MEDICINE IN THE MEDIEVAL URBAN MEDITERRANEAN WORLD

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A concept that students of the role of medicine in contemporary society have come to use widely is that of "medicalization". The term originally gained currency in the 1970s, from social critics complaining of the growing power exercised by medical professionals as agents of the modern state. Subsequent students of the process developed a considerably more nuanced understanding of the process, so that even Michel Foucault came to recognize that medical practitioners applied their expertise in the service of a discourse that was already "immanent", i.e., taken for granted by society, and were not simply imposing or enforcing their authority (Nye, 2003). Broadly speaking, therefore, "medicalization" might be said to refer to the permeation of society by medical culture and especially medical authority, and as such it presupposes not only a high number of medical practitioners but also that they enjoy social recognition as a profession, possessed of a specific body of knowledge concerning, even defining, health and illness, and privileged by society to control access to its use. More narrowly understood, however, it means more than a visible, widespread authoritative profession; it refers to a subtler, unplanned willingness by society to extend that authority to new areas, to effectively redefine certain kinds of unhealthy behavior (like epileptic fits) not as moral or social problems but as medical ones, and to transfer responsibility for them from society, or the individual, to the physician.

An obvious example is what a century ago would have been called drunkenness. Someone who habitually drank alcohol to excess, who routinely drank until he became incoherent or unconscious, was labeled a drunkard. His behavior was a moral and social failing, and it made him the target of scorn, because he chose not to drink with restraint. The law would thus penalize him for his antisocial behavior. Today, in contrast, he would tend to be called an alcoholic, and his behavior would be understood as a medical problem, one that medicine rather than the law (or his own strength of character) should respond to. Drug addiction more generally is often approached in the same way, and there are many other behaviors that have been medicalized in the last hundred years. In a curious way, medicalization has advantages for all concerned: the individual is no longer blamed for his actions (he cannot help them), society can give up the costly effort of imprisoning and policing, and the medical profession is given heightened responsibility that entrenches its social role even more solidly. The example is modern, and the term arose in modern application, but nothing about it limits it to the modern medical world: it might be looked for in any society increasingly prepared to find advantages in widening the authority of medicine; and as a matter of fact, I think we can properly understand the urban Mediterranean world as having undergone just such a medicalization in the 14th and 15th centuries.

1. The process was rooted in the success of the medieval university. Medical faculties first emerged in the first quarter of the 13th century, and by the end of the century they could be found in Lleida, Montpellier, Bologna, Padua, and Paris. They were very small but they clearly responded to a felt need: a premium was placed by society on the new learned medicine — *any* learning, no matter how little. Towns began to seek out the new learned physicians to read their citizens' urines and to give advice on their health, competing with other communities for the few university products that were initially available. The process is easy to trace in Catalunya. In the last years of the 13th century, the towns of Cervera and Valls were the first to insist that their physicians needed to have mastered the *sciència de medicina*, as demonstrated by passing an examination held by the town council, and other towns soon followed suit. Increasingly, a medical degree, or some part of one, was taken to be proof of expertise, but there were still so few that university-trained physicians tended to move to better-paid posts, until finally the supply met demand. The coastal town of Castelló d'Empúries hired a succession of men boasting some medical education who lasted a year or so and then left, until finally in 1326 one — with a full Montpellier degree — settled there permanently. By the 1330s the count-king of Catalunya-Aragó was requiring a high level of medical expertise for anyone wishing to practice medicine in those realms (McVaugh, 1993, pp. 99-101). In a parallel act, in Valencia in 1329, four years of study in a university were required by royal decree; if would-be practitioners could not meet the requirement they would have to undergo an examination, carried out now not by city officials but by two established physicians (García Ballester et al., 1989). Medicine was emerging as a learned profession, in the sense that its practitioners were being given the authority to decide who could join their number.

This commitment to the value of learning underlies various concessions of authority to the new medi-

cine, as the number of educated physicians steadily increased. All around the western Mediterranean, empirical practitioners were being formally prohibited from practice by municipal authorities: in Italy this happened in Florence as early as 1314, in Verona in 1327, and then progressively in other towns down to Parma in 1440. On the other side of the coin, the towns were conceding to their established physicians the right to examine the qualifications of anyone who could not show a medical degree, sometimes vesting this responsibility in the municipal guild; thus in 1349 Florence gave its physicians' guild the right to license all practitioners (Park, 1985). Of course this was hard to enforce, and other kinds of non-learned medical practitioners continued to exist — empirics, apprentices, midwives — but even *they* found it useful to adopt at least the terminology of the new learning, because the public had come to accept that language as defining good medicine (Perarnau, 1982, pp. 58-64) [1:47-78 at Refs.].

It must be noted that this was a process in which practitioners, public authority, and the general public were all willing, if sometimes unconscious, partners. It was not imposed by "the medical profession" by any means: the lay public at all levels was quite happy to concede various kinds of authority to the learned physician. The Italian cities, for example, clearly thought that the new medicine could be a tool in improving "public health." They were concerned with the sick urban poor in particular; they wanted to maintain the health and productivity of workers and to control the spread of epidemic disease, but they co-opted medicine in different ways, depending on their form of government. Milan developed a remarkable system of centrally controlled public health measures into which physicians had significant input. Venice invested in qualified civic doctors, like the Catalan towns but on a vastly larger scale: it was already employing eleven of them by 1324, often distinguished university masters from Padua (Stefanutti, 1961, p. 93). In contrast, until quite late, Florence paid a mere half-dozen or so practitioners, expecting them only to treat immediately curable conditions (fractures, hernias, dislocations) so that its laborers could quickly get back to work.

On the other hand, the chronically ill in Florence could go to a hospital. Hospitals are another instance in which medical authority was coming to replace lay authority. In the early Middle Ages, there were of course charitable hospices for the needy, the poor, the disabled. These patients were tended by religious brethren with no specifically medical expertise. But from the early 14th century many such shelters moved to specialize in acutely ill patients to whom the new medicine could be provided as a charity, and especially in Italy they developed impressively. Florence's Santa Maria Nuova is the most famous: from the mid-14th century to 1500 it expanded its charitable role into a highly developed system of health care. It had a learned medical staff (including pharmacists) and wards that allowed for the isolation of patients with various skin diseases, as well as hundreds of beds for the treatment of patients with different illnesses. Patients were seen daily by doctors drawn from the upper ranks of the profession. Charitable institutions were evolving into an extension of Florentine medical attention, as part of an urban public health program (Park, 1991, pp. 26-45). It was an exceptional institution, certainly — but, still, throughout the later medieval Mediterranean world, urban hospitals were taking on a medical character and were coming to be supported not just by private but also by municipal foundations for public purposes. Charity was becoming medicalized: it was no longer just meant vaguely for the poor and needy but for the acutely and chronically ill as well.

Indeed, we could say that to some extent the very character of illness was changing, as is evident if we consider the public response to identifying and controlling epidemic disease, for here again public authority happily transferred much of its authority to the new medical profession. Leprosy was the first such disease to preoccupy medieval Europe. From the beginning it was perceived as widespread, deadly, contagious, and horrible, with overtones of sinfulness that further encouraged the popular impulse to ostracize and isolate the sufferer. But from the beginning of the 14th century, not only the accused but town governments began to appeal to physicians to decide whether the popular diagnosis was correct. Concerned neighbors were at first clearly unconvinced that physicians deserved credence in so important a matter, but within a few decades the new authority of medicine had won out: leprosy was "medicalized," placed under medical authority, and generally accepted as a disease with purely physical origins rather than as an expression of sin (Demaitre, 2007). One illustration out of many possible ones comes from the town of Vic in Catalunya, where in 1333 Pere Teixidor was denounced by his neighbors as a leper; they were afraid of contagion and wanted him committed to a leper-house. Pere begged that he be examined by physicians to see whether he really had the disease. The judge sent him to the academically trained municipal physician, who examined him and declared that Pere was free of the disease and that therefore he could not pass it on to anyone. Thus, based on the principle that physicians were the best judges of such matters — in a telling phrase, that *medico est credendum in sua arte* — the court allowed Pere to return home and told his neighbors not to persecute him unjustly any longer (McVaugh, 1993, p.221).

By the time the plague epidemic came to Mediterranean Europe, in 1348, academic medicine was well

established, and it had produced a number of treatises explaining the disease, by authors in Catalunya, in southern France, and in Italy. All agreed that it had a cause or causes, that it could be understood, and could be treated or at least defended against: infected air and personal transmission were most important among the identified causes. It might be uniquely horrible, but it is a medical event, one that can be explained physically. Thus, medicalization had penetrated far enough into society that this evolving interpretation was the one that underpinned the social response of communities to epidemic disease thereafter, whether plague or otherwise. In the epidemic of 1348, the Florentine authorities immediately appointed eight officials to make sure that the streets were cleaned, that animals were excluded from the city center, and that foul-smelling occupations (barbering, tanning) were halted. Here public authority implemented policies that clearly responded to a medical interpretation of the cause of the epidemic, and in the decades thereafter towns developed further policies responding to theories about the mode of transmission as well: inspecting and isolating infected houses, isolating victims, quarantining the city as an epidemic approached, though authority remained in municipal hands and physicians were not the agents of control. Still, their discourse shaped public action.

Here Milan provides an exceptional case, because of the centralization of government in the Duke's hands. There, from 1399, the city physicians were involved not only in treating the public during epidemics but in consultations directly bearing on ducal health policy; their confident diagnoses of the disease — who had it? in what part of the city was it truly to be found? — shaped his decisions as to what quarantine measures were necessary. By the middle of the next century, *all* causes of death throughout the city were expected to be diagnosed and recorded by Milanese physicians, not (as previously) by neighbors (Nicoud, 2011). Illness was now defined by physicians. This is again the idea expressed by the judge in Vic in 1333 — *medico est credendum in sua arte* — but the scope of "his art" was continually expanding.

This new confidence in the learned physician is what underlies, from the late 13th century on, the extension of "his art" to still other fields where his accepted expertise could replace prejudiced or self-interested testimony, exactly as in the case of leprosy but now in areas that hadn't previously had particularly medical overtones. This is especially visible in the courts of law in Spain and Italy, where, in the second half of the 13th century, appeals began to be made to physicians to decide on matters of fact in cases like homicides, poisonings, and assaults, with the appeal made sometimes by an individual and sometimes by a judge (McVaugh, 1993; Nicoud, 2011; Shatzmiller 1989). What was often at issue was the severity of a victim's wounds, which were assessed after the attack. If the victim was dead or dying after a scuffle, determination of which wound was the fatal one would determine who was responsible for the death. If all the wounds were declared to be non-fatal, the attacker would not be penalized for murder even if the patient later died — it was assumed that the victim had not taken proper care of himself and had brought his death upon himself.

Originally, officers of the court had made such decisions, but by the end of the 13th century they were being gradually turned over to physicians. This happened particularly early in Bologna, at just about the time that its medical faculty was taking shape: the first surviving document requiring an examination by physicians (two of them) instead of notaries is from 1265. Twenty-five years later it was ordained that a list of well-established city physicians be drawn up, and that the two physician-examiners should be chosen by lot from that list (Fasoli & Sella, 1937, pp. 172-4); then in the 14th century a new qualification was introduced for such physicians — three years of academic study and two of practice. Their decisions, sworn to before a notary, described their careful examination of the victim and gave a conclusion based upon their rational consideration of the facts. The same pattern can be seen across the Mediterranean in Catalunya, where it was equally widespread. Defendants and plaintiffs liked the system because it was objective — the physicians swore to *dicere veritatem* — and not subject to arbitrary or biased judgment: the physicians would be paid a fee whether they decided for the victim or the attacker. Here medical authority — based on the scientific judgment of physicians recognized as *experti*, as *periti* — was accepted as superior to mere lay opinion in a matter of law.

Another rather different instance of the replacement of lay opinion by medical expertise can be observed in the Mediterranean slave trade, especially as it developed in the later 14th and 15th centuries. Buyers were always wary that the seller might not reveal faults in their human merchandise, so they would strip and examine slaves for concealed physical defects that might prevent them from working; the Valencian *furs* of 1329, for example, promised legal recourse to buyers who could prove to a judge that they had been tricked in this way when they bought a slave or, for that matter, a horse. At the outset, cases rested on self-interested claims by the opposing parties. Carmel Ferragud has found that in Valencia, starting in the last quarter of the 14th century, academic medical practitioners began to be routinely appealed to, to help the court in its judgment: typically, one was called by the defendant and another by the plaintiff; they examined the slave independently and reported their findings,

with their diagnoses typically expressed in the language of Galenic medical theory (Ferragud, 2010). Thus in a wide variety of instances, from extraordinary epidemics to the proceedings of daily life, what society understood as sickness or injury was defined by physicians, as neutral and disinterested *experti*: these were not merely social categories now but medical ones.

2. But if sickness and infirmity were being medicalized, so too was health. Again a modern analogy may not be too far-fetched. We may feel happy, comfortable, perfectly well — and then our physician tells us that nevertheless we are *not* healthy: it has left us no signs, but even so he can tell that we have hypertension and will have to take medicines and exercise to lose weight if we want to *become* healthy. To know whether we are healthy today, we cannot trust our self-perception, we have to appeal to medical expertise to define the condition for us. And indeed something very like this attitude was emerging in the later Middle Ages: physicians were coming to insist on the fact of a neutral state between health and illness, in which the patient didn't know that he wasn't healthy, but the expert physician did, could recognize that he was on the way to becoming obviously ill, and could advise him on the appropriate treatment.

Here a central feature of medieval Galenic medical theory comes into play, the "non-naturals." These are factors distinct from the patient and his body that nevertheless inescapably shape his health: the air and the environment, food and drink, exercise, sleep, and the like. To the learned physician, delicious food, sound sleep, fresh air, were not simply things to be enjoyed in themselves, they were therapeutic tools — or, of course, causes of illness. To someone steeped in Galenism, the outside world was not neutral at all, it was loaded with medical meaning, for better or worse. This is the system that the new academic medicine promoted and that its clients automatically accepted: in the process, for the public now as well as for the physicians, the external world was becoming medicalized.

The most obvious sign of this acceptance of a medicalized external world is the explosion in the 14th and 15th centuries of a particular genre of medical literature, the *regimen sanitatis*, which described how one should manipulate the non-naturals so as to live a healthy life (Gil-Sotres, 1996; Nicoud, 2009). It was aimed at the noble and bourgeois elites, who could afford to choose what they ate and how they lived, and Latin and vernacular examples spread widely through Europe. As urban elites encountered this system, with medical expertise behind it, these entities took on particular medical meaning: air could be healthy or unhealthy, food of the wrong kind could be eaten, food could be eaten to excess or eaten at the wrong time, and so forth. Now, over-eating and under-exercising were understood to be bad for health; just as obesity is targeted today, these were not just points on the spectrum of the human condition, but situations with implications for health. If you took *regimen* seriously, your actions in daily life were governed not by your desires and immediate pleasures but by your concerns for health. You might like peaches, but your enjoyment would be tempered or marred or overlaid by your knowledge that Galen had taught that fruit was bad for your health and was responsible for recurrent fevers.

These regimes — *regimina* — were relevant throughout life, and there is evidence that their principles were inculcated in children from an early age; certainly in the case of noble families, like the Dukes of Milan (Nicoud, 2008). To be sure, there was an inevitable tension between the healthful regime of temperance and the noble obligation to display excess as a manifestation of power, a tension that was not always resolved as the ducal physicians would have preferred; but even so the conviction was bound to be engrained that all aspects of life had medical implications, whether you obeyed them or not. And if they were not obeyed, if patients became ill, their physicians' advice would be couched in the same terms as well. We see this in the *consilia* that are such an important witness to the practice of the great Italian physicians of the 14th and 15th centuries: their content shows us how they thought, of course, but thus also how their patients had been trained to think. When the noble gentleman Giovanni da Barzinona came to master Ugo da Siena with panic attacks and depression, the first thing he was told to do was to control the non-naturals: live in clean air, take exercise in the morning on an empty stomach, ensure he slept well by taking lettuce and white poppy, evacuate regularly, especially in winter, and avoid vinegar with his meals — all expressing the impact of the non-naturals on his health (Lockwood, 1951).

The idea of a pattern of life sensitive to considerations of health was not new, of course, and the non-naturals went back to classical times. What was new in the later Middle Ages was the extent of their impact, through a culture-wide acceptance of the new medical ideology, and its institutionalization in various ways. Consider what happened to thermal baths, or spas. Of course baths were known and used back into classical times, certainly in the 12th century, but it is not at all easy to be sure whether at that time their function was therapeutic or simply recreational. However, in the later Middle Ages, particularly in Italy but also in Spain, their use became shaped distinctively by medical thought and professional interest. Bathing fell under the non-naturals, as a way to affect health through the body's environment, and Italian physicians in the 14th century began to assert their ability to judge the waters' contents, to evaluate their effect

upon the body, and to establish therapeutic rules for their proper use. They began to accompany their patients to the baths, or establish themselves there, giving advice to the owners or to public authority on the proper design of the baths. At the same time we see appear the first of what will be a long series of learned treatises on baths which pass into vernacular translations for still wider popular diffusion. These writings by Italian physicians — from Gentile da Foligno in the 14th century to Michele Savonarola in the 15th — listed a spa's medicinal properties and laid down the rules for its proper use, often including the details of a dietary regime that patients should follow as they took the water. Once this happened, there could no longer be any question: thermal baths were not just to enjoy, they had real effects on health that experts could explain (Nicoud, 2005). In the same way, many other features of everyday life were assuming medical implications in the later Middle Ages.

Let us conclude by personifying this idea of medicalization in one particular individual, the poet Petrarch. Petrarch is a good choice because he is well known as someone who was deeply skeptical, even scornful, of the claims of the learned medicine we have been emphasizing; a kind of humanist self-medication was what he believed in. Even so, he could not avoid being influenced by the medicalization going on in the 14th century. Two of his good friends were also learned physicians, Giovanni Dondi of Padua for one, and he occasionally let them give him advice — only out of friendship, he said, not because he really believed them. Yet in 1364 Petrarch had a terrible attack of what his friend diagnosed as scabies, and he went to the hot springs at Abano and actually put himself under a physician's care there. That physician may in fact have been Dondi, who had an almost proprietary interest in those particular springs and wrote a book about their medicinal properties a few years later. In January 1365, Petrarch was still complaining to Boccaccio about his scabies, but by May the episode was over. A few years later, in 1370, Dondi gave the poet a *regimen sanitatis*, focusing on diet; Petrarch's reaction this time was to say that he would follow the part he thought was good for him and discard the rest. What these two events show is that whether or not Petrarch believed that the recommendations of learned medicine were all sound and whether or not he thought its treatments worked, he unconsciously took for granted the foundations on which it was grounded, accepting the idea that the body's health was constantly being affected by non-naturals like food, the underlying idea of the *regimina sanitatis*. Likewise, he accepted the disease label of "scabies" that the professionals gave his condition; and he accepted that thermal springs can have a therapeutic effect on the body (McVaugh, 2006). In such respects Petrarch, along with much of the Mediterranean world of the 14th century, had unconsciously been "medicalized" — in his case, in spite of his own convictions.

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