolised by as many different social, and even professional, categories. More appropriate is the question of authority: which magic and which practitioners of magic are legitimate; which miracles can be attested and confirmed; and in this vein, which practitioners of secular therapies are legitimate and legitimised, and to what extent (Kieckhefer R, Magic in the Middle Ages. Cambridge: Cambridge University Press; 1989; Flint V, The Early Medieval *Medicus*, the Saint and the Enchanter. Soc Hist Med 1989;2:127-45; Horden P, What's Wrong with Early Medieval Medicine?. Soc Hist Med 2011;24(1):5-25; Park K, Magic and Medicine: The Healing Arts. In: Brown JC, Davis RC (eds), Gender and Society in Renaissance Italy. London: Longman; 1998. pp. 129-49; Biller P, Ziegler J (eds), Religion and Medicine in the Middle Ages. York: York Medieval Press; 2001; Foscati A, Tra scienza, religione e magia: *incantamenta* e riti terapeutici nei testi agiografici e nei testi di medicina del Medioevo. In: Golinelli P (ed.), Agiografia e culture popolari – Hagiography and Popular Cultures. Atti del convegno internazionale (Verona, 28-30 ottobre 2010). Bologna: Clueb; 2012. pp. 113-28; Galdi A, Guarire nel medioevo tra taumaturgia dei santi, saperi medici e pratiche magiche. Ibid. pp. 93-112; Pilsworth C, Healthcare in Early Medieval Northern Italy: More to Life than Leeches. Turnhout: Brepols; 2014. p. 149; Bowers BS, Keyser LM (eds), The Sacred and the Secular in Medieval Healing: Sites, Objects, and Texts. London-New York: Routledege; 2016; Veronese J, Guérir et rendre malade: un exemple de l'ambivalence de la magie savante médievale (XIIe-XVe s.). In: Chapelain de Séreville-Niel C, Delaplace Ch, Jeanne D, Sineux P (eds), Maladies et lieux religieux de la Méditerranée antique à la Normandie médievale. Rennes: Presses Universitaires de Rennes; 2020. pp. 241-53).
7. Cf. Nicoud M, Salute, malattia e guarigione. Concezioni dei medici e punti di vista dei pazienti. Quad stor 2011;1:47-74.
8. Cf. Pool R, Geissler W, Medical anthropology. Maidenhead: Open University Press; 2005. pp. 44-5; Dei F, Antropologia medica e pluralismo delle cure. AM 2014;37:81-104. On the introduction of concepts of disease, sickness, and illness by anthropology: Young A, The anthropologies of illness and sickness. Annu Rev Anthropol 1982;1:257-85.
9. Regarding the *vetula* see Agrimi J, Crisciani C, Immagini e ruoli della "vetula" tra sapere medico e antropologia religiosa (secoli XIII-XV). In: Paravicini Bagliani A, Vauchez A (eds), I poteri carismatici e informali: chiese e società medioevali. Palermo: Sellerio;

1992. pp. 224-61; Eaed., Savoir médical et anthropologie religieuse. Les representations et les fonctions de la *vetula* (XIIIe-XVe siècle). Ann Hist Sci Soc 1993;46(5):1281-308. On thaumaturge kings see Bloch M, Les rois thaumaturges. Étude sur le caractère surnaturel attribué à la puissance royale particulièrement en France et en Angleterre. Paris: Istra; 1924.

10. Among several studies, see at least: Shatzmiller J, Femmes médecins au Moyen Âge. Témoignages sur leurs pratiques (1250-1350). In: Histoire et société: mélanges offerts à Georges Duby, vol. 1: Le couple, l'ami et le prochain. Aix-en-Provence: Publications de l'Université de Provence; 1992. pp. 165-75; Green MH, Documenting Medieval Women's Medical Practice. In: García-Ballester L, French R, Arrizabalaga J, Cunningham A (eds), Practical Medicine from Salerno to the Black Death. Cambridge: Cambridge University Press; 1994. pp. 322-52; Park K, Secrets of Women. Gender, Generation, and the Origins of Human Dissection. New York: Zone Books; 2006. p. 10; Cabré M, Women or Healers? Household Practices and the Categories of Health Care in Late Medieval Iberia. Bull Hist Med 2008;82(1):18-51; Green MH, Making women's medicine masculine: the rise of male authority in pre-modern gynaecology. Oxford-New York: Oxford University Press; 2008; Conforti M, *Vetulae*, matrone, mammane. Le donne e la cura. In: Santoro M (ed.), La donna nel Rinascimento meridionale. Atti del convegno internazionale (Roma, 11-13 novembre 2009). Pisa-Roma: Fabrizio Serra Editore; 2010. pp. 121-30; Santoro D, La cura delle donne. Ruoli e pratiche femminili tra XIV e XVII secolo. In: Pacifico M, Russo MA, Santoro D, Sardina P (eds), Memoria, storia e identità. Scritti per Laura Sciascia. Palermo: Associazione Mediterranea; 2011. pp. 779-803; Park K, Medical Practice. In: Lindberg DC, Shank MH (eds), The Cambridge History of Science, 2: Medieval Science. Cambridge: Cambridge University Press; 2013. pp. 611-29, pp. 623-4; Strocchia ST, Forgotten Healers. Women and the Pursuit of Health in Late Renaissance Italy. Harvard: Harvard University Press; 2019; Ritchey S, Strocchia ST, Introduction. In: Eaed. (eds), Gender, Health, and Healing, 1250-1550. Amsterdam: Amsterdam University Press; 2020. pp. 15-38.
11. Cabré M, ref. 10, 23.
12. See e.g. Dumas G, Les femmes et les pratiques de la santé dans le "Registre des plaidoiries du Parlement de Paris, 1364-1427". Can Bull Med Hist 1996;13(1):3-27.
13. Body technologies are defined as the skills, beliefs, and practices about the body's functioning: see Cabré M, ref. 10; Green MH, Bodies, Gender, Health, Disease: Recent Work on Medieval Women's Medicine. SMRH 2005;3s.,2:1-46, p. 3.
14. Regarding domestic space as the main place of healing: Horden P, Smith R (eds), The Locus of Care. Families, communities, institutions, and the provision of welfare since antiquity. London: Routledge; 1997; Pilsworth C, ref. 6, chap. 5; Cabré M, ref. 10. pp. 27 ff.; cf. also Kleinman A, Concepts and a model for the comparison of medical systems as cultural systems. Soc Sci Med 1978;12(2B):85-93, p. 86.
15. Pizza G, ref. 4. pp. 189-91; it should be understood as the main therapeutic strategy, due to not only contingent but also cultural causes: the self-healing power of nature (cf. Brown P, The Cult of the Saints. Chicago: The University of Chicago Press; 1981. pp. 157-62) and the prominence accorded to dietetic-hygienic regimes, as such achievable even without recourse to the medical practitioner (on *regimina sanitatis* as a genre: Nicoud M, Les régimes de santé au Moyen Âge. Naissance et diffusion d'une écriture medicale (XIIIe-XVe siècle), 2 voll. Roma: École française de Rome; 2007).
16. Park K, ref. 10.

17. A turning point came in the 12th century with the conspicuous work of translations from Arabic and Greek, which extended the medical library and provided the theoretical basis for the development of the discipline in Europe: Jacquart D, Micheau F, La médecine arabe et l'Occident medieval. Paris: Maisonneuve et Larose; 1990; Jacquart D, ref. 3; Chandelier J, Avicenne et la médecine en Italie. Le *Canon* dans les universités (1200-1350). Paris: Champion; 2017; see also Nicoud M in this issue. For an overview of the rise of medical universities: Duranti T, The Origins of the *Studium* of Medicine of Bologna: a *Status Quaestionis*. CIAN 2018;21:121-49.
18. An early case is that of Florence: see Ciasca R, L'arte dei medici e speziali nella storia e nel commercio fiorentino dal secolo XII al XV. Firenze: Olschki; 1927; Sandri L, Il Collegio medico fiorentino e la riforma di Cosimo I: origini e funzioni (secc. XIV-XVI). In: Baldassarri SU, Ricciardelli F, Spagnesi E (eds), Umanesimo e università in Toscana (1300-1600). Firenze: Le Lettere; 2012. pp. 183-211.
19. The cases are numerous: for example, Theodoric Borgognoni, bishop, Dominican friar, and well-known 13th-century surgeon (Roversi Monaco F, Teoria e pratica medica nel basso Medioevo. Teodorico Borgognoni vescovo, chirurgo, ippiatra. Firenze: SISMEL-Edizioni del Galluzzo; 2019).
20. Historiography has revealed the cliché of a conflict between the Church and medicine, since Amundsen DW, Medieval Canon Law on Medical and Surgical Practice by the Clergy. Bull Hist Med 1978;52(1):22-44; see also Montford A, Health, Sickness, Medicine and the Friars in the Thirteenth and Fourteenth Centuries. Farnham: Ashgate; 2004. Cf. Crisciani C in this issue.
21. Regarding the integration of the body and the spirit, it will suffice here to refer to Jacquart D, Cinquante ans de recherches sur la médecine des XIIIe-XVe siècles: les contours d'un nouvel objet pour l'historien. In: La medicina nel Basso Medioevo. Tradizioni e conflitti. Atti del LV Convegno storico internazionale, Todi, 14-16 ottobre 2018. Spoleto: Centro Italiano di Studi sull'Alto Medioevo; 2019. pp. 1-24, pp. 19-21; see also Crisciani C, in this issue.
22. Horden P, Sikness and Healing. In: Noble TFX, Smith JMH (eds), The Cambridge History of Christianity, III: Early Medieval Christianities, ca. 600-ca. 1000. Cambridge: Cambridge University Press; 2008. pp. 416-32; Id., ref. 6; Park K, ref. 10. pp. 615-7; Pilsworth C, ref. 1. pp. 386-7 concludes that "it could be said that we are seeing not so much the 'clericalization' of medicine in this period in Italy, as the gradual 'medicalization' (in the loosest sense) of ecclesiastical institutions, including clerical education".
23. Cf. Zettler A, Exkurs I: Zu den Klosterärzten. In: Rappmann R, Zettler A, Die Reichenauer Mönchsgemeinschaft und ihr Totengedenken im frühen Mittelalter. Sigmaringen: Jan Thorbecke Verlag; 1998. pp. 265-78. On the St. Gallen plan: Horn W, Born E, The Plan of St. Gall: A Study of the Architecture and Economy of, and Life in a Paradigmatic Carolingian Monastery. Berkeley-Los Angeles: University of California Press; Berkeley-Los Angeles; 1979. The plan is available at https://www.e-codices.unifr.ch/it/list/one/csg/1092.
24. Cf. Meaney A, The Practice of Medicine in England about the Year 1000. Soc Hist Med 2000;13(2):221-37; Park K, Medicine and Society in Medieval Europe, 500-1500. In: Wear A (ed.), Medicine in Society. Cambridge: Cambridge University Press; 1991. pp. 59-90, p. 68.
25. On the medieval medical expert, see Nicoud M, Faut-il historiciser l'expertise?. Hist Med S 2021;18:9-25; it is also a juridical construction, upon which the process of

professionalisation also lies: Sandrini E, La professione medica nella dottrina del diritto comune. Secolo XIII-XVI (parte I). Padova: CEDAM; 2008; see also ref. 38.

26. About this context, see Cosentino S, La figura del *medicus* in Italia tra tardoantico e altomedioevo. Tipologie sociali e forme di rappresentazione culturale. Med secoli 1997;9(3):361-98; Pilsworth C, ref. 1; Ead., ref. 6. chap. 6.
27. About the shrines as places of healing see Brown P, ref. 15; Sigal P-A, L'homme et le miracle dans la France médiévale (XIe-XIIe siècle). Paris: Cerf; 1985; Canetti L, Terapia sacra. Guarire al santuario. In: La medicina nel Basso Medioevo, ref. 21. pp. 46-75. However, Horden P, ref. 22. p. 2 assumes that only a minority of the sick would resort to the pilgrimage to the saint; according to Ferngren GB, Medicine and Health Care in Early Christianity: Medicine & Health Care in Early Christianity. Baltimore: Johns Hopkins University Press; 2009. p. 13 in the first five centuries, Christians mainly turned to lay healers and domestic care.
28. Cf. Lock M, Scheper-Hughes N, A critical-interpretative approach in medical anthropology: rituals and routines of discipline and dissent. In: Johnson T, Sargent C (eds), Medical Anthropology, Contemporary Theory and Method. Westport: Praeger Publishers; 1990. pp. 47-72. On the subject of efficacy, especially medical anthropology has emphasised the necessity of not restricting to the measurable efficacy of biomedicine: cf. Young A, The relevance of traditional medical cultures to modern primary health care. Soc Sci Med 1983;17(16):1205-11, p. 1208; Pizza G, ref. 4. chap. 8; Lupo A, Malattia ed efficacia terapeutica. In: Cozzi D (ed.), Le parole dell'antropologia medica. Piccolo dizionario. Perugia: Morlacchi Editore; 2012. pp. 127-55. This approach is also considered in historiography, e.g. Horden P, ref. 6. p. 20: "Instead of looking for biomedical efficacy we should perhaps think, as anthropologists do, in terms of therapeutic success: a matter of overall patient satisfaction with the therapeutic encounter rather than altered pathology".
29. Canetti L, ref. 28. p. 51 defines them as "santi educati alla scuola di Ippocrate"; see also Foscati A in this issue.
30. Cf. Siraisi NG, ref. 5. p. IX; see Skinner P, Health and Medicine in Early Medieval Southern Italy. Brill: Leiden; 1997. pp. 79-88; Pilsworth C, ref. 1; Ead., ref. 6; Oliver L, The body legal in barbarian law. Toronto: University of Toronto Press; 2011.
31. On the *schola salernitana*, see at least: Kristeller PO, Studi sulla Scuola medica salernitana. Napoli: Istituto italiano per gli studi filosofici; 1986; Jacquart D, Paravicini Bagliani A (eds), La scuola medica salernitana: gli autori e i testi, Atti del Convegno internazionale, (Salerno, 3-5 novembre 2004). Firenze: SISMEL-Edizioni del Galluzzo; 2007; Ventura I, La Scuola Medica Salernitana. In: Galdi A, Pontrandolfo A (eds), Storia di Salerno. Vol. I: Età antica e medievale. Salerno: Francesco D'Amato Editore; 2020. pp. 245-59. Regarding the rise of medical universities, see Duranti T, ref. 17.
32. Cf. Hanne G, Introduction. Langage du travail, travail du langage. In: Hanne G, de Larivière CJ (eds), Noms de métiers et categories professionelles. Toulouse: Presses universitaires du Midi; 2010. pp. 7-19; Degrassi D, Lavoro e lavoratori nel sistema di valori della società medievale. In: Franceschi F (ed.), Il Medioevo. Dalla dipendenza personale al lavoro contrattato. Roma: Castelvecchi; 2017. pp. 15-43, esp. p. 19.
33. Starting with the papal court: Paravicini Bagliani A, Il corpo del papa. Torino: Einaudi; 1994.
34. In historiography, this concept is now used (at least in some contexts and for the final centuries of the Middle Ages) to refer both to the progressive introduction of forms professional knowledge control; and to the progressive increase in medical care and supply

(including the emergence of *medici* salaried by public authorities): Nutton V, Continuity or Rediscovery? The City Physician in Classical Antiquity and Mediaeval Italy. In: Russell AW (ed.), The Town and State Physician in Europe. Wolfenbüttel: Herzog August Bibliothek; 1981. pp. 9-46; McVaugh MR, ref. 1; Shatzmiller J, ref. 5; Nicoud M, Formes et enjeux d'une médicalisation médiévale (XIIIe-XVe siècles). Genèses 2011;82:7-30; Jacquart D, ref. 21. p. 23.

35. On the medieval hospitals as a place of healing, see Bianchi F, in this issue.
36. Certain changes in the commercialization of secular healing have similar elements to the practice of vows: Park K, ref. 10. p. 618. On the transformation of the concept of holiness and related practices, it is a must to refer to: Vauchez A, La sainteté en Occident aux derniers siècles du Moyen Âge d'après les procès de canonisation et les documents hagiographiques. Roma: École française de Rome; 1981.
37. Cf. O'Boyle C, Surgical Texts and Social Contexts: Physicians and Surgeons in Paris, c. 1270-1430. In: García-Ballester L, French R, Arrizabalaga J, Cunningham A (eds), ref. 10. pp. 156-85. Jacquart D, La médecine médiévale dans le cadre parisien XIVe-XVe siècle. Paris: Fayard; 1998. chap. 1; Ead., ref. 21. pp. 12-3. McVaugh MR, The Rational Surgery of the Middle Ages. Firenze: SISMEL-Edizioni del Galluzzo; 2006 effectively demonstrated that the surgery too was involved in a course of rational and learned dignification. See also Cifuentes L, in this issue.
38. An auto-normative system, a community consciousness, an outlined training path, and some form of selection are the current features that define a profession. However, even the now classic Abbott A, The System of Professions: an Essay on the Division of Expert Labor, Chicago-London: University of Chicago; 1988. p. 1, points out that the very concept of professionalisation is misleading, as it seems to focus more on the forms than on the contents. In the past, a professional interpretation of the trades of the late Middle Ages was preferred (probably with a teleological perspective); Then, especially in the 1990s, there was a counter-reaction, with the profession being considered only from the perspective of the capitalist system; today, we are more cautious, but also less confined by strict definitions of contemporaneity. Certainly, there were certain traits that emerged at that time: we can therefore consider the last few centuries of the Middle Ages as the starting point of professionalization. See at least Bullough VL, The Development of Medicine as a Profession: the Contribution of the Medieval University to Modern Medicine. Basel-New York: S. Karger; 1966; Pelling M, Medical Practice in Early Modern England: Trade or Profession?. In: Prest W (ed.), The Professions in Early Modern England. London: Croom Helm; 1987. pp. 90-128, esp. p. 90. Burnham JC, How the idea of profession changed the writing of medical history. London: Wellcome Institute for the History of Medicine; 1998; Santoro M, "Professione": origini e trasformazioni di un'idea. In: Zardin D (ed.), Corpi, "fraternità", mestieri nella storia della società europea. Roma: Bulzoni Editore; 1998. pp. 117-58, esp. pp. 118-25; McVaugh MR, ref. 1; McCleery I, Medical Licensing in Late Medieval Portugal. In: Turner WJ, Butler SM (eds), Medicine and the Law in the Middle Ages. Leiden-Boston: Brill; 2014. pp. 196-219.
39. On medical licensing, cf. García Ballester L, McVaugh MR, Rubio A, Medical Licensing and Learning in Fourteenth-century Valencia. Trans Am Philos Soc 1989;79(6). Rossi G, La *scientia medicinalis* nella legislazione e nella dottrina giuridica del tempo di Federico II. Studi Mediev 2003;s.3,xlvii:179-218. McCleery I, ref. 38; Duranti T, ref. 1. pp. 4-8. Both McVaugh MR, ref. 1 and Ferragud C, Medicina i promoció social a la baixa Edat Mitjana (Corona d'Aragó 1350-1410). Madrid: Consejo Superior de Investigaciones

Científicas; 2005 emphasise that this introduction was the result of a social change and therefore a bottom-up impulse.

40. Starting with Kibre P, The Faculty of Medicine at Paris, Charlatanism, and Unlicensed Medical Practices in the Later Middle Ages. Bull Hist Med 1953;27(1):1-20, the case of Paris at the end of the Middle Ages offered a very conflicting image, which should not be overestimated, nor understood as paradigmatic for the whole of medieval Europe, but critically examined and contextualized; see also Garrigues L, Les professions médicales à Paris au début du XVe siècle. Praticiens en procès au parlement. BECh 1998;156(2):327-67; Cabré i Pairet M, Salmón Muñiz F, Poder academico versus autoridad femenina: la Facultad de Medicina de Paris contra Jacoba Felicie (1322). Dynamis 1999;19:55-78; Lauwers H, Construire la norme des métiers de santé au Parlement de Paris (XIVe-XVIe siècles). Médiévales 2016;7:137-57.
41. Cf. Hanne G, ref. 32. par. 6: "la possibilité même d'exercer une profession passe souvent par l'appropriation d'une terminologie, par un monopole des mots qui est la première condition d'un monopole de fait" and ff. pp.
42. On the figure of the empiricist, see Duranti T, Ammalarsi e curarsi nel Medioevo. Una storia sociale. Roma: Carocci; 2023. pp. 96-100.
43. This is one of the main differences compared to the category of charlatans during the Modern Age: Gentilcore D, Medical charlatanism in early modern Italy. Oxford: Oxford University Press; 2006. p. 2.
44. Park K, ref. 6. p. 135. Regarding barbers as therapists, cf. Cifuentes L, La promoció intel·lectual i social dels barbers-cirurgians a la Barcelona medieval: l'obrador, la biblioteca i els béns de Joan Vicenç (fl. 1421-1464). Arx textos catalans antics 2000;19:429-79; Collard F, Samama E (eds), Mires, physiciens, barbiers et charlatans: les marges de la médecine de l'Antiquité au XVIe siècle. Langres: D. Guéniot; 2004; Ferragud C, Barbers in the Process of Medicalisation in the Crown of Aragon during the Late Middle Ages. In: Sabaté F (ed.), Medieval Urban Identity: Health, Economy and Regulation. Cambridge: Cambridge Scholars Publishing; 2005. pp. 143-65; Pelling M, The Common Lot. Sickness, Medical Occupations and the Urban Poor in Early Modern England. London: Routledge; 2014; Duranti T, Lavoro, igiene, salute. Studio preliminare sull'arte dei barbieri di Bologna (ante 1348). In: Lazzari T, Pucci Donati F (eds), A banchetto con gli amici. Scritti per Massimo Montanari. Roma: Viella; 2021. pp. 253-64.
45. Cf. Cifuentes L, ref. 44. esp. pp. 430-3.
46. Again, professional labels are not as evident in practice: for some examples, see Pesenti Marangon T, "Professores chirurgie", "medici ciroici" e "barbitonsores" a Padova nell'età di Leonardo Biffi (ob. dopo il 1448). Q St UniPd 1978;11:1-38: pp. 12-3; McVaugh MR, ref. 1, pp. 35-40; Duranti T, ref. 1. pp. 1-3.
47. Cf. Hanne G, ref. 32.
48. Literally: 'doctor of the beard' and "as a surgeon and needed as a physician" (Henderson J, The Renaissance Hospital: Healing the Body and Healing the Soul. New Haven: Yale University Press; 2006. p. 229).
49. The crux of the matter is who has the authority to control and approve; cf. ref. 39.
50. On the relationship between apothecaries and other therapists: Moulinier-Brogi L, Médecins et apothicaires dans l'Italie médiévale. Quelques aspects de leurs relations. In: Collard F, Samama E (eds), Pharmacopoles et apothicaires. Les "pharmaciens" de l'Antiquité au Grand Siècle. Paris: L'Harmattan; 2006. pp. 119-34, and in general studies cited at ref. 5.

51. See Jacquart D, ref. 37. p. 310.
52. About the ‘medicalisation’ of medieval hospitals as a misleading approach, see Henderson J, Horden P, Pastore A, The World of the Hospital. Comparisons and continuities: In: Iid. (eds.), The Impact of Hospitals 300-2000. Oxford: Peter Lang; 2007. pp. 1-56 and Henderson J, ref. 48. See also Bianchi F, in this issue.
53. A label suggested by Friedmann D, Les Guérisseurs. Splendeurs et misères du don. Paris: A.M. Métailié; 1981; cf. Pizza G, ref. 4. pp. 216-8. Furthermore, the mediating function aligns the therapist with that of the priest, a similarity well documented even in the Middle Ages: see Crisciani C in this issue.
54. This is the distinction in medical arenas proposed by Kleinman A, ref. 14. pp. 86-7: “the popular arena comprise principally the family context of sickness and care, but also includes social network and community activities”; the folk arena “consists of non-professional healing specialists”.

SAPIENZA
UNIVERSITÀ DI ROMA

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E-ISSN 2531-7288
ISSN 0394/9001

MEDICINA NEI SECOLI
Journal of History of Medicine
and Medical Humanities
36/1 (2024) 63-80

Received: Settembre 2023
Accepted: Novembre 2023
DOI: 10.13133/2531-7288/2897

Corresponding Author:
Francesco Bianchi
tzimbar@gmail.com

Healthcare and Medicine in Medieval Western Hospitals

Francesco Bianchi

Contract professor of Medieval History at the University of Verona

ABSTRACT

Medicine and Medieval Hospitals

Hospitals are an innovation dating back to Late Antiquity, and their proliferation in the Western world is closely tied to the advancements of Christianity and ecclesiastical institutions. Since their inception, hospitals have provided various forms of aid to various categories of destitute individuals, which could include medical treatments in line with Gospel precepts. However, for much of the Middle Ages, the majority of hospitals struggled to secure the services of medical practitioners on a permanent basis, albeit with some exceptions. Towards the end of the Middle Ages, though, the processes of medicalization within the realm of hospital care gained greater intensity and prevalence. This transformation was facilitated by the increased availability of both financial resources and proficient medical personnel, particularly physicians and surgeons trained in academic settings.

Keywords: Hospitals - Middle Ages - Healthcare - Medicine

The origins of hospitals in the Western world are closely linked to the development of monasticism[1]. Andrew Crislip has pinpointed the late 4th century as the period when the first hospital emerged, representing "the institutional extension of the monastic health care system and related commodities and services". In monastic hospitals "the sick were guaranteed health care from a variety of professional and nonprofessional providers, a system that was without precedent in ancient Mediterranean society. The sick had access to a range of medical treatments corresponding to the best types available outside the monastery: dietary treatment, pharmaceuticals, surgery, rest, and comfort care"[2].

The institutionalization of hospitality and healthcare services followed the spread of churches and monasteries, which embraced the evangelical teachings about one's neighbor, addressing all needs without specific distinctions. This explains why, during the Early Middle Ages, hospital structures were primarily reliant on ecclesiastical institutions, which, in turn, received constant funding, known as the *quarta pauperum*, mainly designated for charitable actions. While there were sporadic hospital initiatives sponsored by sovereigns or lay aristocrats, the primary impetus came from religious entities. Monks and bishops were obliged to set an admirable example, as highlighted by the Benedictine rule and the teachings of Pope Gregory the Great, emphasizing the evangelical duty to extend assistance to the indigent and the infirm[3]. Furthermore, the corporal works of mercy mentioned in *Matthew* 25:35-45 provide explicit guidance on the behavior that Christians are obligated to adopt in response to requests for aid, particularly as a means of safeguarding their spiritual salvation.

The devotional motivations and charitable intentions inherent to Christian ethics persisted even into the Late Middle Ages. During this period, there was a significant increase in initiatives by lay individuals or groups aimed at establishing and/or managing hospitals. This surge reached a point where these initiatives surpassed the older welfare institutions associated with ecclesiastical entities, in both quantity and significance. Nonetheless, for a long time, Catholic hierarchies retained oversight of hospitals, regardless of whether their administration was secular or ecclesiastical, as hospitals were considered *pia loca*, akin to churches and monasteries.

From the 13th century onward, hospitals underwent widespread processes of municipalization, and, by the end of the Middle Ages, explicit claims of secularization emerged. A significant example is the case of Simone Vespucci, a Florentine silk merchant who, in the 1400s, founded the Hospital of Santa Maria dell'Umiltà (also known as San Giovanni di Dio). To underscore the secular nature of the institution, Vespucci had it certified by a notary that "dictum hospitale […] perpetuo sit et reputetur, et reputari debeat, et esse intelligatur et censeatur, et intelligi et censeri debeat, res et locus, penitus et totaliter, proprius, purus, privatus, laicalis, secularis, et profanus, et non religiosus nec ecclesiasticus"[4]. These statements about secularization are unequivocal. However, they do not negate the dedication of the hospital to Santa Maria and

San Giovanni, reflecting genuinely Christian devotional sentiments. Overall, these are distinct signals that foreshadow the pursuit of early social policies based on effectiveness, alongside spiritual goals tied to the quest for eternal happiness.

The Christian origins of the Western hospital tradition are undeniable. Although contemporary hospital management generally no longer adheres to religious mandates and pious sentiments, except for institutions run by religious orders, their fundamental roots remain evident. This continuity is manifest through historical dedications that bear clear Christian signs. Consider, for instance, the case of Saint Bartholomew's Hospital in London, founded in 1123 and still named after the same apostle and martyr. Furthermore, the use of the quintessential Christian emblem – the cross – serves to symbolize the presence of medical, paramedical, and pharmaceutical facilities, albeit not exclusively.

Now, let us delve into the degree of medicalization of care services provided by medieval Western hospitals. While this may not be the ideal platform for a comprehensive comparative evaluation with other civilizations, it is worth briefly acknowledging that, for a significant portion of the Middle Ages, hospitals in the Byzantine Empire and Muslim lands stood out for their early specialization and medicalization compared to the West, although there may be exceptions[5].

The corporal works of mercy include assistance to the sick, as evoked by the words "I was sick and you looked after me" (*Matthew* 25:36). Moreover, Jesus' actions are characterized by frequent instances of miraculous healings, contributing to the depiction of Christ as the divine healer: "Christ was portrayed as the divine physician who cured men's spiritual diseases. Disease was equated with sin and health with virtue, as Augustine makes clear in one of his sermons"[6]. In Christian thought, illness is tied to sin, physical rehabilitation to moral rehabilitation, and miraculous healing to an act of faith. This sentiment is exemplified by the figures of the martyr Saints Cosmas and Damian, who embody both medical expertise and miraculous abilities. Their worship is deeply rooted in both hospitals and sanctuaries, both being places of healing[7]. Consequently, Christianity encourages the treatment of bodily infirmities, nurturing the hope for divine intervention through miracles, alongside earthly intervention facilitated by the mercy of one's neighbor. However, this perspective is not devoid of ambiguity. At times, the salvific significance of physical suffering is emphasized, and, in the case of certain saints, bodily suffering is not avoided[8]. On the contrary, it assumes a privileged role as a sign of spiritual perfection[9], as demonstrated by the stigmata of Saint Francis of Assisi or the deeper wounds that cover the body of the lesser-known Saint Theobald of Provins, following the *imitatio Christi*[10].

In the early centuries of the Middle Ages, a significant portion of *xenodochia* or *hospitalia*, on one hand, and *scriptoria*, on the other, were closely associated with churches or monasteries. Therefore, spaces dedicated to the care of the sick and those intended for the transmission of ancient knowledge, including medical wisdom, were

managed by the same ecclesiastical institutions. It is noteworthy that there are at least 158 manuscript codices from the Early or High Middle Ages that originate from ecclesiastical contexts and are entirely or partially dedicated to medical sciences, comprising a total of 1098 medical texts[11]. Nevertheless, it is not easy to determine to what extent the clinical practices of this era drew from the teachings of medical texts copied by scribes.

Monastic rules appear to have primarily reserved comprehensive medical assistance solely for monks themselves, at least until the 12th century. However, from the High Middle Ages onward, there are documented cases of hospitals established by bishops, which employed qualified medical personnel to assist pilgrims and the infirm[12]. In this context, the renowned *Plan of Saint Gall* is particularly enlightening. Created in the early 9th century at the Reichenau Abbey and presented to Gozbert, the abbot of Saint Gall, this intricate plan spans five stitched-together parchment sheets (measuring 113x78 cm) and includes approximately 350 captions illustrating different sections of an idealized abbey and their respective functions. Notably, the plan showcases the *scriptorium* and the library, alongside a hospice for pilgrims and the poor. Most notably, the plan incorporates medical facilities such as a house for bloodletting and purging, a complex of infirmaries, a residence for physicians, a pharmacy, and a garden of medical herbs[13]. This depiction underscores once again the interrelated nature of sites for knowledge dissemination and those dedicated to medical and charitable assistance. Indeed, these facets were conceived as integral and harmonious components of the same Christian society.

Furthermore, the assimilation of Arabic and Greek medical knowledge into Western culture, achieved through the translation of scientific texts into Latin, was predominantly undertaken within ecclesiastical centers, especially between the 11th and 13th centuries. An illustrative case in point is the cathedral of Toledo[14].

The connection between ecclesiastical settings and medical care is further emphasized by the existence of hospital orders[15]. An exemplary instance is represented by the statutes enacted by the general chapter of the Hospitallers in 1182. These statutes stipulated that the large Hospital of Saint John in Jerusalem would be served by "quatuor sapientes medici […], qui urinarum qualitates et infirmitatum diversitates discernere sciant, et qui in medicinis conficiendis consulere possint eis"[16]. Moreover, the statutes established additional care protocols, as also evidenced by other contemporary documents, and a papal letter from 1184 mentions the presence of four surgeons alongside the four physicians in the same hospital[17].

The emergence of the first medical schools in the Western world dates back to the High Middle Ages, with the School of Salerno taking the lead. Although its origins remain somewhat unclear, they are typically placed around the year 1000. The subsequent centuries witnessed the proliferation of universities offering medical programs, with the School of Montpellier becoming operational as early as the 12th century[18]. The

advent of graduate physicians laid the groundwork for both secularization and further advancement of medical sciences in Europe. This development occurred outside the traditional ecclesiastical contexts of studying and transmitting medical knowledge based on Galenic principles, but it is important to consider the limitations imposed by the Church on clergy regarding the practice of medical professions[19].

University-educated physicians expanded and systematized the availability of healthcare practitioners, setting them apart from those emerging from non-academic environments, such as surgeons and barbers (*barbitonsores*), as well as apothecaries and other therapists (both men and women), often characterized by a more experiential approach to medicine[20]. Naturally, these figures were also identifiable within the hospital. According to a biographical list of medical practitioners active in Britain from the Anglo-Saxon period to the early 16th century (excluding barbers), the number of practitioners nearly tripled, rising from 117 in the 12th century to 310 in the 13th century, and eventually reaching 350 in the 14th century[21]. This escalation underscores the growing presence and importance of medical professionals over these centuries.

Between the 12th to the 14th centuries, Europe witnessed a significant proliferation of hospitals in both urban and rural settings. To provide quantitative overview, here are a couple of statistics related to two distinct regions within Western Europe. In the major urban centers of the Lombardo-Venetian plain, 75% of the 356 hospital foundations recorded between the 8th and 15th centuries occurred within the 12th to 14th centuries. A similar percentage is observed in the region stretching from Aachen to Mulhouse, encompassing the area between the Rhine and the Meuse, where 72% of the 528 hospitals (excluding leper houses) documented throughout the medieval period were founded or first mentioned between the 12th and 14th centuries[22].

Most of these hospitals grappled with limited resources, barely enough to accommodate and feed a small number of passing indigent individuals or provide assistance to the disabled, but not sufficient to employ specialized medical personnel on a permanent basis[23]. The financial capacity to engage doctors or other healthcare professionals for continuous service was a rare occurrence, and the assistance offered by most hospitals founded between the High and Late Middle Ages retained a character more inclined toward charitable support than comprehensive therapy. Nevertheless, it is worth acknowledging that the therapeutic efforts undertaken by medieval hospitals went beyond the sporadic or continuous involvement of more or less specialized physicians. These efforts, indeed, included the provision of tailored dietary regimens, the offering of spiritual comfort, and sometimes the creation of aesthetically pleasing environments, such as the frescoed *Pellegrinaio* within the Hospital of Santa Maria della Scala in Siena[24]. These measures could have a positive impact on the psychophysical well-being of the patient, on the regulation of the *res non naturales* (the six non-natural factors influencing health) and facilitate the healing of the body.

Nevertheless, the more pervasive processes of medicalization began to impact large urban hospitals starting from the 13th century, with further acceleration observed during the 14th and 15th centuries. This change was possibly more pronounced in Italy when compared to other regions of Europe[25]. For instance, considering Florence, it has been pointed out that "the 'medicalization' of hospitals in the first half of the Trecento cannot, however, simply be attributed to the urgings of the medical profession. It was also a part of a more general growing belief in the efficacy and importance of medical practitioners in public health"[26].
Hospitals garnering the favor of urban bourgeoisie and local ruling classes could benefit a steady influx of donations, accumulate substantial assets, and secure costant stream of income. This financial flow allowed them not only to concurrently assist numerous individuals in need but also to employ full-time medical experts, including those with university education. At times, municipal authorities themselves assumed the responsibility of funding physicians for major city hospitals, in addition to paying the salaries of the first public medical officials. The onset of this trend dates to the 13th century, when civic administrations expanded their scope to include health matters[27]. For instance, as early as 1270, a hospital in Padua named Domus Dei was granted an annual allocation of 75 lire by the municipality for paying "unus vel plures medici tam in physica quam cyrologia ad providendum et curam habendum de infirmis dicte domus"[28]. Another significant example comes from the Catalan city of Tortosa. In 1346, the municipality had already hired public medical staff, including two physicians, two surgeons, and a *herbolarius*. The principal duty of the medical practitioners was to treat the "malaltes des espital", while the apothecary was "obliged to go daily to the hospital of the city and make up the clysters, juleps, and ointments that he knows how to prepare for the hospital, with his own hands, free and for no payment"[29].
Overall, it can reasonably be argued that, by the end of the Middle Ages, hospitals had become more receptive to the provision of therapeutic services and the involvement of medical professionals while retaining their charitable purposes. The lack of medicalization of healthcare services was primarily due to constraints in economic resources rather than cultural factors. The hiring of medical practitioners and the provision of medical care in major urban hospitals were largely dependent on the extent of their financial endowments. As a result, the increase in economic resources facilitated the hiring of dedicated administrative staff responsible for ensuring proper financial and accounting management of substantial assets[30]. These developments have not only encouraged the growth of administrative roles, but also the increase in documents production. In turn, this documentation extended beyond normative and financial matters, beginning to encompass more aspects of assistance and therapy. For example, the practice of recording incoming patients and documenting deaths became widespread, especially in better-equipped hospitals[31]. This evolution in record-keeping reflected enhanced organization and emphasis on comprehensive patient care within these institutions.

The medicalization of hospitals gained further momentum due to the economic and societal ramifications in Western civilization during the last two centuries of the Middle Ages, marked by devastating wars, famines, and plagues. The recurring outbreaks of plagues, starting from the mid-14th century, compelled civic authorities to implement innovative health policies, guided by a new public authority, known in Italy as *Uffici di Sanità* (Boards of Health). This period also saw the establishment of hospital facilities dedicated to the isolation of contagious patients, called *lazzaretti* (plague hospitals), characterized by a greater focus on healthcare rather than charity[32]. The establishment of numerous *lazzaretti* was part of broader hospital reforms that took place in Europe between the 15th and 16th centuries, leading to a clearer distinction between institutions focused on medical care and those aimed at social assistance[33]. The reorganization of the traditional healthcare and welfare system sought to overcome the generalist approach typical of the medieval period, favoring instead specialization and the infusion of medical principles into the delivery of care. This trajectory also included the incorporation of pharmacies within hospitals, a practice documented as early as the 14th century, and which spread throughout the 15th century[34].
As noted by Giorgio Cosmacini, the hospital reforms of the 15th century marked the beginning of a "nuova era sanitaria" (new healthcare era)[35]. Although these reforms did not negate the hospital's role as a charitable foundation, they elevated it to a privileged position for medical care based on scientific principles. The case of Pavia provides a significant example of this transformation. The services offered by the Hospital of San Matteo, founded in 1449 by a confraternity of laymen, were regulated by statutes that ensured the admission of individuals "sive pauper, sive dives, sive ignobilis, sive nobilis, sive indigena, sive alienigena", without distinctions of class, origin, or status, thus adhering to the charitable tradition of the medieval period. However, these statutes explicitly stated that "soli infirmi qui et decumbentes sunt et qui fideli et vero medicorum hospitalis iudicio curari sanarique possunt adhibitis congruis medicine remediis" would be admitted[36]. This provision established an unprecedent criterion for healthcare guidance, imparting a stronger therapeutic direction to the hospital's mission and new triage procedures that followed stricter criteria for evaluating and defining the needy than the evangelical parameters.
These trends, destined to mature in the centuries that followed, marked the beginning of a closer integration between the advancement of medical knowledge in academic spheres and its practical application or experimentation in hospital environments. Confirmation of this phenomenon stems from the involvement of medical professors in clinical activities within hospitals, combined with the use of hospital facilities for anatomical examinations. For instance, in the city of Padua, which hosted one of Europe's leading medical schools[37], the Hospital of San Francesco served as a venue for anatomical dissections as early as the mid-15th century, with admission charged. In the following century, this hospital began to be used as a university clinic

by professors from the local university and their students. However, documents from the 15th century already highlight the presence of university physicians and their apprentices within Padua's hospitals, with notable cases recorded within the aforementioned Domus Dei[38]. This interaction between academia and hospital environments foreshadowed the deeper synergy that would develop over time, eventually leading to the dynamic relationship between medical education, research, and patient care that characterizes modern medical institutions.

Giovanni Battista Da Monte, a professor of practical medicine who assumed the role in Padua from 1539, also held his lectures within the Hospital of San Francesco. His perspective was rooted in the belief that "in the hospital two things can be seen and practiced, namely diseases and their symptoms"[39]. In Venice, the College of Physicians and the College of Surgeons organized their anatomy lectures at the Hospital of Santi Pietro e Paolo between 1487 and 1563[40]. Between 1482 and1483, Jehan Henry, a canon of Notre-Dame and superintendent of the Hôtel-Dieu in Paris, the largest hospital in France, wrote the *Livre de vie active de l'Hôtel-Dieu de Paris*. This book aimed to provide a sort of service manual inspired by devotional feelings while addressing the professional duties of hospital's medical staff[41]. Additionally, Gabriele Zerbi, who held a chair in theoretical medicine at the University of Padua, in his work *De cautelis medicorum* from 1495 argued that "the good doctor is he who has been well exercised as a young man in practice, having sought out hospitals and other places where there are many patients, diseases, and skillful doctors"[42].

Last but certainly not least, towards the end of the Middle Ages hospitals themselves embraced the responsibility of training specialized medical professionals. An illustrative example is the charitable institution of Santa Maria dei Battuti in Treviso, on the Venetian mainland. In the late 14th century, this hospital began awarding scholarships for medical education to aspiring students at the University of Padua. Once graduated, these students had the opportunity to secure employments within the hospital itself[43]. During the same period, hospitals could also house small collections of medical texts: for example, the Hospital of Santa Maria della Scala in Siena inherited three volumes of Galen and one of Avicenna in 1365[44]. This attests that hospitals were not solely arenas for medical practice but also actively promoted medical education and the preservation of medical knowledge.

Throughout the Middle Ages, hospitals were regarded as privileged spaces for the embodiment of Christian *caritas*, a principle that inherently involved the care of the sick from the outset. However, under the guidance of both ecclesiastical and lay figures, these institutions steadfastly maintained their commitment to providing healthcare services, adapting their efforts to different levels of intensity, available resources, and medical expertise. Simultaneously, hospitals remained receptive to incorporating advancements in medical sciences that were emerging from academic centers as the Middle Ages drew to a close.

In conclusion, as John Henderson eloquently articulated, “the hospital itself played a central role in the development of Renaissance medicine, a role that is often ignored by historians of medicine, who concentrate instead on the development of learning within the university world, the evolution of the medical profession or the careers of individual physicians”[45].

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Non-ISO4 abbreviations
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Ric st soc rel = Ricerche di storia sociale e religiosa

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The Western Medieval Medical Literature, its Books and Readership: A Complex Reality

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E-ISSN 2531-7288
ISSN 0394/9001

Marilyn Nicoud

Avignon University CIHAM-UMR5648

MEDICINA NEI SECOLI

Journal of History of Medicine
and Medical Humanities

36/1 (2024) 81-102

Received: Settembre 2023
Accepted: Novembre 2023
DOI: 10.13133/2531-7288/2898

Corresponding Author:
marilyn.nicoud@univ-avignon.fr

Abstract

The aim of this article is to present the main characteristics of the development of medical literature in the Western world from the 12th century onwards, in relation to the intellectual context of its production and the social conditions of its reception and reading. By connecting the theoretical and practical dimensions of the discipline with the materiality of manuscript books, and the cultural context of the writings to the expectations of the medical readership, this article aims to highlight the great diversity of this literature. Written in universities, but increasingly in the court *milieux* and the urban world, these texts primarily aimed at students and colleagues to help them in learning and practice, but also at a wider public concerned about its health.

Key words: Medical Literature - Manuscripts - Readership - *Regimen sanitatis* - *Consilia* - Universities - Courts

The history of medicine began with the history of its literature. Until the mid-19th century, these studies, mainly carried out by physicians, took the form of surveys of texts and manuscripts[1]. Émile Littré, Charles Daremberg, Salvatore De Renzi, Valentin Rose, Julius Pagel, Karl Sudhoff and his pupils, Lynn Thorndike, Henry Sigerist, Ernest Wickersheimer, Adalberto Pazzini, Paul Oskar Kristeller and Pearl Kibre, all represented the leading figures in this new historical field based on philology, which studied medical doctrine and some of the major figures of the *ars medica*[2]. Although many of the medieval authorities remain unpublished, numerous editions and manuscript catalogues were published to gain a better understanding of medical thought and identify its written tradition[3]. This primary trend is still ongoing, particularly thanks to the work of historians, philosophers, and philologists[4].

Some of these early studies highlighted the epistemological and cultural revolution of the 11th and 12th centuries and the significant transformations that occurred between Late Antiquity and the Late Middle Ages. In the Latin West, from the 5th to 10th centuries, there was a lesser production and dissemination of texts, with approximately 158 surviving manuscripts, most of which date from the Carolingian period[5]. In addition to the translation into Latin, between the 5th and 7th centuries, of treatises originally written in Greek by famous *auctoritates* of Antiquity and the early Middle Ages (Hippocrates, Dioscorides, Rufus of Ephesus, Galen, Oribasius, Soranus of Ephesus, Alexander of Tralles, Paul of Aegina), most of the corpus consisted of practical knowledge focused on health prevention, prognosis, and therapeutic tools. These included dietary calendars, herbariums, lists of *quid pro quo*, recipes, books about secrets, semiology, diseases, *lunari*, *compendia*, as well as a few texts on medical ethics[6]. Written by known, anonymous, or mistakenly attributed authors, these works, often rearranged, were copied and preserved, like most books of that period, in the monastic *scriptoria*.

However, from the 11th century onwards, the proliferation of medical manuscripts, their wide distribution and the transformation of their contents changed the profile of this literature, in terms of discursive forms, genres, and languages: *expositiones*, *quaestiones*, *summae*, *compendia*, treatises dedicated to a specific topic, works in verse, *epistolae*, etc. Although Latin remained the primary means of communication throughout the Middle Ages, vernacular languages began also to be used for writing about medicine, pharmacology, semiology, and surgery[7]. This variety was the result of both the acquisition of new knowledge (which allowed medicine to establish itself as a theoretical science based on natural philosophy rather than a mechanical art) and of a social demand for care that promoted erudite practitioners.

This quantitative and qualitative transformation can be explained by three main factors. Firstly, the spread throughout Europe of Latin translations of Greek and Arabic philosophical and medical works from Antiquity and the medieval period, which profoundly reshaped medical knowledge[8]. Secondly, the development of medical

schools, mainly in Salerno, Montpellier and, to some extent, Paris, which were more renowned for their intellectual output than for their structural aspects[9]. Thirdly, the transformation of the schools into universities, with the institutionalization of a curriculum, learning methods and authoritative texts, and the emergence of the figure of the *physicus*, recognized not only through diplomas but also by political authorities[10]. Although the community of medical practitioners remained heterogeneous throughout the Middle Ages (as learned physicians constituted a minority[11]), these phenomena nonetheless led to a significant transformation of medical theory and practice[12].
If the 'internal' history of medicine remains important, it is also necessary to link doctrinal contents and formal discourses to the cultural and social conditions of its production and transmission[13]. An approach that connects the intellectual dimension to the materiality of manuscript books, and the cultural context of their writings to the expectations of their readership, could help delineate the contours of a complex literature.

1. From a "theoretical turn to a practical turn"

As part of the profound institutional and cultural transformations that began in the 11th and 12th centuries, the profile of medical literature underwent changes characterized by two major trends: the first was the comprehension and absorption of the new knowledge transmitted through Latin translations of Greek and Arabic texts; the second was the proposal of a new learning method suitable for the training of students. In this regard, teachers in schools and universities began to write different texts, using the tools of scholastic exegesis to facilitate the reading of ever-expanding corpus of authoritative sources, such as the *Articella* (a collection of Hippocratic and Byzantine manuals augmented, from the middle of the 12th century, by new texts), al-Majûsî's *Pantegni* replaced by Avicenna's *Canon* and other Arabic encyclopedias, the "new Galen", etc[14]. This syllabus constituted a constantly evolving curriculum. Their readings and commentaries contributed create a body of consensual knowledge also aimed at establishing the theoretical dimension of medicine based on the principles of natural philosophy. It also helped to impose an ethical approach to medicine common to all physicians studying at the university[15].
These works, primarily intended for students and colleagues, reflected the teaching activity and they intricately connected writing and reading[16]: there were numerous commentaries considered as the result of academic *lectio* of authoritative texts[17]. Consisting of literal explanations, questions, *dubia* and sometimes digressions[18] (either revised by the professor or simply reported from *reportationes*, i.e., students' notes), these *expositiones* were the outcome of a dialogue between the master, the reference text, and the disciples. However, universities also promoted other types of texts: useful tools for clarifying divergent positions among medical authorities (such

as the *concordantiae*, a kind of dictionary by the two Parisian masters from the 13th and 14th centuries, Johannes de Sancto Amando and Petrus de Sancto Floro); *summae* that collected all medical knowledge, like the *Sermones medicinales* by the Florentine Niccolò Falcucci (d. 1412) in 7 volumes, or personal statements like the famous *Conciliator* by the Paduan Pietro d'Abano (d. 1316), in an attempt to reconcile medicine and astrology[19]. In a highly competitive medical market, these works may have represented a means to stand out from the others. By choosing a specific form of discourse, a personal style, distinct opinions, particular subjects such as anatomy, gynecology, innovative theories or debates, a singular author or school of thought could be easily identifiable and recognized[20]. Despite the long tradition of these discursive genres, it would be wrong to believe that continuity is synonymous with uniformity. As Joël Chandelier has shown for the art of commentary, which dates back to Antiquity, "si les autorités sont parfois restées les mêmes, les modes de commentaires et les questions posées aux textes ont grandement varié en fonction des intérêts des lecteurs mais aussi des besoins de leur public ainsi que du contexte institutionnel et intellectuel"[21].

These developments also revealed a stronger connection between theory and practice, teaching and the practice of medicine, as a result of the growth of a medical market based on an increased demand for care and treatments[22]. A significant number of texts directly related to medical practice were written until the 13th century by more or less famous practitioners, as well as anonymous authors. These texts included tools of semiology, the treatment of diseases (*practicae*), new therapeutic instruments such as balneotherapy, collections of *experimenta* (remedies tested and authenticated by a famous physician), pharmacological works, and so on[23]. These treatises were often based on personal experiences and observations and aimed sometimes to propose new ideas[24]. Most of this practical literature, like the works of Bernard de Gordon, a professor in Montpellier in the early 14th century, was intended for students and practitioners to help them in learning and practicing medicine in all its possible applications. However, some of these works were also aimed at a wider audience and should be seen as a medical response to new expectations.

2. Responding to a demand for care

This new medicine also had a social impact. Starting from the 13th century, the development of the *ars medica* as a profession revealed certain forms of medicalization, particularly visible in the Western Mediterranean[25]. This process took on different forms – the extension of medical boundaries to new subjects, the claiming of expertise, a greater penetration of medicine into medieval societies… It also implied an interest from political authorities in health matters, in terms of providing medical care (even before the plague), with the recruitment of town practitioners, for example, and

in terms of extending control over medical practice, with the creation of colleges to prohibit empirics from practicing[26]. While being treated by an educated physician remained a privilege of the social elite, much of the medical literature written in the 14th and 15th centuries reflects this concern to better adapt theoretical doctrine to the specific conditions of practice, to help practitioners in their daily practice and to inform a lay public with up-to-date advice.

The plague is a typical example of this strong connection between intellectual perspectives and social interaction. Its sudden arrival gave rise to an impressive number of treatises written from 1348 onwards, entirely dedicated to this *new* disease[27]. They constitute one of the most widespread medical genres. Often dismissed by the historiography of epidemics - with a few exceptions[28] - this literature of over 300 texts is, on the contrary, a symbol of medical concerns in the face of a dreaded disease. It represents a collective effort by the community of scholars to provide an understanding of its onset and spread, and to propose practical solutions. Written at the initiative of practitioners or at the request of private individuals, public authorities, professional colleges or colleagues, these texts in Latin and vernacular languages from all over Europe were an attempt to address, first and foremost, an intellectual challenge, as the plague called into question the etiological principles of epidemic diseases. Secondly, they aimed to address a public health issue, as the disease disrupted the demographic balance and threatened the survival of medieval societies. Widely disseminated in numerous manuscripts and printed works, these *Pestschriften* also attest to the need for medical advice, both for physicians on how to treat patients and for the lay public on how to prevent diseases. They reflect both the demand for expertise and confidence in learned medicine.

They also bear witness to a transformation in medical ethics, which could not resign itself to not attempting to cure a disease that was generally recognized as fatal[29]. Representing a sort of written communication between different levels of practitioners, as well as between physicians and laypeople, these plague treatises disseminated enlightened knowledge, often based on personal experience, to a wide audience. However, they were only a later avatar of other genres (*regimina sanitatis* and *consilia*) that already connected theory and practice, physicians and laypeople, and from which they borrowed part of the content and organization.

The *consilia*, originating in Italy at the end of the 13th century and likely based on a legal model, were initially records of a professional act: a practitioner or a patient sought the advice of a physician on a specific case[30]. The early examples, such as the *consilia* of Taddeo Alderotti or Gentile da Foligno from the 13th and 14th centuries, varied widely in composition, ranging from simple prescriptions to comprehensive advice that included a description of the case and the treatment (including dietary and pharmacological recommendations), which would soon become the classic form of *consilium*. These prescriptions could be the result of a personal

examination or simply notes taken on a case, but they were often written in *absten-tia*, without direct consultation.

While in modern tradition, patients' letters were often kept in the personal archives of famous physicians[31], in the Middle Ages, only the physicians' responses were generally preserved, typically copied into extensive collections of *consilia*[32]. As Chiara Crisciani has recently pointed out, these selections and compilations, mostly organized by author, were used in the classroom to learn medicine by specific case[33]. This development, particularly significant in the late Middle Ages, certainly changed the nature, perception, and use of these individual prescriptions, which became a fixed genre primarily aimed at students. However, they also reflected professional communication among different practitioners. Alongside Latin[34], the professional language, the writing of *consilia* in the vernacular confirms the existence of direct written communication between patient and physician[35].

Closely related to the *consilia*, the *regimina sanitatis* represent another form of advice aimed at a lay audience, with a different objective: not to treat diseases but to prevent them and maintain the body healthy. Originating in the early 13th century and often based on ancient models (the pseudo-Hippocratic letters and the pseudo-Aristotelian *Secret of secrets*), these texts quickly became a distinct genre of medical literature[36]. Often aimed at an aristocratic audience, they gradually expanded their readership through translations of the most widely read texts, by writing in vernacular languages or through anonymous compilations copied into common books[37]. From a medical perspective, the *regimen* was necessary due to the uncertainty of therapeutic procedures and the Galenic conception of the state of health, which was constantly changing and had to be monitored. In a sense, this monitoring could be carried out even without the presence of a physician at the patient's bedside, simply by reading the text. The rules, based on the proper use of the "six non-naturals"[38], were meant to be applied by the patients-readers themselves. Not only did they have to understand the education content, but they also had to be willing to follow the rules, even if they went against their own habits. To turn the reader into an active participant in his/her own health, the author would adopt a specific tone, which could vary from a prescriptive approach to a more pedagogical one. In the latter case, especially in texts written in the 15th century, the *regimina* became a kind of health education manual[39].

This gradual expansion of the readership that shaped a part of this literature, including less informed practitioners and laypeople, is also revealed by the material diversity of medical books.

3. Medical books and their readership

The proliferation of medical works in the late Middle Ages and the early modern period is characteristic of the expansion of the public interest in medical culture and the extension of the "lieux de savoir"[40]. In addition to universities, which remained the

primary place for medical writing, towns and, especially, courts provided new settings from the 14th century onwards, giving rise to specific medical genres[41]. Similar to the *regimina sanitatis*, which were often written for, or even at the request of, an aristocratic readership, the numerous treatises on poisons reflected the fear engendered by these criminal practices[42]. The diversity of medical topics encouraged by both intellectual interests and social needs, is mirrored in the variety of manuscript books. The formal presentation, content, conditions of production and, more broadly, the materiality of books may reflect different reading habits and uses. While each manuscript can, in some respects, be considered a *unicum*, certain trends reveal the different audiences for these books, which can also be seen in the inventories of private libraries, where they appear in the collections of professionals and laypeople (aristocrats and scholars)[43].

As Danielle Jacquart has recently observed, miscellanies that brought together different works in the same codex were in the majority but referred to very different realities[44]. Many copies made by workshops, but also by students, often corresponded to an academic use with large margins left for remarks; they could combine texts from the curriculum, such as the *Articella*, parts of Avicenna's *Canon* or anthologies of passages considered to be the most important within the same codicological units[45]. However, they could also assemble texts from different periods or on different themes, like the books commissioned from the copyist Hermann Zurke in the mid-fifteenth century by the physician Gilbert Kymer[46]. Composed in 1453 by Niccolò Dati da Visso, a physician from Siena, ms 1177 of the Riccardiana library in Florence contained around thirty different texts, mainly related to curing illnesses. Called "Quodlibetum" by its author, this compilation represented a kind of personal library, contained within a single book[47]. Commissioned or created by professionals themselves, these practical collections could also be of interest to a lay audience, as in the case of ms Laud Misc. 617, an anthology copied by various Italian hands and owned by an English squire at the end of the 15th century[48]. Sometimes, medical texts could also be copied in a non-medical environment, such as *regimina sanitatis* or recipes added to a blank page as a token of personal interest in health.

Alongside these collections, some books fell into the category of the "libro unitario"[49]. These were compilations of texts by a single author, such as the works of Rhazes or Galenic translations[50]. This development, which prefigured Renaissance editions, also concerned medieval authors whose works were brought together to form a kind of *opera omnia*, such as certain manuscripts of Antonio Guaineri's works (d. 1458), or the compilations composed by the Schedel of *consilia* written by Antonio Cermisone (d. 1441) and Bartolomeo Montagnana (d. 1452)[51]. Generally produced for intellectual purposes, some of these anthologies reveal a more antiquarian intention and the role of the copyist as an author. The "libro unitario" as a single book with a single text is logically the result of dedication copies made at the request of the dedicatee or to

recommend oneself to him or her. The two dietary treatises written by Bernardo Torni (d. 1497) for Cardinal Giovanni de' Medici or the *Summa lacticiniorum* by Pantaleone de Confienza (d. *ca* 1497) sent to Pope Sixtus IV, which all remained single copies, thus illustrate the secular audience of medical discourse[52]. This same readership was also targeted by certain illuminated manuscripts; alongside the appearance of technical drawings and urine diagrams, intended for professionals[53], certain dietetic *codices* were often the subject of illustration programs, such as Aldobrandino da Siena's *Livre de Physique*, written in the mid-13th century, or the illustrated tradition of Ibn Butlân's *Tacuinum sanitatis*, where the original text was reduced to make way for paintings[54]. Created by workshops and illuminators, these copies bear witness to the lay dissemination of medical knowledge in the late Middle Ages.

4. Conclusions

A holistic approach connecting the intellectual, cultural and social dimensions of medical literature highlights its polyphonic aspects and the gradual diversification of its readership. Its intellectual dimensions have contributed to build knowledge and shaping a community of practitioners asserting a specific identity. Furthermore, it has provided a means of expressing expertise in health-related matters to public authorities. While primarily aimed at the professional community, a didactic and accessible part of this literature has also piqued the interest of a lay audience, increasingly interested in self-care. This wider dissemination of medical knowledge, even though partly limited to the social elite, attests to its practical dimension and its concern for health issues, as reflected in the involvement of practitioners in medieval societies. This comprehensive approach enables to link the history of texts with the history of practices, and the history of medicine with the history of health and to history in general.

Bibliography and notes

Non-ISO4 abbreviations
Arch Gesch Med = Archiv für Geschichte der Medizin
Eng Manuscript Stud = English Manuscript Studies 1100-1700
Hist Med S = Histoire, Médecine et Santé
Sci Context = Sciente in Context
Hist Compass = History Compass
Roman Philol = Romance Philology

Websites
eTK - eVK2 (https://cctr1.umkc.edu/search).
Galeno Latino (https://www.galenolatino.com/).
La ciència en la cultura catalana a l'Edat Mitjana i el Renaixement (https://sciencia.cat/).
Manmed (*Manuscripta Medica*) (https://www.manuscripta-medica.com/).

Manuscripts

Città del Vaticano, Biblioteca Apostolica Vaticana, ms Pal. lat. 1195 (collection of *incubabula*).
Città del Vaticano, Biblioteca Apostolica Vaticana, ms Vat. Lat. 4479.
Firenze, Biblioteca Medicea Laurenziana, ms Plut. 20.53.
Firenze, Biblioteca Medicea Laurenziana, ms Plut. 73-34.
Firenze, Biblioteca Riccardiana, ms 1177.
Milano, Biblioteca Ambrosiana, ms A 108 inf.
Nantes, Musée Dobrée, ms 20.
Oxford, Bodleian Library, ms Bodl. 361.
Oxford, Bodleian Library, ms Bodl. 362.
Oxford, Bodleian Library, ms Laud Misc. 558.
Oxford, Bodleian Library, ms Laud Misc. 617.
Oxford, Merton College, ms 268.
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E-ISSN 2531-7288
ISSN 0394/9001

MEDICINA NEI SECOLI
Journal of History of Medicine
and Medical Humanities
36/1 (2024) 103-132

Received: Settembre 2023
Accepted: Novembre 2023
DOI: 10.13133/2531-7288/2902

Corresponding Author:
lluiscifuentes@gmail.com

Vernacular Surgery in the Medieval and Early Modern Latin West: Works, Individuals, and Research Methodologies

Lluís Cifuentes i Comamala
Universitat de Barcelona

ABSTRACT
One of the most surprising aspects of the history of surgery in the medieval and early modern periods is the intense use of vernacular languages in the dissemination of treatises on the subject, via translations, and even in the writing of originals. This vernacularization of surgery began in the thirteenth century and is closely associated with the creation of a new medical system in the Latin West and with the birth of a rational "new surgery", linked to Galenism, to school education, and to the transmission of knowledge in books. This article presents a summary of this interrelationship and the role played by the vernacularization of surgery in the success of these processes, and it upholds the need for an interdisciplinary research methodology in order to gain an overall understanding of it.

Keywords: Surgery - Vernacularization - Surgeons - Latin West - Middle Ages and Renaissance

This study offers a summary of the vernacularization of surgery in the Latin West in the latter centuries of the Middle Ages and the Renaissance. This synthesis uses as a basis the already lengthy research work conducted by the Sciència.cat research group and the researchers who have mentored it[1]. The accumulated research experience makes it possible to place special emphasis on the methodological issues of the study of the subject. The exposition is based on the Catalan-speaking countries, the heart and soul of the composite monarchy known as the Crown of Aragon, which straddled the Iberian, Franco-Occitan and Italic cultural spheres. Precisely for that reason, this Catalan-based exposition will include comparisons with other nearby European contexts. I should point out that in the following summary it is not possible to be exhaustive with the cited bibliography, already very abundant, and more so bearing in mind the multiple facets of the subject that will be taken into account. The exposition will not be limited to the works and translations, as is usually the case, but it will place them in their corresponding historical and social context.

1. A new medical system for a new society

In Western Europe, from the eleventh century onwards, thanks to the initiative of the Church and the peasantry, the limitation of the very high levels of internal violence to which feudalism had led, produced relative stability. This made the creation of a "middle class" possible and, with it, the revival of urban society, which had disappeared from the continent since the end of the Roman Empire. By the thirteenth century urban society was dominant, and it played a key part in strengthening the power of monarchies and other similar rulers over warlords, which at the same time, stimulated its development.

This new model of society, superimposing itself over the feudal system, generated many changes in thinking, beliefs, education or social organization. One of these was the need to manage and guarantee, both individually and collectively, the most highly-prized asset in an urban context: health. This need is increasingly more in evidence during the thirteenth century, which also witnessed the creation of the university as an institution for the education of those aspiring to positions in government and the judiciary, as notaries, and in the Church and medicine. For medicine, the Hippocratic-Galenic medical doctrine – Galenism – was revived, enriched with Byzantine and especially Arabic contributions, and later with those of the academic doctors themselves. With the direct involvement of bourgeois and noble elites and of the rulers (monarchies, municipal councils, the Church), from the last quarter of the thirteenth century a new medical system began to be constructed founded on the model of academic medicine and on that of the university-trained medical practitioner. This model was regarded as the tool most useful for managing healthcare and offering the proper guar-

antees. It was however unable to provide the graduate physicians (*fisici*) needed to meet the healthcare needs of the whole population, and even less so at a price that the majority could afford. Therefore, for centuries, it had to rub shoulders with the reality of the traditional training and practice of medicine, and all the other healthcare professions, which shared the same unschooled master-apprentice system as all the artisanal trades – a system of training and practice that, in the history of medicine, has been called the "open system" in opposition to the other one, based on formal studies. The history of the first centuries of that new medical system (which, with many changes, is still in use today) is the story of how to make the two models of professional training and practice coexist and, in particular, of how to integrate the vast majority of non-university-trained medical practitioners in the system, among whom those who practised surgery stood out. It was a success story, as the new medical system was soon embraced by the elites and society as a whole down to the lowest sectors, by the medical elite and non-academic practitioners, in the towns and cities and the countryside. It was a process that began in the north-western Mediterranean arc, from Sicily to Valencia, where urban society developed first and most intensely, and in no time it spread throughout the Latin West[2].

The urban society that had created the universities and introduced a new medical system posed a challenge hitherto unprecedented in the field of knowledge. The clerical elites, by definition Latin scholars, who had previously monopolized the creation and spread of knowledge, reading and writing, and everything that depended on it, beginning with the government, made way for new "lay" sectors – that is, not clergymen and not acculturated in Latin – who wished to take part in it and make use of it. These lay urban sectors, who were gradually making the change from the oral to the written transmission of knowledge, realized that the ability to read and write was a formidable asset for managing everyday life and for the possibilities of advancement. Contrary to what the commonplace says, more widespread than it seems, the spread of literacy was intense and growing[3].

For these lay urban sectors, reading and writing was not just useful for keeping the books of businesses; it was also for gaining access to the knowledge contained in books. In this context, the favourable reassessment of technique – work done with the hands, as that of the surgeons was – previously highly stigmatized, and in general that of all urban occupations, encouraged the search for ways to gain access to knowledge. Knowledge could improve the management of one's profession and make it more profitable, and more generally people realized that knowing more meant being more successful in that society.

For those sectors there was however a serious problem with books. It was not the price, because the recent appearance of paper in the thirteenth century had made them much cheaper and therefore an attainable goal. The serious problem was the language: with few exceptions, up to the thirteenth century books were written in Latin. As the

century progressed, and as had happened in many other areas of writing, the production of books in the vernacular went from exceptional to normal (in the Catalan context, the turning point came in about 1270). Western Europe thus entered a situation of diglossia that was to last for centuries, with Latin for the more prestigious, more formal functions, or those which were sanctioned by the authorities (the more formal writings of government, notaries or the Church, liturgy, university knowledge), and the vernacular for the most everyday informal uses, or those which facilitated access to useful knowledge for those who did not know enough Latin (private communications, the management of government bodies and businesses, preaching, translations of works on almost any subject).

In effect, the combination of the wish to gain access to useful knowledge and the fact of not knowing enough Latin led to a process of the transferral of an important part of the accumulated knowledge into the vernacular languages, a process that is known by the name of the vernacularization of knowledge, and which had a huge effect on the area of interest, an absolute priority for urban society, that was health, and on many others too[4]. I should point out that this vernacularization of knowledge was not restricted to transferring works in Latin into the vernacular, nor to the translations, and that it was not merely, or even chiefly, a case of popularization. Besides the highly prized works in Latin that could be found in university circles, in the European regions in contact with the Arab world – the Iberian Peninsula especially – readers of these vernacular translations had to hand works written in Arabic that had not been translated into Latin, and they translated some of them directly into the vernacular language[5]. Moreover, when the readers of the medical works in the vernacular were of a particular social rank, and in particular when they began to be numerous, works began to be written directly in the vernacular: original works whose authors, significantly, were usually medical practitioners trained in university medicine, surgeons too, as was also the case with many translators. University circles were involved more heavily than is supposed in the vernacularization of medical knowledge and, consciously or not, they used it to disseminate the new medical system[6].

The readership of these medical works was made up of laymen in medicine (kings, noblemen, bourgeois) and by healthcare professionals who were not university trained (surgeons, barbers, female practitioners, apothecaries). The former sought information in it that could be profitably applied in their circles, but also medical culture that, in view of the prestige attained by Galenism, could advance them socially. The latter sought in it technical handbooks that would enable them to gain access to knowledge applicable to their profession that was generated in the universities and their circles (for example schools of surgery) or which was within reach via other channels (the case of the Arabic texts). It was knowledge that, given the social demand favourable to that model of academic medicine and university-trained medical practitioners, could advance them professionally. All of them responded in this way to the prestige of uni-

versity and school education, to that of Galenism and its authors, to that of knowledge in general, and to that of the book as the conveyer of knowledge, and they sought to profit from it. For these people, therefore, works in the vernacular were a real intellectual and social bridge capable of providing them with the desired advancement[7].

As a sociocultural phenomenon, the vernacularization of knowledge was very important in the history of Western Europe. However, this perception has only become evident as research has been done into it, mainly philological (the history of old texts and language, lexicography) and historical (the history of culture and science), and since the moment when this research, instead of moving along parallel lines, began to converge. In these two disciplines two powerful research traditions have arisen, very fruitful but not always well connected: one focused on the study of the textual and intellectual tradition, and the other on that of the cultural and social contexts. Overcoming this lack of communication and mutual understanding has not been easy, but these days even the most recalcitrant scholars have to bear in mind and understand the existence of a number of texts in the vernacular on surprising subjects, quite unknown until recently.

The need to understand the phenomenon has led to further questions and interrelationships. The cultural study of non-university-trained people and the active role they played – not passive as was believed – not only in the search for ways to gain access to highly prized knowledge, but also in the creation of knowledge, is particularly interesting. This is the case of the new understanding of figures that were misunderstood until not long ago and therefore considered strange and undervalued by research, such as Ramon Llull. He was the creator of a method of gaining access to knowledge that was alternative to the current university method, valued by non-university-trained people and by not a few university-trained ones. It was a method that mechanized thinking and was applicable to theology, philosophy, mathematics, medicine and, according to him and his many followers (who went so far as to create a faculty of Llullian medicine), to all fields of knowledge. Llull was not just the inventor of a method of reasoning, which fascinated figures such as Leibniz and Newton, but also a producer of vernacular knowledge, not so much for the language used but for being conceived, created and spread from outside the university, vernacular knowledge that has begun to be identified in theology or in philosophy, and in medicine too, particularly in some key instruments of surgeons' and barbers' professional practice: medical recipe books[8].

2. The practice of surgery in medieval and early modern times

The majority of the non-university-trained medical practitioners who promoted the process of vernacularization were surgeons and barbers. Texts on surgery also played an outstanding part in it. These facts could not be accidental, and it is necessary to

explore their reasons and understand their importance. However, we ought to start at the beginning, and try to understand who was who in surgery in that period and what we ought to understand by "surgery" and "treatise on surgery" [9].

To understand who was who in the practice of surgery, and in general the vernacularization of surgery during that period, it is absolutely essential to study it using an interdisciplinary methodology. This methodology has to merge together those of history and philology, and in both of them the two abovementioned research traditions, because it is necessary to interrelate the study of the intellectual production of works and translations, and that of the practice of surgery and the healthcare professions involved, codicological research, the identification and critical edition of the texts and documentary research, as systematically as one can in the historical archives, the analysis of the old book and documentary sources, and the study of the old language and lexicon. Therefore, a complete study of the subject cannot dispense with the skills pertaining to the history of medicine, social history, the history of the texts, of the language and the old lexicon, textual criticism, palaeography, codicology, diplomatics and the study of archives, the history of the book and written culture, to mention just the most obvious ones. Moreover, for a study of surgical technique and the contributions that were made to it, medical knowledge is essential, but it cannot ignore or minimize Galenism: interdisciplinarity is also required of the doctors who are interested in the history of their profession. In this respect, palaeogenomics, palaeopathology and, in general, retrospective diagnosis do not always make valuable contributions. Modern and Hippocratic-Galenic medicine are separate scientific constructs. Trying to connect them is not impossible, but it does require a profound knowledge of Galenism and a great deal of caution, conditions that do not usually arise when one tries.

The application of this interdisciplinary methodology has shown, in general terms, that during that period surgery was mainly practised by surgeons and barbers (who traditionally performed bloodletting and minor surgery), all of them Christian men. However, they did not constitute a homogeneous group; as the new medical system was put in place, the difference between those who acquired a medical education – in Galenism – and those who did not became greater and greater. The prestige of university medicine and the demand in society for medical practice with the guarantees that people assumed it provided, together with the mechanisms of social control introduced by the rulers (examinations and licences), converged and stimulated the desire for social and professional ascent. This desire could only pivot around the knowledge of that medicine and its transmission in books, whose authors upheld this model of advancement. Notwithstanding that, only a tiny minority were able to obtain medical training at university; others gained it in schools of surgery created by the surgeons themselves, but the majority acquired it on their own, getting hold of the right books, or rather, of the vernacular translations of the right books. With this real situation, it was not possible to demand qualifications from them until the early modern period.

Surgeons' and barbers' strategies for advancement gave rise to a complex highly significant nomenclature, which coexisted with "surgeon" and "barber", and which, however, was not used systematically, especially among barbers: "physician and surgeon" (physician-surgeon), in the case of surgeons with a medical education, and "barber and surgeon" (barber-surgeon), in the case of the barbers who sought in the practice of surgery, and more so in rational surgery imbued with Galenism, an advancement that they could not find by restricting themselves to shaving beards and the elementary surgical tasks that they already performed. It was not surprising that those practitioners should have changed the name of their profession throughout their lives, nor that they achieved advancement from one generation to the next[10].

The healthcare situation – very precarious, more so if we only think about those who had knowledge of Galenism – required having these non-university-trained medical practitioners. Authorities (kings, municipal councils, lay and ecclesiastic nobility), with the acquiescence and collaboration of the people involved, introduced mechanisms of social control of medical practice aimed at integrating these non-university-trained medical practitioners in the new medical system. The kingdom of Sicily, under Frederick II, in the first half of the thirteenth century, led the way when it came to requiring guarantees from physicians, surgeons and apothecaries, imposing on the former the need for studies, passing an exam and obtaining a licence in order to practice. The Catalans found out about this innovative organization when they took control of Sicily in 1282 and immediately began to transfer it to the kingdoms of the Crown of Aragon. However, managing to make all non-university-trained medical practitioners pass exams and obtain licences did not begin to become a reality until the second half of the fourteenth century. The king reserved the right to grant the licence after the candidate had been examined and approved by the physicians who he had previously commissioned, although quite soon one of the king's physicians was appointed examiner general. In the fifteenth century these examiners were called proto-physicians because the post was held by the king's chief doctor.

The non-university-trained medical practitioners who underwent this process were in actual fact the healthcare umbrella of the majority of the population, given that graduate physicians were a minority, and an expensive minority, during that entire period. Very particularly, it was the barbers, far more numerous and affordable, who played this part. Surgeons and barbers, especially if they practised with the required guarantees, became necessary experts in times of peace and war, and they were called upon to issue expert reports in trials and to offer armies and navies medical care. When hospitals and baths were medicalized, their care, bloodletting especially, became part of these institutions' medical services. Social demand led to specialization, and experts in treating hernias, teeth and eyes appeared[11].

Notwithstanding all that, the variety of non-academic practitioners was not restricted to these surgeons and barbers, Christian men. Jews and Muslims, in the countries

where communities of them still existed, female medical practitioners, other women with knowledge of healthcare and apothecary-physicians completed the list of people involved in medical care, including the practice of surgery. These sectors had in common the fact of being excluded from the universities, reserved for Christian men and medical studies. Furthermore, non-Christians and women were discriminated against, persecuted, and the former eventually expelled from some countries.

Medicine was one of the few prestigious professions permitted for Jews and it is known that they stood out especially in it, being highly valued by the Christians who were discriminating against them. Jewish medical practitioners, even though the sources do not usually say so, had the double facet of being physicians and surgeons, and they were trained according to the open system. The Iberian Muslim (*morisco*) communities had their own healers, who were usually low-profile because due to the Christian conquest the elites had gone into exile[12].

Likewise, many women practised medicine and surgery, in both the cities and the countryside. Despite being marginalized, it was not unusual for kings and other members of the social hierarchy to require their services, especially, but not solely, if they were women. Apart from those the sources call *medicissae* (Catalan *metgesses*, female practitioners), there were women with medical knowledge, particularly about phytotherapy, who were usually old (*vetulae*). It is moreover useful to bear in mind the role of guardians of the family's health that women have traditionally played. Finally, despite the fact that the laws that were being enacted prohibited it, some apothecaries also practised as physicians[13].

All these situations, with the twin paradox of discrimination/appreciation or prohibition/action, can be explained by the need to fill the large gaps existing in healthcare. But once the medical system had been consolidated, it was thought that they had to practise with the same guarantees that were required of Christian non-university-trained medical practitioners, and Jewish physicians, female practitioners and apothecary-physicians were obliged to pass an exam or at least to obtain a royal licence to be able to regularize their situation.

Despite this regularization, women, and especially Jews, were increasingly discriminated against, and the latter suffered bloody persecution (pogroms in 1348 and 1391 in the Crown of Aragon) which placed them in the difficult position of having to convert in order to try to avoid it. Everything seemed to go better for the Jews who took this step, even much better, as some *converso* physicians even became proto-physicians. In the late fifteenth century, however, in the Crown of Aragon and Castile the new model of government known as authoritarian monarchy was being consolidated, incompatible with all forms of dissidence or, simply, plurality. The decree to expel the Jews in 1492 caused another wave of conversions, but despite that they were harshly persecuted as a result of the reform of the Inquisition. The kings of Castile and Aragon turned it into an ecclesiastical and civil organ of repression responsible for the social

and ideological control of the new authoritarian monarchy, and of a Catholic Church always eager to impose its mediation exclusively. Many *converso* physicians, accused of observing Jewish rites in private, were the subject of reprisals and even burned at the stake. Famous physicians and proto-physicians and their wives and families became a prime target, in order to make examples of them. The Moorish communities were also a target of the Inquisition, in particular the practices related to magic, which were important among their healers, but the fact of them being rural communities very necessary for sustaining the land-owning nobility delayed their expulsion until 1609. As for the women, those with therapeutic knowledge that was also interrelated with magic were persecuted and attacked as witches.

3. Defining "surgery" in the medieval and early modern context

In Hippocratic-Galenic medical doctrine, medicine is divided into *medicina theorica* and *medicina practica.* Surgery was part of *medicina practica*, in which it was, after diet and medication, the third and last of the so-called therapeutic "intentions", which corresponded to the degrees of growing intervention that the medical practitioner could apply. For Galenism, then, it was an integral part of medicine, and thus the great authors of works on surgery demanded it from the thirteenth century onwards (*Inventarium seu collectorium in parte chirurgicali medicinae* is the assertive original title of Guy of Chaulhac's in 1363)[14].

Despite that, prejudice against manual labour – surgery was also, in effect, the technical or manual part of medicine – relegated it for centuries to a less prestigious position, until the processes mentioned above took place. In the new urban society manual work would be vindicated and surgeons and barbers did it just as much as the practitioners of other professions, although they had weightier arguments, those provided by Galenism and the social demand for medicine practised with guarantees.

Notwithstanding that, when medieval surgery is analysed, we see that a "presentist" interpretation must be avoided, which would make it a corpus of hyper-specialized knowledge focused on only the strictest surgical technique. Treatises on surgery contained them, but they also had many others that were directly associated with the basic healthcare function performed by surgeons and barbers. Moreover, treatises became more complex as surgeons and barbers stood up for themselves, from a simple structure in which general and particular surgery were reviewed in a basic order, to a more diverse one, with more parts and knowledge, and an increasingly elaborate order. After the end of the thirteenth century, they usually contained an introduction, with the basic definitions and deontological advice, and more or less differentiated parts on general surgery, relative to surgical problems that affect the whole body or different limbs at the same time; particular surgery, relative to problems that affect each organ of the body, classified from the head to the feet; surgical pathology, relative to diseases

that require surgery or which, in general, were treated by surgeons (this part, increasingly large, is the one that best corresponded to that function of surgeons); fractures and dislocations; and an antidotary, which included a choice of medicinal formulas for surgical use. In this way, treatises on surgery eventually contained quite a lot of *medicina practica* topics and were thus adapted to the needs that surgeons and barbers had as the medical practitioners of the majority of the population. In the end, among this majority, surgery became synonymous with medicine.

This more complex structure was consolidated in works on surgery from the end of the thirteenth century, and it gradually incorporated more subjects that are considered necessary to know for those practising surgery. The authors classify the information better and present it more rationally, making it easier to find it. The high point of this tendency was Chaulhac's treatise, mentioned above, and it is directly indebted to the impact caused by Avicenna's *Canon,* some parts of which – in particular Book IV, which deals with surgery – were also disseminated in the vernacular[15]. Moreover, the information they give, although logically based on experience, is information increasingly documented and packed with references to ancient medical authors, Arab and university trained, and to other treatises on surgery, and Chaulhac's work is again the most finished example. Likewise, they provide more practical information, like the clinical cases, abundant from William of Saliceto's treatise (1275 or 1276) onwards. Even though treatises on anatomy were available, they also begin to incorporate this subject regularly after Saliceto[16]. The final section on making up medicines echoes alchemical experimentation, after Theodoric Borgognoni's treatise (*c.* 1262-1266)[17].

Alchemy is one of the forms of knowledge that were part of the way in which the world was understood in the period. Treatises on surgery also contain elements of magic (some charms for hopeless cases, as in Theodoric) and, even more so, astrology (when calculating when to perform operations, bloodletting, purges or medication). In the end, surgical treatises were part of that cosmology, assumed by everyone despite the fact that from a mistaken "presentist" interpretation the criticisms have been magnified and misunderstood. On the other hand they responded to the general desire to seek ways to maintain health with guarantees, the ones that offered all these forms of knowledge, respected at that time.

Hippocratic-Galenic medicine, of which surgery was a part, on one hand, and the academic doctors and other medical practitioners – surgeons and barbers chiefly – who were eager to appropriate the part of that medicine that was useful to them in order to be able to improve their knowledge and adapt to the demand and the systems of control that were imposed on them, on the other, gradually started to play a larger part in everyday life. This process, which the vernacularization of medical knowledge encouraged to no less a degree, has been called – stretching the concept of modern sociology – the medicalization of society. Various sources bear witness to this medicalization: chiefly, the great number of documents about the practice of healthcare

professions; the books, handwritten and later printed, especially the information they might contain about their use and users (*marginalia*, paratext); the technical lexicon, in particular the spread of its use in society; the literature, in which the motifs related to health, medicine and those who practised it were increasingly present; and the figurative artistic depictions, in books, paintings and sculptures.

It is only possible here to mention a few brief points about the subject, which will be limited to literature and art, while the lexicon will be discussed later. In the nineteenth century it was observed that works of literature in the Latin West contained more and more references to these subjects, but, as in other cases, only recently have we gone from inventorying curious facts to a contextualized interpretation, which in this case must be focused on what in the history of culture is known as reception. As for surgery and surgeons, and female practitioners too, it is enough to bear in mind a few works: surgeons and barbers appear in war and in peace in *Roman de Troie*, *Roman de la Rose*, *Cantigas de Santa Maria*, the lives of Alexander, the Manesse chansonnier, the Arthurian stories, and others. In Catalan literature, they are mentioned in the *Llibre de contemplació* by Ramon Llull, *Crestià* by Francesc Eiximenis, the sermons of Vicent Ferrer, or *Espill* by Jaume Roig, among others[18].

The artistic depictions appear in deluxe codices of surgical treatises and other medical works. Leaving to one side the Latin ones, we have, among others, the Sloane codex of the French translation of the treatise by Roger Frugardo (13th-14th C), the Montpellier codex of the Occitan translation of Albucasis (14th C), and the Vatican codex of the Catalan translation of Chaulhac (second half of the 15th C), which contains an entire iconographical programme designed to make the profession of surgery more prestigious and which may have belonged to a physician-surgeon[19]. There are also figurative depictions of surgery in the deluxe codices of the first works of literature mentioned (wounded knights and surgeons, surgical operations, field hospitals, etc.), in encyclopaedias, in psalters and books of hours (burlesque *marginalia*), in the *Liber ad honorem Augusti*, about the imperial conquest of Sicily (a surgeon and two female assistants, very interesting)[20], and so on. Away from the codices, there are the depictions of the miracle of the leg of Saints Cosmas and Damian, patron saints of physicians and surgeons, on some altarpieces (Fra Angelico, the workshop of Bernat Martorell, Jaume Huguet, *et al.*). In sculpture, there are burlesque depictions of the motif of the enema at the castle of Savallà (now in Peralada) or in the Palace of King Martin in the monastery of Poblet.

All these figurative depictions are the result of costly commissions by the lay and ecclesiastical elite, from the urban patriciate to the king himself, and also by the wealthiest physicians and surgeons. In the codices, the relationship between text and image has been particularly studied, and hypotheses have been produced about the function of the images, beyond mere ostentation, as facilitators of access to the text or of advancement[21].

These deluxe books were not the only ones to contain illustrations. Medical manuscripts in the vernacular have survived, in particular relatable to the practice of surgery, that contain ink drawings, diagrams or tables that do not seem to have a decorative function or one conceived to underpin the desire for advancement, but rather a more practical one, to ensure the comprehension and the memorization of procedures or concepts. Notable are the Cambridge codex of the Anglo-Norman translation of Roger's treatise (13th C), the codex of the works in English by John Arderne, with some famous female practitioners at work (second quarter of the 15th C), or, in the Catalan context, that of the recipe book by Joan Llopis, a Valencian barber-surgeon active in Sicily, with a large diagram of uroscopy (15th C), or the codex by an anonymous physician-surgeon conserved in Krakow, with tables about the fevers and other concepts (15th C). These illustrations, more or less slapdash, definitely less attractive than the ones painted with gold and bright colours, are perhaps even more interesting because they are testimonies from the front line of medical practice, very difficult to get to know[22].

4. Works on surgery and their dissemination in the vernacular language

Despite the varying degrees of consideration it enjoyed, surgery never ceased to be practised in Western Europe in the Middle Ages, not just because of surgeons' role as the medical practitioners of the majority of society, but also due to the presence of violence everywhere. Wars between the great powers, private warfare among the nobility and fights of all kinds required the practice of surgery, and the creation of the new medical system normalized the presence of surgeons and barbers in all these situations, in which they found, moreover, an important avenue for improving their training[23]. It was soon necessary to write down the increasingly complex knowledge they needed in handbooks, born of experience and taken from the books they had to hand. These, few in number to begin with, gradually increased with the ones that came from the Byzantine area and above all the Arab world. The latter were of capital importance, because they brought to the West Arab physicians' idea that medicine was for healing and not for philosophical speculation, a medical instrumentalism controversial in the universities but very convenient for all the non-academic practitioners.

The first school of medicine and surgery in medieval Europe came into existence in the ninth century, in Salerno, near Naples, and schools of surgery sprang up during the thirteenth century, in Bologna, Padua, Montpellier and Paris especially, annexed to the universities. In these schools, authors emerged who wrote the surgical treatises of the period, who expounded a rational surgery, based on those foundations. In a first stage, the most important handbooks were by Roger Frugardo, also called of Parma or of Salerno (*c.* 1180), Roland of Parma (*c.* 1240), and the Four Salernitan Masters Gloss (mid 13th C), written in the circles of the School of Salerno. In the second

half of the thirteenth century, in the schools of northern Italy a second stage began presided over by a "new surgery", the new way of understanding surgery, clearly part of Hippocratic-Galenic medicine. Examples of this are the treatises by Bruno of Longobucco, or Longoburgo in Latin (1253), Theodoric Borgognoni, also called of Lucca or of Cervia (*c.* 1262-1266), William of Saliceto (1275 or 1276), and Lanfranc of Milan (1296). The latter, upon being forced to go into exile due to the conflict between the Guelphs and the Ghibellines, took the "new surgery" to France, and there two more outstanding authors emerged, Henry of Mondeville (1306-*c.* 1320) and Guy of Chaulhac or Chauliac (1363). Moreover, some of the authors of the "new surgery" (Bruno, Lanfranc, Chaulhac) also wrote brief compendia designed to provide surgeons and barbers with handbooks that were more manageable and quicker to use than the great summae (to make it easy, Renaissance printers entitled them *Chirurgia parva*, or small, and *Chirurgia magna*, or large, respectively).
The spread of the "new surgery" outside Italy, however, was not just the work of Lanfranc, nor was France the only direction. The time that Theodoric and the Catalan Andreu d'Albalat, both clergymen, spent together in the papal administration in Rome, led to a friendship between them, and Albalat, having been made the bishop of Valencia, convinced Teodorico to finish the treatise and send it to him – contrary to what is pretended by a very common cliché, the Church was not opposed to the development of surgery. Theodoric's treatise was particularly well known in the Catalan Countries, especially after it was the subject of a rapid translation into Catalan by a surgeon trained in medicine (*c.* 1302-1308), and revised shortly afterwards by a university-trained physician (1310-1311)[24].
All the main treatises on surgery, both the great summae and the brief compendia, were translated into many of the vernacular languages of Western Europe. However, critical editing of the works on surgery in the vernacular did not begin until recently and most of this patrimony has yet to be consulted in manuscripts or in Renaissance editions. This is due not only to the length of these texts but also to the prejudice that the subject arouses in many philologists, who are the ones that possess the relevant editorial knowledge[25].
One of the most interesting translations is the abridged Occitan one of Roger Frugardo's treatise, done in verse. This translation was done by one Raimon d'Avinhon, identifiable as the Provençal troubadour of the same name, and it was done – initially at least – for a readership of noblemen who were demanding to be able to gain access to updated surgical knowledge, in order to use it in wartime when they did not have a surgeon available, thanks to the ease of memorization offered by verse. The only surviving manuscript bears witness to its success, copied in the second half of the thirteenth century in Catalonia, far from the place where it was written[26].
Translations of works on surgery were not always done by a translator identified by his name; some of them, including those of important works, are anonymous. This differ-

ence is striking, and more so because when the translator identifies himself, he usually adds a prologue that is very interesting for learning about his motivations and the readers for whom it is intended. Based on the analysis of the Catalan case, it seems that the translations by an identified author were done by surgeons trained in medicine, sometimes revised by graduate physicians, who could be teachers or students, and initially intended for a homologous audience, but also for a layman interested in the subject, even the king. In the Catalan case, King James II of Aragon (1291-1327), who encouraged his surgeons' medical training, ordered the translation of Albucasis' *Surgery* and perhaps Mondeville's too, although both of which are now lost. Theodoric's treatise and the breviaries by Lanfranc and Chaulhac have known translators, while the translations of the former and of Chaulhac's major treatise were revised by identified physicians and surgeons. The anonymous translations seem attributable to translators and to circles that did not belong to these scholarly milieux with formal training, probably barbers, done by or commissioned by them to laymen with knowledge of Latin – this is the case of the treatises by Lanfranc and Chaulhac; we do not know if it was also the case of those by Roger, the Four Masters, Bruno and Saliceto, which have been lost. Of great interest is the case of some barbers from Barcelona who in 1400 were fighting over a copy, almost certainly in the vernacular, of Chaulhac's treatise, which seems to suggest that it was translated in these barbers' circles[27].

When the vernacularization of surgery – or of any other field of knowledge – is analysed, it is not enough to bear in mind the surviving works. As is well known, the surviving written patrimony is only part of what existed, hard to measure but probably not very large. Limiting ourselves to these materials can easily lead to erroneous conclusions. However, avoiding this way of working is only possible if documentary sources on the possession and circulation of the book have been conserved, if they have been exploited by research, and if the specialist researchers make use of this research. Making this effort means placing the research in an interdisciplinary context, something that is not usually easy to do.

Interdisciplinarity often requires extensive knowledge, or working with researchers who master the necessary areas of it. This is particularly essential for studying translations into Hebrew and *aljamiated* texts. In the Jewish communities of medieval Western Europe, Hebrew was a language reserved for the religious sphere and for other formal uses, while in everyday life the language of the country was used. But Hebrew also made communication possible between communities in different countries, besides sharing book resources between them. In these Jewish communities, among both physicians and the rest of the population, the model of medicine based on academic Galenism and the university-trained medical practitioner that the new medical system had introduced so successfully were very attractive, due to the fascination aroused in them by scholastic medicine and to the need to submit oneself to the social control of the practice of medicine that was being imposed.

The appropriation of that model of medicine and medical practitioner led to the wish to possess its writings, in both Latin and the vernacular, and very often in translations into Hebrew. The Hebrew translations also included some of the works on surgery. The recourse to *aljamia* is especially interesting, that is, copying works in Arabic, Latin or the vernacular using Hebrew script, not the Latin alphabet. *Aljamiated* texts are far less known than Hebrew translations, because they require knowledge of the languages in which they were written. Nevertheless, it has been possible to locate some works on surgery in the vernacular *aljamiated* in Hebrew, including an introduction to Theodoric's treatise in Castilian (perhaps Aragonese). It is very significant that the manuscript in which it is conserved also contains a set of questions and answers for preparing the examination and obtaining the licence to practise, also in Aragonese Castilian transcribed in Hebrew script. Hebrew translations often contain *aljamiated* vernacular words, as is the case with a translation of the same work with words in Catalan that give away its origin. One of the codices of the Catalan translation of this work, full of *marginalia* in Hebrew and in *aljamia*, also informs us of the interest that the work and its vernacular translations aroused among the Jews[28].

Illustrated deluxe books were also copied among the Jews to perform the same functions as among the gentiles. Among the medical works, there is the magnificent Bologna codex of the Hebrew translation of Avicenna's *Canon*, a work that, as we have already said, deals with surgery in book IV (Bologna, Biblioteca Universitaria, MS 2197, first half of 15th C).

As occurred in other fields of knowledge, the vernacularization of surgery was not restricted to translations. Compendia in the vernacular were soon produced on the subject that were adaptations of these works and other materials, often anonymous, or else the work of known surgeons, among which the ones produced in the Low Countries stand out and have been studied. In the Catalan context original works on surgery in the vernacular took the form of a commentary, with which the authors – surgeons trained in medicine – expounded the complex contents of a work to make it easier to understand and made contributions to complete or update them. Commentaries on the brief compendium of surgery by Lanfranc (1329), and various ones on different parts of Chaulhac's treatise (three handwritten, from the fifteenth century, and one printed, from 1501), have survived. Original works in the vernacular begin to appear when vernacularization is consolidated as a means to gain access to valued knowledge and when surgeons and barbers require more tuned resources, more adapted to their situation. For all the implications that we have been commenting on, it is important to study the profiles of the authors, translators, commissioners, target readership and any other types of people associated with the translation and writing of the works, as well as their handwritten and printed transmission, and to interrelate the data with the history of surgery and surgeons. The language and the specialized lexicon in vernacular works on surgery are elements that have above all attracted the interest of philologists, who have not forgotten them

in the editions and studies that have been published. As in the case of the texts in Hebrew, they are the researchers needed to study them. However, one must dismiss the idea that it is a subject only of interest to linguistics and lexicography. The process of vernacularization involved a series of operations in this field: it was necessary to adapt the oral language in order to construct a formal text, find the type of language suitable for expressing scientific and technical subjects with precision, and create the specialized terminology that could reproduce the one that was used in Latin texts, at least. The translators complain in their prologues about the difficulties involved in constructing all of that from scratch. It was however not just the language and the lexicon that had to be established in vernacular texts, but also, as in all the written texts that used this new tool of communication, the *scripta* or conventional graphic model for writing formal texts; a graphic model that must no longer be confused with linguistic phenomena and which, in the Catalan case, is very important for establishing the chronology of the text. These efforts provide precious data for all kinds of historical and cultural studies, very especially for learning about the social penetration of the new kind of medicine and medical practitioner in which surgery and surgeons are inserted[29].

The real impact of vernacularization in the history of surgery is a controversial subject. Based on solid research – but from methodological positions very much focused on intellectual history – relative to the creation of rational surgical knowledge in the medieval Latin West, it has been argued that it was precisely the great importance of the transmission of the subject in the vernacular – in a context in which the university elite functioned exclusively in Latin – that slowed down its advance, principally because the vernacular broke the terminological and intellectual tradition that had been constructed in Latin. On the other hand, from other standpoints, which take social and cultural history more into account, it has been noted that vernacularization played a key role in the training of surgeons and barbers, in the social control of their activity, in the extraordinary increase in levels of healthcare, and in the penetration of rational medicine and surgery in society, even in the domestic sphere, and therefore, in the spread and consolidation of the new medical system. It seems that texts in the vernacular were a means of access to knowledge contained in books, in particular to the rational "new surgery", absolutely essential for those non-academic medical practitioners; that these practitioners could be examined on this knowledge because they had acquired it in this way; that it was possible to have many more medical practitioners working with the required guarantees as they had been able to pass the examinations; and that this knowledge could be valued socially because it could be known and thus become general medical culture. Some translations underwent revisions in which, precisely, the citations and the terminology were refined. Nor is it strange that in the libraries of these practitioners there were copies of the works in Latin, and in fact it has been suggested that the first translations could have been done as tools to support

access to the Latin originals. The real situation of medical care, in which the great majority of practitioners had been trained by the open system, probably prevented rational surgery from evolving in a more linear way[30].

5. Uses and users of vernacular surgery: treatises on surgery and other works

When analysing surgical treatises in the vernacular, different uses and users can be identified. They were initially conceived, and mostly translated, as technical handbooks. Surgeons, barbers and female practitioners used vernacular treatises on surgery for their professional activity, in times of peace and war. This is demonstrated by the many surviving inventories of goods. Their participation in war is particularly interesting: it is highly significant that medieval Western European society constructed a healthcare system in armies and navies in response to social demand, that it should have done so entrusting it to a profile of medical practitioner who could work with the guarantees that were requested, and that the recipients approved of it. Inventories of naval medical practitioners have survived – who were generally barbers – that contain treatises on surgery in the vernacular, and miscellaneous codices containing inventories of their box of medicines and instruments, codices whose size and lettering was designed to be used on board galleys and ships[31].

Apart from this initial purpose, surgical treatises were also works designed for the training of surgeons, and in some cases this objective determined their vernacularization. All the treatises of the "new surgery" reproved "idiotic" and "lay" surgeons, those who practised without having the medical and surgical knowledge that was acquired in books. In their prologues, the translators state that they are translating the works for the training of these sectors in order to incorporate them in the new trend. In the Catalan context, this is the case of the translation of Theodoric and the minor compendia of Lanfranc and Chaulhac. A manuscript is conserved of the Catalan translation of Lanfranc's major treatise, copied by a Castilian apprentice living in the Catalan Countries interested in the work as a technical but also formative tool.

Of special interest is the case of the revised translations. The Catalan translations of Theodoric and Chaulhac were both revised by university-trained physicians with the undeclared intention of making them more useful resources. The evident success of these revisions (of the language and, in particular, of the terminology and the quotations of authorities) proves that this was their intention. The translation of Theodoric was revised as soon as it was finished, in the early fourteenth century. The one of the Chaulhac translation, done in collaboration with a surgeon, is related to other vernacular surgical treatises designed to serve as handbooks for the students of the school of medicine and surgery in Barcelona at the turn of the sixteenth century. This educational and didactic proposal remained alive in handwritten works produced in Catalan in the early modern period[32].

The existence has already been mentioned of sets of questions and answers to prepare for the examination that was gradually imposed on non-university-trained practitioners, which also continued in the vernacular in early modern times, even in a far more elaborate manner. The form of these resources, in questions and answers or "problems", corresponded to an ancient didactic tradition that, in medicine, was developed especially at the School of Salerno, and which was also quite successful in the education of the general public (*Dragmaticon philosophiae*, *Livre de Sidrac*) and in the dissemination of medical knowledge (*Il Perché*). Apart from the Q&A to prepare for the exam, surgeons appreciated the method as a means of access to the principal works, and they produced versions with that format, such as three of the commentaries surviving in Catalan on different parts of Chaulhac's treatise[33].

Finally, treatises on surgery were also perceived as handbooks of practical domestic medicine. This is what that their appearance in the libraries of kings, noblemen and bourgeois would seem to suggest. Their extensive contents, useful for a practice of "surgery" that went further than surgery proper and for domestic self-help, and the accessibility that the vernacular made possible, encouraged this role, unthinkable now[34].

If the books that surgeons, barbers and female practitioners had in their libraries are analysed, one can see that they made use of other works directly associated with the practice of surgery, above all the "new surgery"[35]. On one hand, the *practicae*, the large collections of *medicina practica,* that is, of all the branches of therapeutics (dietetics, medication and surgery). These works were produced by medieval physicians based on the model of *De ingenio sanitatis* (*De methodo medendi*) by Galen, a work also known precisely with the title *Therapeutica*. Arab physicians also provided models for it, some of them with enormous scope, such as the great summae by Rhazes (*Almansor*), Haly Abbas (*Liber Pantegni*), Albucasis (*Taṣrīf*), Avicenna (*Canon*) and Averroes (*Colliget*). Among those produced in Latin Europe the one by the author from Montpellier Bernard of Gordon (*Lilium medicinae*) stands out for its dissemination. It comes as no surprise that many of these works were translated into the vernacular, at least partially, including those by Galen.

The followers of the "new surgery" had to know the fundamental concepts of *medicina theorica*. These concepts were expounded by a successful university handbook that was a synthetic introduction to Hippocratic-Galenic medicine, known as *Isagoge Johannitii*. Three initiatives in Catalan on this *Introduction to Galen's Art of Medicine* are evidence of the desire to learn this theoretical framework: two different translations and, quite significantly, a Q&A version[36].

Of the nascent surgical specialities mentioned above, ophthalmology generated specific texts in both the Arabic and Latin worlds. Outstanding, respectively, are the works by Alcoatí and Benvenuto Grafeo (Benvenutus Grassus). The latter was a highly appreciated handbook and therefore translated into many vernacular languages. Of the one by Alcoatí, incomplete in Latin until later, there is a complete translation into Catalan from the Arabic due to a royal initiative[37].

Finally, with regard to medicines, surgeons, barbers and female practitioners possessed collections of simple and compound medicines (*antidotaria*). In this field, however, the "medical recipe book" was especially important. These works, which were self-produced, contained not just medical recipes, sometimes extracted from the vernacular translations of the treatises on surgery, but also other short works on different aspects of the practice of "surgery", from deontology to bloodletting and medical astrology. It was a true vade mecum of the non-academic medical practitioner, and therefore an extraordinary window on to the world of professional practice. Moreover, given that it was not easy to obtain medical care when it was needed, in the domestic sphere similar works were also produced, with significantly different contents, and therefore they have been divided into "professional medical recipe books" and "domestic medical recipe books", the last of which survived until at least the late nineteenth century. They were also habitual among the Jews (*sefer refu'ot*), and testimonies of both kinds survive in Hebrew and *aljamia*. This genre, essentially vernacular – for both the language and for being conceived, created and spread outside the universities – which was based on earlier Latin models and which has only recently been highlighted, was the product of late medieval urban society, of the medical practice of non-academic practitioners increasingly more integrated in the new medical system, of the wishes to guarantee one's health, and of the poor level of healthcare that dogged it for a long time[38].

6. Conclusion

The creation of a new medical system in medieval Latin Europe, based on the model of Hippocratic-Galenic rational medicine and of a medical practitioner with university degrees, led to great changes in the production of surgical handbooks, the training of surgeons and the practice of surgery. With these changes surgery went from being an empirical technique to a rational form of knowledge that had to be learned in books and which constituted a "new surgery" decidedly inserted in that medicine. The social consensus meant that only this "new surgery" would provide opportunities for advancement to those who practised it, most of them trained outside the universities. The impact was great because these male and female practitioners, Christians and Jews, increasingly obliged to pass exams with those contents and to obtain a licence, and later, if they were Christians, to have formal studies, were the healthcare umbrella of the majority of the population.

Because of all this, these male and female medical practitioners opted to translate and write in the vernacular language the texts that could facilitate for them all those goals, and they were thus some of the main promoters of the vernacularization of medical knowledge. Not the only ones because in the new urban society, that had unleashed all these processes and many others that were decisive in European history, the desire

to have this highly prized knowledge to hand, for necessary domestic self-help and to demonstrate to society that one was part of the system, promoted both the production and possession of texts in the vernacular among laymen in medicine, of surgery too. The vernacularization of this knowledge may have slowed down the academic development of surgery, but it played a crucial role in the professional and social success of the "new surgery" and the new medical system all over Western Europe. This large number of implications demands that any study of these vernacular works intended to be complete must follow an interdisciplinary methodology.

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SAPIENZA
UNIVERSITÀ DI ROMA

© Author(s)
E-ISSN 2531-7288
ISSN 0394/9001

4.0 INTERNATIONAL

MEDICINA NEI SECOLI
Journal of History of Medicine
and Medical Humanities
36/1 (2024) 133-148

Received: Settembre 2023
Accepted: Novembre 2023
DOI: 10.13133/2531-7288/2903

Corresponding Author:
alessandra.foscati@kuluven.be

Miracle Tales as Privileged Sources for a Historical Investigation of the Diseases in the Middle Age: Canonization Processes and *Libri miraculorum*

Alessandra Foscati
KU Leuven

ABSTRACT

In the varied spectrum of healers to whom the sick people could turn to in Middle Ages, including physicians, surgeons and different kind of empirical practitioners, the saint was often the first to whom they would refer. Miracle tales, therefore, represent an essential source for a historical investigation into diseases and sick people. Without claiming to be exhaustive, this article aims to briefly outline this topic through several examples taken from miracles accounts in some canonization processes and *Libri miraculorum*, compiled between the thirteenth and the fifteenth centuries. It will be highlighted how these sources, when properly interpretated, are of fundamental importance for understanding the relationship between the sick and his/her community of reference, as well as the work of some empirical healers who approached the sick person's bedside. Furthermore, these sources are unique lexicographical treasures related to the vocabulary of disease – an aspect still largely overlooked.

Key Words: Healing miracles - Canonization processes - *Libri miraculorum* - Disease's lexicon - Sickness in the Middle Ages

This work was supported by Research Foundation-Flanders (FWO) in the framework of the SIDELINE project (Marie Skłodowska-Curie Actions – Seal of Excellence, Ref. 12ZZU22N).

In the fourteenth century, the well-known French surgeon, Henri de Mondeville could not refrain from his sarcasm towards those sick people who had undertaken a pilgrimage to Noyon, visiting the grave of Eligius, a saint of the Merovingian period. Starting from the thirteenth century, this saint, for cultic reasons still unknown, began to be invoked for the healing of a disease (in fact, several diseases that manifested as severe ulcerative lesions), that popularly took his name, being known as *morbus/malum sancti Eligii*. Mondeville wrote:
"For the common people and country surgeons, all ulcers, sores, apostemes and fistulas which require prolonged treatment turn out to be Saint Eligius' disease. If it is pointed out to them that some of these sick people are healed when they go on a pilgrimage to St Eligius, while others are not, they respond that those who are not cured only have themselves to blame as they have not made the pilgrimage with sufficient devotion, or that it was not really St Eligius' disease"[1].
Moreover, Mondeville, ironically, reports an anecdote whose main character is a surgeon. His mortar, used to prepare a medicine to cure St Eligius' disease, broke. This event triggered resentment among those present, who interpreted it as the saint's revenge against those who persisted in trying to cure that disease[2].
Mondeville's stories and his sarcasm towards the behavior of common and sick people, allow us to speculate on how the surgeon and every representative of profane medicine, carrying out his duties could not help but face the 'medicine' performed by saints. Therefore, the saints, to whom sick people constantly turned to, were part of a diversified therapeutic option, constituted by physicians, surgeons and a number of empirical healers[3]. This is further highlighted by the fact that some saints were invoked as 'expert' healers and became eponymous for several diseases (Eligius was not the only one)[4].
Starting from the twelfth century, there is a proliferation of accounts of healing miracles that took place both at the relics of the saints, where the sick people would go pilgrimage (as described by Mondeville), and directly at the residence of the sick (even in this case, the burial place of the saints plays a fundamental role in the pact made between the worshipper and the saint)[5]. In these accounts, alongside the narration of how the saint's thaumaturgy operated, there was, to a greater or lesser extent, a description of the patient and how the disease manifested itself on his/her body, as well as the behavior adopted to cope with the disease and the pain before the miraculous healing occurred. Therefore, from the perspective of a historical investigation into the disease and the sick, miraculous healing accounts are a source of fundamental importance.
The sources we refer to in this article are two kind of hagiographic texts: the *Libri miraculorum* and the dossiers of the investigations *in partibus* of the canonization pro-

cesses (henceforth CPs), which were established starting from the end of the twelfth century[6].

The investigation *in partibus*, carried out at the burial places of candidates for sainthood and at the various places where they had lived, was aimed to collect testimonies regarding the episodes of their lives, especially the miracles that occurred through their intercession (in life or *post mortem*) including healing miracles, which were often the most numerous. In such cases, the individual who had benefited from the miraculous healing was directly questioned, unless it was a child. Furthermore, those who had been present at the event, such as family members, relatives, neighbors, and various secular healers, were called upon to testify as well.

The testimonies, despite being addressed within functional questioning schemes aimed at demonstrating the sanctity of the candidate, were characterized by an intrinsic spontaneity, and variously influenced by the cultural *milieu* in which the investigation took place[7]. In addition, these testimonies were translated from the vernacular, the language commonly used by the people, into Latin. It should also be noted how, in the course of time, accounts of miracles become richer, more detailed and circumstantial in their description of the phenomenology of diseases, also documenting a growing medical awareness on the part of the witnesses.

The *Libri miraculorum* are collections of miracle tales occurred after the death of a saint. Mostly in Latin, the *Libri* are structured as a series of miracle tales written by one or more authors. These tales often included detailed descriptions of the sick people, although it is important to note that in Christian anthropology, the disease was often associated with the sin, both in soteriological (as a potential means of redemption for the soul of the sick) and etiological terms (as a consequence of the sin)[8]. This association could influence how the authors of the *Libri*, who were typically Churchmen, depicted the sick. Furthermore, these texts, to varying degrees depending on the level of education and cultural background of the author, contain quotations from various sources, including the Holy Scriptures, theological texts, and other hagiographic works, which were once again useful to describe the sick people and their disease[9]. For example, in a passage from one of the thirteenth-century still unpublished account in the *Liber miraculorum* of St Edmund of Abingdon, the anonymous author wrote to have learned about a “reliable” story directly from a sick man who claimed that “due to an overabundant melancholy, namely a congested blood mass, he had grown suffering from the quartan disease”[10]. The description of this disease had not actually reached the author through the sick man (who would have had to be a medical expert to express himself in that way), nor can it be said to have been originally invented by the author, and therefore, to be the expression of his medical knowledge, as it had been written[11]. This is because it is a verbatim quote from a passage written by Gregory of Tours about a miracle performed by St Martin[12]. Therefore, for a comprehensive understanding of this passage within the context of a historical

investigation on disease, including an analysis of the author's knowledge, we should refer to Gregory of Tours and thus to the sixth century. This does not indicate that the authors' description in the *Libri* were not original or that they did not have access to the testimonies of the sick who had turned to the saint, including a possible meeting with the sick in the sanctuaries. However, a study of these texts from a historical and cultural perspective is essential to recognize the narrative intentions of each author, the sources and literary models used, to avoid forced interpretations[13].

Given these premises, this article aims to briefly outline, through several examples, the most relevant topics that CPs and *Libri miraculorum*, written from the thirteenth to the fifteenth century, offer in the context of a historical investigation on disease and the sick people, without claiming to be exhaustive. This study is based on numerous stories of miraculous healing, and the investigation is still ongoing, with the aim of conducting further in-depth research in the future[14].

About physicians and empirical healers

A vital aspect of the CPs in the Middle Ages (sometimes even of the *Libri*) is the continuous reference to many empirical healers, who, alongside physicians, worked at the patient's bedside, about whom we often have only limited and indirect knowledge.

These texts depict the image of the sick person willing to turn to different healers simultaneously, often considered of equal importance. In a miracle tale from the CP (1445-50) of Bernardino of Siena, a paralyzed woman testifies that before reaching the relics of this saint, she had unsuccessfully resorted to medicine and to "enchantresses", from whom she had received "multa brevia et multas incantationes", and had even gone on a pilgrimage to the column where Christ had been bound[15]. This represent a combination of multiple remedies, including also the 'magical' ones, although the latter tend to be rarely mentioned in the CPs and in the *Libri*, due to the general aversion of many Churchmen.

Sometimes, the aversion extended even to those who were skilled in the use of the *incantamenta*, such as the *vetula* (old woman), although her empirical knowledge was not too dissimilar from that of educated physicians[16], as also demonstrated by a testimony from the CP of Philippe de Bourges (1265-66). It narrates of a *vetula* who had provided *cerebrum cati* (cat's brain) to a man and his mistress (*garcia*), through which they had driven madness in man's wife[17]. It is crucial to emphasize that a description of the cat's brain, as a substance causing *stoliditatem* (foolishness), will be found in treatises on poisons written by some learned physicians in a period shortly after Philippe de Bourges' CP. The first of these treatises is Pietro d'Abano's *Tractatus de venenis*[18]. This account demonstrates the continuous exchange of knowledge among individuals from different cultural background and, specifically, highlights the 'popular' origin of the belief regarding the properties of *cerebrum cati*

which will later be found in the treatises. In this case, the *vetula* qualifies as an intermediary for this knowledge.

From the sources under examination, several figures of therapists emerge, including barbers, midwives, and other individuals whose name derives from their specialization, with regional variations. For example, this is the case of the *medicus/chirurgus cretorum* in Thomas Aquinas' CP (Fossanova, 1321) who was a specialist in treating the *cretus*, which, in the same source, indicates a person suffering from inguinal hernia[19].

The account of a testimony in Bernardino of Siena's CP (1445-50) is an example of how a figure like that of the *erbolarius*, a seller of medicinal herbs, could, when necessary, also serve as a therapist. One of these figures, while in the square "selling herbs for doctors", also acted as a *magister dentium* (dentist), and, moreover, treated the witness's diseased eye[20].

Above all, miracle tales are among the few sources that partially inform us about the work of midwives during the Middle Ages. From these accounts, we can learn, for instance, about the 'resuscitation' methods used with the newborn when extracted from the mother's uterus in a state between life and death. These methods consisted of blowing into the newborn's mouth and nose (and even ears!) after drinking wine and eating spices. It should be noted that information about these practices performed by midwives can only be found in medical texts from the sixteenth century onwards[21].

From the perspective of physicians, there was an increasing mention of them in the testimonies of CPs. Starting with a general reference that depicted the patient who had turned to them in vain before obtaining healing through the saint's intercession, as described in the most ancient CPs (and in the *Libri miraculorum*), we move towards more specific details about their name and actions[22].

However, there are few direct testimonies from physicians compared to the total number mentioned in the CPs[23]. This is a proof of the fact that the opinions of physicians (and surgeons), who were increasingly held in greater consideration to support the miracle, had not yet acquired the probative value they would have had in the early modern period[24]. Furthermore, it is an aspect which, in the Middle Ages, distinguished the CPs from the criminal investigations, where typically the surgeon was called to testify as an expert when injuries and homicides occurred[25].

Historians often tend to quote, as a significant example of physician's testimony, the statement made by Jean de Tournemire, in the CP (1389-90) of Cardinal Peter of Luxembourg[26].

Tournemire, an important physician from Montpellier, who played a prominent role for the *studium* of the city, describes the characteristics of the breast cancer that had affected his daughter[27]. The text of the testimony, in which the disease is explained with significant references to the humoral theory and authoritative figure like Hippocrates, was assimilated to a medical *consilium*[28]. However, it is essential to con-

sider its uniqueness compared to any other statement made by physicians in the context of the investigations of CPs. This represents an exception in both the content and significance of the text, as well as in the stature of the witness (miraculous healing testimonies in medieval investigations rarely involved famous professionals)[29].
Tournemire, despite underlying the incurability of breast cancer, also shows his confidence in the relics of the cardinal (in contrast to what was done by Henri de Mondeville previously mentioned), to the point of recommending their therapeutic use (the physician refers to the use of some threads of cloth from a dress that belonged to the saint), as well as promising two *ex-voto* in wax in the shape of breasts. Therefore, this statement needs to be contextualized. As Danielle Jacquart pointed out, Tournemire attended the ecclesiastical *milieu* surrounding the saint, being called upon to testify about the exemplary life of the latter and to ascertain the unnatural state of his corpse, and therefore "the investigators... sought to measure the authenticity of the physician's devotion", and, in addition "taking into account the father's emotional state"[30]. We must not forget that Tournemire gave testimony regarding breast cancer especially because the patient was his daughter. As a matter of fact, individuals belonging to the patient's social network were typically called upon to describe and interpret the latter's disease.

About the relationship between the sick and the community

Miracle stories show how the sick people would immediately turn to the members of their social network, who were actively involved in the management of the disease, starting with the formulation of the diagnosis, which often became a subject of debate. For instance, in the *Liber de miraculis sanctorum Savigniacensium*, edited in Normandy in the thirteenth century, regarding a woman's disease, it is mentioned: "Some said that it was the disease that was popularly called *porfil*, others [said it was] *antrax*, others that it was *lupus*, which is equivalent to *morbus regius*"[31].
Leaving aside the meaning (or rather, the meanings) of the different disease's names, it is acknowledged that those who approached the sick were inclined to formulate their own personal diagnostic interpretation (there are numerous examples in this regard).
Therapeutic suggestions were also provided, along with the statement of the prognosis, and the opinion of common people was regarded on par with that of professional healers. In the CP (1318-19) of Clare of Montefalco, for example, the remission time of a fever suffered by a woman is questioned by a neighbor who doubted what the physician had said[32].
Furthermore, common people's knowledge was sufficient to demonstrate that the disease was incurable, thus ensuring the authenticity of the miracle. In the CP of Bernardino of Siena, a woman indeed declares herself an expert in her own illness (leprosy) and, in addition to her testimony, those of neighbors are included, but not

those of the healers[33]. In the same CP, it is the brother of an individual suffering from "pestilential fever", who had been abandoned by physicians as hopeless, confirming that the healing had occurred thanks to the contact with the saint's relic[34]. The man had not only considered the peak of the fever but had also evaluated the patient's urine, as it was one of the diagnostic methods par excellence performed by physicians. Furthermore, in the CP (1363) of Dauphine de Puimichel, the inquisitors asked the noblewoman Francesca to comment on her niece's "critical days" of the fever to assess whether it was a spontaneous recovery rather than a miracle[35], even though the witness had stated that her niece had been treated by a Jewish doctor[36].

With reference to the miracle of resurrection, the community of the sick is always involved in identifying the signs of death. Even from a legal perspective, except in cases of injuries and homicides, common knowledge was considered sufficient to determine an individual's death. Detailed indications of what were believed to be the signs of death and of some empirical evidence aimed at their detection can be found in miracle tales. In many cases, these signs and examinations correspond to those described in medical texts[37].

The relationship between the sick and the community leads us to the topic of the perception of the sick in medieval society. Both the *Libri* and the CPs reveal how certain types of patients tended to be marginalized – for example, in the case of leprosy – due to the fear of contagion and their bad smell and repulsive appearance. Despite the evangelical precepts on welcoming the sick, they were sometimes even driven away from sanctuaries for the same reasons mentioned above, including the fear their bodily fluids might offend the sacredness of the place. For example, in a miraculous tale from the *Liber* of Guillaume de Bourges, written in the thirteenth century, the author emphasizes the description of the 'inhuman' appearance of a dropsical patient, whose fetid breath was unbearable for those who approached him. Moreover, the patient had been removed from the saint's relics for fear that a rupture of his belly (the less noble part of the body) would occur, to the point of compromising and causing 'scandal' in the sacred place[38].

About the disease's lexicon

Besides being described in both the testimonies of the CPs and in the accounts of the *Libri*, the disease is often named, making these sources an valuable lexical treasure for disease terminology in Latin and occasionally in the vernacular. In the latter case, these are expressions of 'popular' use that, lacking a Latin equivalent, were included in the vernacular form in both the *Libri* accounts and in the Latin transcriptions of the testimonies of the CPs.

These sources are therefore bearers of a nosographic lexicon often unfamiliar to historians of disease, characteristic of specific geographic areas. For example, the expression *lo tac* (or *lo tat*) can be found in two testimonies of the CP of Dauphine

de Puimichel and in three miracle tales in the collection of miracles (1376-79) attributed to Urban V[39]. Both sources originate from Provence. The term is listed in the most recent dictionary of medieval French vernaculars, where it is indicated as the name of the plague commonly used in Provence in the year 1382[40]. The hagiographic texts state that the term was more properly considered as a symptom associated with a 'pestilential' event (not synonymous with the plague), and a sign of patient's imminent death[41]. Moreover, these sources demonstrate that it was in use before 1382.

In miracle tales, specific names often have different meanings than those found in medical texts. For instance, in the above-mentioned quote found in the *Liber de miraculis sanctorum Savigniacensium,* the *lupus* and *morbus regius* are identified as the same disease, whereas in the medical texts, these two terms referred to different diseases[42]. Moreover, in medical texts *lupus* indicated a gangrene strictly localized in the lower limbs, but by reading miracle tales, we learn that the term could also refer to a disease localized in other parts of the body[43].

In the *Liber*, it is repeatedly mentioned the *morbus hispanicus*, associated with severe gangrenous cutaneous manifestations[44]. The expression is also found in medical sources, but only starting from the sixteenth century, where it is used as a synonym for syphilis, a disease not documented in the Middle Ages[45]. Beyond the origin of the term *morbus hispanicus,* which is probably linked to cultural and social factors that still require further investigation[46], the awareness of the age of the *Liber* edition demonstrates that it is a conceptual error to associate it exclusively with syphilis.

In addition, we should underline how the hagiographic texts explain the origin and meaning of diseases names of 'popular' origin (including diseases with the names of saints), then adopted by medical texts and, in some cases, used nowadays although with variations of meaning[47].

To briefly conclude

The inclusion of narratives about the daily life of the sick people in healing miracle tales allows us to draw information about how they coped with their disease, their relationship with the community of reference and with various types of healers, including empirical ones. In this regard, these specific sources emerge as particularly enlightening regarding the work of midwives.

It is these very sources that primarily highlight how, in the Middle Ages, individuals' diseases were always perceived as a collective experience. This underscores the importance of the relationship between the sick and the community, expressed in terms of continuous interaction and, at times, exclusion.

At the same time the miracle tales are characterized by being among the sources that best reveal the names of diseases normally employed in more or less narrow contexts

of society in the Middle Ages and how it may also be influenced by religious, cultural and social life.
When examined through a proper interpretation of the sources, these themes are fundamental in the perspective of a historical study related to disease and the sick.

Bibliography and Notes

Non-ISO4 abbreviations
CF = *Collectanea Franciscana*
Frate Francesco = Frate Francesco. Rivista di cultura francescana
PL = Migne JP (ed.), Patrologia Latina cursus completus..., Series Latina. 221 voll. Parisiis: J. P. Migne /Garnier; 1844-

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1. Henri de Mondeville, *Chirurgia*, II, II, 3. In: Pagel JL (ed.), Die Chirurgie des Heinrich von Mondeville. Berlin: August Hirschwald; 1892, p. 320.
2. Ibid., *Tract*. II, *Notabilia introductoria*, p. 68. A theory on the reason for Saint Eligius' specialization can be found in Foscati A, Malattia, medicina e tecniche di guarigione: il *Liber de miraculis sanctorum Savigniacensium*. RetiMedievaliRiv 2013;14(2):59-88, pp. 78-81.
3. For an effective synthesis on empirical healers, see Duranti T, Ammalarsi e curarsi nel Medioevo. Una storia sociale, Roma: Carocci; 2023, pp. 73-110.
4. See Foscati A, Saint Anthony's Fire from Antiquity to the Eighteenth Century. Amsterdam: Amsterdam University Press; 2020.
5. In the vow to the saints the promise of pilgrimage to their remains always appears.
6. On the medieval processes of canonization is a must to refer to Vauchez A, La sainteté en Occident aux derniers siècles du Moyen Âge d'après les procès de canonisation et les documents hagiographiques. Roma: École française de Rome; 1981. On the subject of healings at the sanctuary and for a reasoned bibliography, see Canetti L, Terapia sacra: guarire al santuario. In: La medicina nel Basso Medioevo. Tradizioni e conflitti, Atti del LV Convegno storico internazionale, Todi, 14-16 Ottobre 2018. Spoleto: Centro Italiano di Studi sull'Alto Medioevo; 2019. pp. 47-75.
7. To cite an example: in the CP of St Frances of Rome the theme of 'magic' is a vital one. Bitterly fought (Frances burns books of spells and admonishes the enchantresses),

'magic' is also present in the works of Giovanni Mattiotti, confessor of Frances and active in promoting her worship and canonization process. See Bartolomei Romagnoli A, Santa Francesca Romana nel quarto centenario della canonizzazione. Rassegna storiografica e nuove ipotesi di lettura. Benedictina 2008; 55:153-80 (see also below ref. 15).

8. Agrimi J, Crisciani C, Malato, medico e medicina nel Medioevo. Torino: Loescher; 1980; Foscati A, ref. 4. pp. 20-8.
9. On the reference sources of hagiographic texts, see at least Berlioz J, Identifier sources et citations. Turnhout: Brepols; 1994.
10. Ms Auxerre, Bibiothèque Municipale, 123G, f. 151ra. "Ex cuius fida relactione accepimus quod increscente melancolia id est decocti sanguinis fece quartane pestis intemperancia extiterat pregravatus".
11. Louise E. Wilson interprets this passage of the *Liber* as a proof of the author's medical culture and as evidence of alleged knowledge circulating in the thirteenth century: Wilson LE, Conceptions of the Miraculous: Natural Philosophy and Medical Knowledge in the Thirteenth-Century Miracula of St Edmund of Abingdon. In: Mesley M, Wilson LE (eds), Conceptualizing Miracles in the Christian West, 1100-1500. Oxford: The Society for the Study of Medieval Language and Literature; 2014. pp. 99-126, pp. 122-3.
12. Gregory of Tours, *De miraculis S. Martini*, II, 58. In: PL 71, col. 967.
13. It is well known that hagiographic texts represent important sources for social and diseases history. Such bibliography is indeed very extensive. However, there is sometimes a tendency to disregard the contamination between texts and, above all, the specificity of these sources. In this respect, see Alessandra Bartolomei Romagnoli's accurate definition of hagiographic texts as 'meta-texts' "il cui ordine veritativo non è quello della realtà fattuale. Non per questo la *fictio* medievale è una "invenzione" ma è un genere di racconto che, pur non escludendo la storia, intende prima di tutto comprendere e comunicare i fatti spirituali e mistici"; Bartolomei Romagnoli A, Un viaggio dentro i racconti delle stigmate. CF 2022;1-2:357-65, p. 360.
14. Most of the CPs studied by Vauchez A (ref. 6), and various *Libri miraculorum* (also unpublished) written in the territory of present-day Italy and France, more uniform in terms of medical practice, have been taken into consideration. The texts of the CPs have been studied on critical editions, when existing, or directly on the manuscripts, in order to avoid the errors that may be present in the *Acta Sanctorum*, the repertoires in which many of the texts under examination are transcribed. For the need to be concise, we can only indicate in this article the CPs and the *Libri miraculorum* from which the examples given derive.
15. Pellegrini L (ed.), Il processo di canonizzazione di Bernardino da Siena (1445-1450). Grottaferrata: Collegium Sancti Bonaventurae; 2009, p. 80. The *brevis* (usually translated as *brieve* in Italian and *brief* or *brevet* in French) was, in general, a sheet of paper or parchment folded several times on which were written some words, invocations, drawings. It was placed in contact with the body and had an apotropaic and therapeutic function. It could not be opened, and therefore the content had to remain secret, otherwise it would lose its effectiveness. See Cardini F, Il "breve" (secoli XIV-XV): tipologia e funzione. RicFolk 1982;5:63-73; Boudet JP, Descamps J-P, Pouvoir des mots et brevets magiques. In: Bériou N, Rosier-Catach I, Boudet J-P (eds), Le pouvoir des mots au Moyen Âge. Turnhout: Brepols; 2014. pp. 381-408. In the Bernardino of Siena's CP, unlike that of Frances of Rome (see above ref. 7), there are references to therapeutic acts such as the *carmina* (and therefore to enchanters and enchantresses) without any negative judgment.

16. Regarding the *vetula,* the study by Jole Agrimi and Chiara Crisciani is a must: Agrimi J, Crisciani C, Immagini e ruoli della "vetula" tra sapere medico e antropologia religiosa (secoli XIII-XV). In: Paravicini Bagliani A, Vauchez A (eds), Poteri carismatici e informali: Chiesa e società medioevali. Palermo: Sellerio; 1992. pp. 224-61.
17. Ms Città del Vaticano, BAV, lat. 4019, f. 75v.
18. Pietro d'Abano, *Tractatus de venenis*. Marburg: Eucarius Cervicornus; 1537, p. 63: "Ille, cui in poto datum fuerit cerebrum catti, patiebatur stoliditatem". The same quote is also found in Guglielmo de Marra's *Sertum Papale de venenis* and in the books on poisons by Antonio Guaineri and Sante Ardoini. In the miracle tale we also find references to the toad, another animal included in the treatises on poisons. This miracle's story was studied in the past by Goodich M, The Multiple Miseries of Dulcia of St. Chartier (1266) and Cristina of Wellington (1294). In: Goodich M (ed.), Voices from the Bench. The Narratives of Lesser Folk in Medieval Trials. New York: Plagrave Macmillan; 2006. pp. 99-125. The scholar, in the absence of references to treatises on poisons, insists on an interpretation, we would say anachronistic one, of the *vetula* as a witch. We have to point out that the *garcia* (woman of easy morals) was a figure included among the ones considered as the poisoners: see Collard F, *Veneficiis vel maleficiis*. Réflexion sur les relations entre le crime de poison et la sorcellerie dans l'Occident médiéval. Le Moyen Âge 2003;1(t.CIX):9-57, p. 10. The tale deserves an appropriate insight.
19. Laurent MH (ed.), *Processus canonizationis S. Thomae*. In: *Fontes Vitae S. Thomae Aquinatis*. Saint-Maximin: Revue Thomiste; 1937. pp. 483-5, p. 492.
20. Pellegrini L, ref. 15. p. 130. In the same CP, the one who sold herbs to physicians, but from inside a shop, is referred to as *aromatharius.* About this specific character, see Moulinier-Brogi L, Médecins et apothicaires dans l'Italie médiévale. Quelques aspects de leurs relations. In: Collard F, Samama E (eds.), Pharmacopoles et apothicaires. Les "pharmaciens" de l'Antiquité au Grand Siècle. Paris: L'Harmattan; 2006. pp. 119-34.
21. The insight on the topic is in Foscati A, Retracing Childbirth through Hagiographical Texts and Canonization Processes in Italy and France between the Thirteenth and Sixteenth Centuries. In: Dopfel C, Foscati A, Burnett C (eds), Pregnancy and Childbirth in the Premodern World. European and Middle Eastern Cultures, from Late Antiquity to the Renaissance. Turnhout: Brepols; 2019. pp. 195-224, pp. 205-8. The first physician to report these methods of resuscitation proper to midwives was Simon de Vallambert in his 1565 treatise on puericulture: Simon de Vallambert, Cinq livres de la maniere de nourrir et gouverner les enfans des leur naissance. Poitiers: Marnesz et Bouchetz; 1565. pp. 35-6.
22. The statement of the failure of profane medicine before the saint's healing is a *topos* of hagiographic literature aimed at demonstrating the latter's thaumaturgic power. It is likely that instead, the sick person immediately invoked the saint.
23. The number of physicians and healers who testify in the most relevant medieval CPs is indicated in Foscati A, Il ruolo del guaritore profano nell'identificazione del miracolo. I processi di canonizzazione tra XIV e XVI secolo (Italia e Francia). In: Andreani L, Paravicini Bagliani A (eds), Miracolo! Emozione, spettacolo e potere nella storia dei secoli XIII-XVII. Firenze: SISMEL-Edizioni del Galluzzo; 2019. pp. 207-24, pp. 209-11. Also Joseph Ziegler who, in a quoted article, aims to demonstrate the significant presence of physicians in medieval CPs admits that most of the healing miracles are accepted without any apparent proof from the medical authority: Ziegel J, Practitioners and Saints: Medical Men in Canonization Processes in the Thirteenth to Fifteenth Centuries. Soc Hist Med 1999;12(2):191-225, p. 220. See also, within given limits to the CP of Nicholas of

Tolentino, Lett D, *Judicium Medicine and Judicium Sanctitatis*. Medical Doctors in the Canonization Process of Nicholas of Tolentino (1325): Experts Subject to the Inquisitorial Logic. In: Salonen K, Katajala-Peltomaa S (eds), Church and Belief in the Middle Ages: Popes, Saints, and Crusaders. Amsterdam: Amsterdam University Press; 2016. pp. 153-69.

24. See Pomata G, Malpighi and the Holy Body: Medical Experts and Miraculous Evidence in Seventeenth-Century Italy. Renaiss Stud 2007;21(4):568-86.
25. See Duranti T, "Ius civile credit Hypocrati": medicina e diritto in dialogo, oltre le dispute universitarie. In: La medicina nel Basso Medioevo. Ref. 6. pp. 313-47.
26. See, for example, Ziegler J, Ref. 23. pp. 202-5.
27. Ms Paris, BnF, lat. 9747, ff. 333r-337r.
28. It is included among the *consilia* by Crisciani C, *Consilia*, responsi, consulti. I pareri del medico tra insegnamento e professione. In: Casagrande C, Crisciani C, Paravicini Bagliani A (eds), *Consilium*. Teorie e pratiche del consigliare nella cultura medievale. Firenze: SISMEL- Edizioni del Galluzzo; 2004. pp. 259-79, pp. 271-3.
29. See, for example, the comparison between the medical witnesses in the CP of Bernardino of Siena and in that, of the late sixteenth century, of St Filippo Neri: Lavenia V, La canonizzazione di Bernardino: tra storia, diritto e pietà. Frate Francesco 2011;77(2):435-45, p. 442.
30. Jacquart D, Médecine, miracles de guérison et mort apparente à la fin du Moyen Âge. In: Andreani L, Paravicini Bagliani A (eds), Ref. 23. pp. 247-68, pp. 255-6.
31. Ms Paris, BnF, NAL 217, f. 39.
32. Menestò E (ed.), Il processo di canonizzazione di Chiara da Montefalco. Scandicci: La nuova Italia; 1984, p. 398.
33. Pellegrini L, Ref. 15. p. 459.
34. Ibid., p. 265.
35. Cambell J (ed.), Enquête pour le procès de canonisation de Dauphine de Puimichel, comtesse d'Ariano (†26/XI/1360). Torino: Bottega d'Erasmo; 1978. pp. 426-7. The cited texts show that the notion of 'critical days' was widespread at several cultural levels. Especially regarding medical texts, see Recio Muñoz V, *Medicus artifex sensualis est*: Amato Lusitano ante la teoría de los días críticos. eHumanista/Conversos 2019;7:39-58.
36. It must be said, however, that Jewish doctors, although recalled in several CPs as therapists who were often the performers, are never called, in the analyzed CPs, as direct witnesses. The topic is covered in Foscati A, Ref. 23. p. 215.
37. On the signs of death and empirical evidence in the miracle tales, see ibid, p. 220-22. Regarding the signs of death in medical texts, see Duranti T, La morte nella medicina bassomedievale (secc. XII-XV). In: De Ceglia FP (ed.), Storia della definizione di morte. Milano: FrancoAngeli; 2014. pp. 165-81.
38. *Sancti Gulielmi archiepiscopi Bituricensis. Vita, miracula post mortem et canonizatio (…)*. Analecta Bollandiana 1884;3:271-361, pp. 332-33. However, for a correct evaluation of the account, we have to consider about the fact that the dropsy weighed on a symbolic surplus, because for the tradition, it was the disease which had affected some great sinners. See Foscati A, Ref. 4. pp. 23-8. In the same volume some examples of removal and rejection of the sick by the sanctuaries are mentioned (ibid., pp. 80-5).
39. On Dauphine de Puimichiel's CP: ms. Aix-en-Provence, Bibliothèque Méjanes 355, ff. 134r; 136v. The manuscript is taken into consideration because in the 1978 Cambell edition, quoted above (see above ref. 35), the transcription of the lemma is not correct. About

Urban V, see: Albanès JH, Chevalier U (eds), Actes anciens et documents concernant le bienheureux Urbain V, pape (…). Paris: Bibliothèque de l'École des chartes; 1897. pp. 124-365, pp. 225, 228. The dossier of Urban V consists of a collection of testimonies each referring to a single miracle, transcribed, dated and signed at the bottom by various notaries. The quote mentioned is from the nineteenth-century edition which is an exact transcription of the only manuscript which contains the text (ms. Marseille, Département Bouche du Rhône, 1 H 676).

40. https://www.cnrtl.fr/lexicographie/tac/0 (last access: August 2023). The dictionary indicates also other meanings, including that of a disease typical of cattle. The lemma is a captivating example of the polysemy of the medical lexicon of the past. We have an ongoing study and publication dedicated to the semantic meanings and changes of this lemma.
41. For example, we read in a tale of Urban V's dossier: "Petrus Garini… asseruit… quod… uxor sua… graviter infirmabatur, que patiebatur febrem continuam et habens lo tat, quod est signum mortale"; Albanès JH, Chevalier U, Ref. 39. p. 228.
42. See, Foscati A, "Dicitur lupus, quia in die comedit unam gallinam": Beyond the Metaphor: *Lupus* Disease between the Middle Ages and the Early Modern Period. Mediterranea 2023;8:27-53.
43. *Lupus* as a nosographic term still exist and is used to indicate various pathologies. The most common among them is the Systemic Lupus Erythematosus, an autoimmune disease, which is different from the medieval *lupus.* This term has a metaphorical origin. In fact, for ordinary people, the way to fight the disease, that 'ate' the flesh of the sick person like the ferocious beast, was to feed it with chicken meat. Confirmation of the use of such a form of therapy, and to our knowledge the earliest evidence of this, comes from a miracle tale included in the twelfth-thirteenth century Pseudo-Hebernus' collection of *miracula* attributed to the intercession of St Martin (see, ibid., pp. 33-5).
44. Paris, BnF, ms. NAL 217, ff. 25; 38; 39; 69; 73; 76; 78.
45. See, Foscati A, Il linguaggio della medicina fuori dalla medicina nel Medioevo. I *libri miraculorum* e i processi di canonizzazione come repertorio lessicografico dei nomi delle malattie. In: La medicina nel Basso Medioevo. Ref. 6. pp. 441-66, pp. 453-4.
46. The question we ask ourselves is: why was gangrene associated with the Spanish in Normandy in the thirteenth century? It is possible, but it is all to be demonstrated, that the expression *morbus hispanicus* originated following contacts made owing to pilgrimages to Santiago de Compostela.
47. For example, let's focus on the expression solely used in Italy 'fuoco di Sant'Antonio' which today popularly means the disease caused by the virus *herpes zoster*, but which in the past indicated, in great part of Europe (in the Latin form *ignis sancti Anthonii*), gangrene, of whatever etiology (see Foscati A, Ref. 4). See also above Ref. 43.

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E-ISSN 2531-7288
ISSN 0394/9001
4.0 INTERNATIONAL

MEDICINA NEI SECOLI
Journal of History of Medicine
and Medical Humanities
36/1 (2024) 149-162

Received: Settembre 2023
Accepted: Novembre 2023
DOI: 10.13133/2531-7288/2905

Corresponding Author:
Francesca.roversi@unibo.it

"A Closeness to God, to Nature, and to Community"[1]: Medical Medievalism in Contemporary Society*

Francesca Roversi Monaco

Alma Mater Studiorum - University of Bologna

ABSTRACT

For several decades now, medical practices referred to as traditional or natural have been increasingly popular in Western society. These practices are often perceived, defined, and connoted as medieval, regardless of their characteristics and historicity. Attributing traditional medicine to a generic medieval time reflects one of the most relevant contemporary cultural phenomena: the pervasiveness of images, narratives, and references to the Middle Ages in popular culture. However, this Middle Ages is not the historical period interpreted through the sources; it is a dreamed, imagined, meta-historical time, represented according to the dual model of the Dark Ages and the 'good' Middle Ages of fantasy, fairytale, nature not yet subject to modernity and techno-science. The imagined Middle Ages is the field of study of a specific disciplinary area, medievalism. This paper aims to identify the representations of medieval medicine that this reshaped and imagined medieval world produces and disseminates in society.

Keywords: Medievalism - Healers - Nature - Medicine

*il presente contributo è pubblicato nell'ambito del Prin FRAME-Framing Medievalisms: Historiography, Cultural Heritage, Media Communication and Languages in Italy (1980-2022) [Codice progetto: 2022HMH5MJ; CUP: B53D23001570006], finanziato dall'Unione Europea-NextGeneration EU.

Medievalism: a short definition

For several decades now, medical practices referred to as traditional[2] or natural such as therapies, diets, potions, decoction, rituals, and mysterious preparations have been increasingly popular in Western society. These practices were attributed to an arcane wisdom handed down over time thanks to a nebulous but reassuring and centuries-old chain of transmission between men and women chosen to practise that wisdom. These practices are often perceived, defined, and connoted as medieval, regardless of their characteristics and historicity. Attributing traditional medicine to a generic medieval time reflects one of the most relevant contemporary cultural phenomena: the undeniable pervasiveness of images, narratives, and references to the Middle Ages in popular culture.

However, this Middle Ages is not the historical period interpreted through the sources; it is a dreamed, imagined, meta-historical time, represented according to the dual model of the Dark Ages and the 'good' Middle Ages of fantasy, fairytale, nature not yet subject to modernity and techno-science.

The imagined Middle Ages is the field of enquiry of a specific disciplinary area, medievalism, which identifies "the continuing process of creating the Middle Ages" and "is concerned with the remaining meanings, the study of the scholarship which has created the Middle Ages we know, ideals and models derived from the Middle Ages, and the relations between them"[3].

Therefore, the imagined Middle Ages is the result of centuries-long rewriting processes that have generated a series of themes, tropes, images, and references perceived as medieval, even if they are not historically reliable: castles, knights, princesses, dragons, witches.... neither science and technology, "a medieval imaginary in which many of the popular ideas we have about the medieval period come to form a recognisable set of signs and ideas, eventually forming a reflection of the period that, although imaginary, was paradoxically perhaps more 'real' to the modern audiences"[4].

From a methodological point of view, medievalism adopts the perspective of *histoire croisée*, which investigates the objects of research through their mutual interaction by focusing on the consequences of their intersection and the theory of adaptations, as medievalism encompasses the ongoing processes of rewriting or adaptation of a historical period- the Middle Ages - over time. Finally, as a key to interpretation, medievalism makes use of the concept of nostalgia codified by Svetlana Boym as a model of interaction with the past in the two forms of restorative nostalgia - which seeks to recreate the past through tradition - and reflective nostalgia - which focuses instead on its irrevocability. In the study of medievalism, the former prevails as an active part in shaping the historical consciousness of communities since, through it, the past becomes a collective value for the present and the future[5].

Medical medievalism

In the contemporary imaginary, medical medievalism intended as the “modern representation of medieval medicine intended for a popular audience”[6], follows the dual model of the Dark Ages and the immersion in Good Nature; on the one hand, the scientific backwardness resulting from inadequate medical knowledge and the inability to address diseases considered characteristic of the Middle Ages, such as leprosy and plague[7]; on the other hand, the decoctions and potions of healers who were seen as witches and subsequently persecuted because they held knowledge rejected by modernity and scientific medicine. Therefore, as the scholar April Harper notes in a very recent essay “the medieval reality of hospitals (depending on time period and geographic location), educated practitioners, medication and even cleanliness must remain absent from this constructed medieval world entirely in order for the medieval imaginary to be fully constructed”[8]. However, what is of interest here is not so much recognising the scientific dimension of medieval medicine beyond stereotypes[9] nor analysing the reliability of contemporary practices that refer to it; instead, it is of interest to identify the representations of medieval medicine that this reshaped and imagined medieval world produces and disseminates in society. The representation of the past through literary, artistic, audiovisual and digital forms, in fact, has a social-political function. On the one hand, it shapes the collective perception of the historical cadence depicted regardless of the reliability of the narrative; on the other hand, it disseminates and reinforces, among the ‘general public’, models of behavior suitable for the society concerning central issues such as ideological affiliation, national identity, gender roles and health as a common and global good. With reference to medical medievalism, the Dark Middle Ages, brutality, plagues, and backwardness appear, for example, in audiovisual and multimedia products: think about the brutal amputations performed by improvised surgeons that characterize episodes of TV series such as *Vikings*, also to enhance the strength and virility of the warriors[10]. Another relevant example is offered by the “Greyscale”, a dreaded disease that afflicts the kingdoms of Westeros and Essos in the well-known TV Series *Game of Thrones*[11]. It manifests itself with a hardening of the skin on the extremities, slowly spreading throughout the body, stiffening the internal tissues and preventing normal vital activities until death occurs: “the skin cracked, flaking, and stone-like to the touch. Those who manage to survive a bout with the illness will be completely immune, but the flesh damaged by the ravages of the disease will never heal, and they will be scarred for life”[12]. As can be seen, the “Greyscale” immediately recalls leprosy, the medieval disease par excellence alongside the plague, both in its pathological manifestations and in its social consequences: the exile of the sick, the so-called “Stone Men”, who were persecuted, hunted down, even killed and the consequential creation of lazarettos.

Nevertheless, when referring to the Middle Ages, traditional medicine practices depict it as the golden age of closeness and fusion with nature, as a pearl of ancestral wisdom now almost entirely lost due to the deceptive and perilous progress and the disenchantment of the world. By virtue of that natural wisdom, the Middle Ages became the place where the spiritual dimension was still a fundamental part of the treatment and healing processes. The sacred knowledge was the basis of good healing practices because they were natural and holy at the same time[13]. Indeed, "while brutality is one of the common ways in which medieval medicine is immediately identifiable to a modern audience, medieval imagery is often realized through a complete sacrifice of both logic and realism in the portrayal and acceptance of the fact that the only effective medieval medicine is related to magic and herbal knowledge"[14] as the primary skill of physicians and healers.

The connection between magic/religion/medicine, magical thinking, and the biological and cultural origins of the patient/physician relationship are widely investigated topics from anthropological, philosophical, and historical perspectives[15]. Regardless of the different interpretations, in popular representations of medieval medicine, the relationship between the healer and the intermediary with the supernatural is recognised and linked to another important aspect: the role of women in the matter of continuity between medieval remedies and modern folklore or folk medicine.

Women's role in medical medievalism

The centrality of the feminine in contemporary medical medievalism is undeniable. A widespread narrative postulates the equation woman = art of healing as a biological imprint and not just a cultural one. Thanks to the feminine characteristics of humility, respect, curiosity, and positive irrationality, as opposed to the control and violent appropriation typical of men, this narrative attributes to women an absolute fusion with nature and, therefore, the ability to use its gift. The transmission of traditional, magical, and therapeutic knowledge, the skilful use of herbs following precise ancestral rituals, the daily custom of preparing food and remedies for family ailments, enable women to be healers, priestesses, and good witches, the only ones holding the power to heal[16].

In collective imagination, the equation woman = art of healing often implies another analogy: the healer considered as a witch, persecuted in the past precisely because of her ability to cure and heal thanks to her natural wisdom.

This image of the healing witch, keeper of ancestral knowledge, the priestess who cures and heals, the physician who alleviates the pains and sufferings of the body and spirit with her herbs and potions, reviving age-old practices, has its roots in the 19th century and the Romantic reinterpretation of the Middle Ages, particularly in the work of Jules Michelet, *La Sorcière*, published in 1862 and continuously reprinted since then[17].

Michelet depicts the witch as a symbol of nature oppressed by the Church, which, fearing the revolutionary force expressed in female action – "Nature les fait sorcières" - would have implemented practices of exclusion and protection of the social order through persecution[18]. The French historian, in his desire for the "'résurrection de la vie intégrale' du passé, formule qui fait de Michelet une sorte de medium doublé d'un chamane et donne à son histoire une dimension superbement partiale"[19], does not write a history about witchcraft but about the Witch in a medieval era still connected to antiquity, on the verge of becoming modernity. In his passionate interpretation, the witch becomes the protagonist of the progressive dichotomy between culture and nature and the opposition between Christianity and paganism. Michelet's witches are the *bonnes femmes* who, thanks to their strong connection with nature, practised folk medicine and healed the minds and bodies of the communities in which they operated. Michelet's witches are the healers turned into witches by the ecclesiastical and male power, and much of 20th-century feminist theory draws inspiration from them.

The innate vocation for healing, the supernatural ability to cure and the legacy of an ancient female powers silenced by the rise of patriarchy, outline "a kind of pseudo-feminist Romanticism of the imagined medieval (pagan) past"[20] and along with herbal knowledge, represents one of the fundamental elements of medieval medicine and healers in popular perception.

Hildegard of Bingen is the sacred healer par excellence of the Middle Ages:

> *No actual or virtual library does not offer works such as Hildegarde of Bingen's Holistic Health Secrets: Natural Remedies from the Visionary Pioneer of Herbal Medicine, Hildegard of Bingen's Medicine, St. Hildegard of Bingen's Nutrition: Spelt - The Super Food depicting her as a gentle, good witch, gathering herbs along rivers and in places known only to her to prepare medicines and decoctions that are still effective, as evidenced by the offerings swarming the web. Moreover, it matters little that this oleographic flattening does not correspond to Hildegard's image rendered by the sources contemporary with her and her works - the Rhenish Sibyl was one of the most prominent personalities not only of the 12th century but of the entire medieval era. She was a woman of power in the term's broadest and most political sense. What matters is the contemporary perception of the healer that joins with nature and draws from it the principles of healing, spiritual and material*[21].

If in the popular perception the historical-political dimension Hildegarde's figure is absent, the image of the healer in harmony with nature recalls the connection between religion and medicine of medieval religious communities as repositories for medical knowledge, where they practised "remedies derived from plants found in the herbal or infirmary garden, special diet, surgical procedures, the application of amulets, and the uttering of formulaic words, often with religious overtones—cures representative of the natural and unnatural realms"[22]. Moreover, as Debra Stoudt points out, "along with medicines, surgery, and diet—the three types of treatment identified in the *Etymologiae* of St. Isidore of Seville (*c.*560-

636)—charms, amulets, and ritual healing remained commonplace as means to care for and cure the sick throughout the Middle ages. Reflexes of all of these methods are referenced among Hildegard's healing arts"[23].

Therefore, Hildegard's contemporary image of the medieval healer is not misrepresented. Nevertheless, it is anachronistically normalized around the ability to cure and heal through 'natural' medicine – "ma come poteva essere, altrimenti, nel Medioevo?"[24] - and, by definition, pure, sacred and, above all, feminine and feminist[25].

The *Liber Subtilitatum diversarum naturarum creaturarum* - better known as *Physica* - and the *Causae et curae* are the works on which the saint's reputation as a physician is based[26]. These are encyclopaedic texts, which offer a combination of philosophical-theological reflections and empirical practices, remedies, rituals, chants, and prayers. They recall the holistic vision of the sick proper to medieval medicine, founded on the Galenic and Aristotelian concepts of complexion. As is known, the complexion is the mixture of the qualities of elements characteristic of each individual. Several factors influence it, such as the proportion of humours, sex, age, and environment, the alterations of which affect the state of health of each individual. Hildegard focuses primarily on the female body and, above all, by applying the individual nature of the medieval conception of illness, she proposes a 'classification' of human temperaments by gender[27].

As Michela Pereira remarks, Hildegard brings the power of feminine weakness back to the fore: in direct relation to the cosmic power of creation and the human task of governing it and bringing it to completion, it is not the strength of man that gives life to the whole humanity, but the weakness of woman; this is because the maternal function directly connects her to the divine creative force. Hildegard attributes female weakness to the mode of creation, as being derived from the earth makes man strong, while being derived from man's flesh makes woman weaker. However, the derivation of Eve *de medullis* from the marrow of Adam's bones, leads Hildegard to attribute to her an airy mind, "a merit, a fineness that makes woman, the last of creatures, the most accomplished of them. Being second in creation implies, therefore, in her eyes, a refinement of human nature rather than a deficiency: Hildegard finds herself here at the exact opposite of the conception of the naturalist philosophers of her time"[28].

This undeniable focus to gender, combined with the herbalist knowledge, has significantly contributed to the contemporary representation of the herbalist of God, the holy healer who encapsulates millennia of natural, sacred, and feminine knowledge, to the point that Hildegard is now referred to as the founder of gender-based medicine[29]. Her harmonious and integrated vision of the interactions between body, soul, and environment - typical of medieval medicine as a whole - is reflected in the most recent approaches to health from a holistic perspective. Therefore, it characterises not only traditional medicine and its narrative, often played out in a controversial and alternative role compared to 'official' medicine, but also the scientific and institutional reflection on health as a common good. In fact,

> *contemporary medical practice and public health initiatives have begun to recognise the value of holistic approaches, of identifying the origins and social contexts of medical conditions, rather than simply prescribing treatments...critical medical humanities argues for the importance of clinical generalism, the need for practitioners to understand the person holistically, in terms of the interdependence of mind, body, and affect, and in wider cultural and social contexts. It also underlines the need to recognise the practitioner as embodied, and so stresses the complex interrelation of physical, mental, and affective elements of practice. The medieval thought world speaks to all these concerns*[30].

Conclusions

The world of medieval thought addresses all these concerns: this statement also reflects an interpretation and adaptation to the contemporary age of a substantial aspect of the medieval period, namely medical and philosophical theory and practice. So far, medical medievalism, primarily identified in the colorful empirical galaxy of natural remedies, herbs, potions, signatures, and ‘natural’ food, expands to encompass scientific medicine, biomedical theory, the philosophy of health, and the complex relationship between them and traditional, complementary, and alternative medicine.

The topic is delicate since the political-cultural dimension is closely intertwined with the economic-social dimension – think of the marketing linked to the vast and sometimes opaque system of supplements and organic or natural products, without delving into the more burning issue of the relationship between doctor/healer and patient.

The topic is sensitive and goes beyond the scope of these brief considerations and my expertise, but it is interesting to emphasise the importance of medievalism as a cultural phenomenon that can provide valuable interpretative tools to investigate the contemporary world. Medievalism, by connecting the past and the present regardless of anachronisms and whether it adheres to actual medieval historicity, becomes a tool for understanding the dynamics of the context that produces it. On the one hand, it enables the transmission of its dominant contents and values, on the other hand, it encourages reflection on its critical nodes within society. The concepts of health and illness, their biological and cultural characteristics, the balance between the individual and collective spheres, the respect for social and cultural differences, and the awareness of social imbalances in managing health as a common good represent critical issues in society.

In a phase of evolution like the current one, marked by the recent global shock of COVID-19, these vital issues are even more evident, and their collective management and processing are even more delicate.

Medical medievalism, in reclaiming from medieval culture the holistic dimension of the individual as the union of mind and body in its interactions with the environment through figures like Hildegard of Bingen and traditional practices, reflects the challenges, fears, and hopes of the present.

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Non iso-4 abbreviations
Scientiarum Hist = Scientiarum Historia
Stud Medievalism = Studies in Medievalism

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11. On medievalism and Game of Thrones, see Carroll S, Medievalism in A Song of Ice and Fire and Game of Thrones. Woodbridge: Boydell and Brewer; 2018; Larrington C, Winter is coming: The Medieval World of Game of Thrones. London: I.B. Tauris & Co., 2016; Larrington C, Czarnowus A (eds), Memory and Medievalism in George RR Martin and Game of Thrones. The Keeper of All Our Memories. London: Bloomsbury; 2022. For a specific perspective on humanities, Álvarez-Ossorio A, Lozano F, Moreno Soldevila R, Rosillo-López C (eds), Game of Thrones - A View from the Humanities Vol. I, Time, Space and Culture. London: Palgrave Mc Millan; 2023; Iid. (eds), Game of Thrones - A View from the Humanities II, Heroes, Villains and Pulsions. London: Palgrave Mc Millan; 2023.

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13. Duranti T, Ref. 7. pp. 73-100.
14. Harper A, Ref. 8. p. 60.
15. Corbellini, G, Storia e teorie della salute e della malattia. Roma: Carocci; 2014. pp. 43-52.
16. Duranti T, Ref. 7. pp. 100-7. The image of the woman-magician/curator in possession of medical knowledge or secret knowledge is also codified in medieval literature: think, for example, of the healing-magic arts of Isolde, see Altpeter-Jones K, Love Me, Hurt Me, Heal Me—Isolde Healer and Isolde Lover in Gottfried's Tristan. The German Quarterly 82 (1), pp. 5-23.
17. Michelet J, La Sorcière. Paris: Gallimard; 2016, pp. 424-34.
18. Ibid., p. 29.
19. Millet R, Préface. In: Michelet J, Ref. 17. p. 9.
20. On magic, sorcery, and female power in TV series see Harper A, Ref. 8. p. 60: "In these productions, the inadequate medieval medicine practiced is the preserve of men whose patriarchy proves impotent in the face of real disaster. The only capable healers in these dramas are female, often greatly sexualized, pagan priestesses or witches, who wield true, though often dangerous, power"; see also De Rentiis D, Houswitschka C (eds), Healers and redeemers: the reception and transformation of their medieval and late antique representations in literature, film and music. Trier: Wissenschaftlicher Verlag Trier; 2010. For a general overview of the healer witch, see Whaley L, Women and the Practice of Medical Care in Early Modern Europe, 1400-1800. London: Palgrave Macmillan; 2011, pp.174-95.
21. Roversi Monaco F, A Few Remarks on Witchcraft and Medievalism. In: Maraschi A, Montanari A (eds), Becoming a Witch. Women and Magic during the Middle Ages and Beyond. Budapest: Trivent publishing*;* 2023. pp. 273-91, p. 281: "Hildegard of Bingen still confronts us, after eight centuries, as an overpowering electrifying presence - and in many ways as an enigmatic one...in the Middle Ages, only Avicenna is in some ways comparable: cosmology, ethics, medicine and mystical poetry where among the fields conquered by both of the eleventh-century Persian master and the twelfth-century 'Rhenish sibyl'"; Dronke P, Women Writers of the Middle Ages. Cambridge: Cambridge University Press; 1984, p. 144. The prophetic virtues have, however, overshadowed the complexity of her figure in the standard perception, flattening her into the cliché of the healer and ignoring both the cultural and scientific depth and the political and administrative role that the Rhenish Sibyl found herself playing with an authoritative and indeed not only mystical air. For a recent overview of the topic, see Embach M, Hildegard of Bingen (1098-1179): A History Of Reception. In: Mayne Kienzle B, Stoudt DL, Ferzoco G (eds), A Companion to Hildegard of Bingen. Leiden-Boston: Brill; 2014. pp. 273-304;
Stoudt DL, The Medical, the Magical, and the Miraculous in the Healing Arts of Hildegard of Bingen. Ibid. pp. 249-72. On the contemporary success of Ildegardian medicine, see Moulinier-Brogi L, Habemus sanctam! La vie sans fin de Hildegarde de Bingen/ Habemus sanctam! The Endless Life of Hildegard of Bingen. Médiévales 2012;63: "DVD, régimes de santé et sachets d'infusion sont donc les principaux avatars de Hildegarde dans la société occidentale actuelle".
22. Stoudt DL, Ref. 21. p. 250. See also Moulinier-Brogi L, Hildegarde de Bingen, les plantes médicinales et le jugement de la postérité. Scientiarum Hist 1994;20:77-95.
23. Stoudt DL, Ref. 21. p. 252. See also Moulinier-Brogi L, La connaissance de la nature selon Hildegarde de Bingen, entre sagesse de Dieu et savoir d'une moniale. In: Bartolomei

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26. On the complex tradition of Hildegard’s scientific work see Moulinier-Brogi L, Le manuscript perdu à Strasbourg. Enquête sur l’oeuvre scientifique de Hildegarde. Paris: Publications de la Sorbonne-Presse Universitaires de Vicennes; 1995; for the editions of *Liber Subtilitatum* e del *Causae et curae*: Hildegard von Bingen, Physica. Liber subtilitatum diversarum naturarum creaturarum, Hildebrand R, Gloning T (hrsg.). Berlin: De Gruyter; 2010; Hildegard von Bingen’s Physica: The Complete English Translation of Her Classic Work on Health and Healing. Trans. Throop P (transl.). Rochester VT: Healing Arts Press; 1998; Moulinier-Brogi L, Berndt R (eds), Beate Hildegardis Cause et cure. Berlin: Akademie Verlag; 2003. For the Italian editions: Calef P (ed.) Ildegarda di Bingen, Cause e cure delle infermità. Palermo: Sellerio; 1997; Ead., Campanini A (ed.), Libro delle Creature. Differenze sottili delle nature diverse. Roma: Carocci; 2011. See also Montesano M, Malattie e rimedi negli scritti di Ildegarda di Bingen. In: Paravicini Bagliani A (ed.), Terapie e guarigioni. Firenze: SISMEL-Edizioni del Galluzzo; 2010. pp. 215-32.
27. Duranti T, Ref. 7. pp. 55-6.
28. Pereira M, Ref. 25. p. 184: “in relazione diretta con la potenza cosmica della creazione e col compito umano di governarla e portarla a compimento, dando vita all’intera umanità, non sta infatti la forza dell’uomo, ma la debolezza della donna, in quanto la funzione materna la connette direttamente alla divina forza creatrice...La debolezza attribuita da Ildegarda alla donna in genere...è legata alla modalità della sua creazione: l’uomo, che deriva dalla terra, è più forte, la donna che deriva dalla carne dell’uomo, è più ‘aerea’... Idlegarda adombra ancora una voltala tradizionale etimologia di *mulier* da *mollior (mollis),* ma riportandola alla qualità più raffinata della sua origine de medullis, e connnettendola dunque a un pregio, una finezza che fa della donna, ultima delle creature, la più compiuta di esse. Essere seconda nella creazione implica, dunque, ai suoi occhi, un raffinamento della natura umana, piuttosto che una manchevolezza: Ildegarda si trova qui esattamente all’opposto della concezione dei filosofi naturalisti del suo tempo”.
29. See Malorni W, Melino S, Ildegarda e la medicina di genere. Prometeo 2023;41.162:56-61, p. 61: “Va infatti sottolineato che l’interazione uomo-ambiente come possibile fonte di disequilibrio e di patologia così come l’individuazione di elementi di ‘segnalazione’ all’interno del corpo umano oggi riconducibili agli ormoni, rappresentano intuizioni sorprendenti per l’epoca. ...le differenze tra donne e uomini, oggi definite dalla medicina di genere o genere-specifica, sono una ulteriore intuizione di Ildegarda. La Badessa, infatti, mostrando doti imprenditoriali di tutto rispetto, aveva dato vita a tre monasteri con relativa produzione di ‘agenti farmacologicamente attivi’ (diremmo oggi), aveva individuato le differenze di sesso (biologiche) e di genere (socioculturali) come elementi chiave per cure appropriate, un must della moderna farmacologia...alcuni aspetti della visione salutistica (stili di vita diremmo oggi) e biomedica di Ildegarda rappresentano una premonizione di molti aspetti della farmacia e farmacologia attuale, con una visione delle specificità di tutti gli esseri viventi (vogliamo dire non meramente antropocentrica) e delle differenze tra uomini e donne sia in sé (per la loro struttura) che per sé (per la loro

interazione con l'ambiente che li circonda)"; see also Melino S, Mormone E, On the Interplay Between the Medicine of Hildegard of Bingen and Modern Medicine: The Role of Estrogen Receptor as an Example of Biodynamic Interface for Studying the Chronic Disease's Complexity. Front. Neurosci. 2022;16:745138 http ://www.frontiersin.org/articles/10.3389/fnins.2022.745138/full.(accessed 1 September 2023).

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