Inquiry: The University of Arkansas Undergraduate Research Journal

Volume 2 Article 9

Fall 2001

Medicine and Health Care in Later Medieval Europe: Hospitals, Public Health,, and Minority Medical Practitioners in English and German Cities, 1250-1450

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MEDICINE AND HEALTH CARE IN LATER MEDIEVAL EUROPE:

HOSPITALS, PUBLIC HEALTH, AND MINORITY MEDICAL PRACTITIONERS IN ENGLISH AND GERMAN CITIES, 1250-1450

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Abstract

Hospitals and individual caregivers helped meet the physical and psychological needs of medieval people, just as they do today. My overall objective is to explain social and individual responses to disease within the context of Christian theology and the urban community, focusing on England and Germany in the period between 1250 and 1450.

First I investigate social responses to disease, including hospitals and public health ordinances. Christianity mandated the care of the afflicted, yet physical and mental illness was associated with sin and divine punishment. Urban authorities often attempted to deal with plague outbreaks by imposing quarantines and strict regulations on minorities and outsiders. In addition to these more immediate concerns, the experience of plague permeated every aspect of medieval European culture, from the philosophy of health care to artistic representation.

Next I discuss individual encounters with disease, focusing on the ambivalent positions that female and Jewish physicians occupied within the medical profession. Women were perceived as nurturers with natural healing abilities. In spite of restrictions on formal university education, many women trained privately under male physicians. Jewish physicians exerted a considerable influence on the medical profession, even though religious and racial discourse pervaded popular perceptions of their work in the medieval urban community. Yet municipal authorities occasionally engaged the services of Jewish physicians, and Jewish doctors often treated Christian patients. The roles of minority medical practitioners illustrate tolerance as well as prejudice, one aspect of the ambiguity that characterizes medieval views of health care and disease.

Introduction

Health and disease have always been of paramount importance to people, and the goal of medicine remains constant in every place and time: to ease human suffering. Thus the history of medicine holds lessons not only for the social historian but also for the practicing physician and the public health policy-maker as students of human nature and condition. This interdisciplinary study, written from the standpoint of an aspiring physician, seeks to contribute to the humanistic dimension of medicine by helping to integrate it further with its past, illuminating the meaning of health and disease in medieval society while adding depth to current thinking about medicine and public health. This study places various aspects of health and disease within the framework of two major topics, religious beliefs and urban social history. Nowhere do these important aspects of medieval society appear more intertwined than in ideas about health and disease. I have restricted the focus of my research to English and German towns in the time period between 1250 and 1450, grounding these issues in a Western European context.

Hospitals and Public Charity

The first chapter of this study investigates the normal spectrum of disease in urban communities, and the attempts to come to terms with these problems through the endowment of charitable institutions such as hospitals, originally conceived as institutions devoted to the aid of the "sick poor." From the beginning, Christianity mandated the care of the afflicted, and hospitals fulfilled part of this responsibility. Yet Christians also associated physical and mental illness with sin and punishment, and fear of bodily and spiritual contagion tempered the Christian ethic of aiding the poor and sick. In England, the monastic model was especially important to the foundation of hospitals. Because of these ecclesiastical underpinnings, England provides an ideal base for tracing the various legal and moral justifications behind the medieval European hospital. During the course of the Middle Ages, the dispensation of charity in both England and Germany became more of a civic and humanistic goal, in contrast to a Christian communal goal. Hospital charity became more individualized and more fragmented as private citizens gave their resources not to the general poor, but to those they thought were "deserving," or preferentially to specific groups.

Epidemics

The second chapter deals with the extraordinary pressures of epidemics on urban society. Deadly plagues caused dislocation, social upheaval, and sheer human misery. Above all, the Black Death, which began in 1348 and never completely left the European continent until the late 17th century, produced unique cultural and social responses. Overcrowding, poor sanitation, and malnutrition made city dwellers especially vulnerable to plague. The experience of plague resulted in an ever-greater concern with public health in urban areas. In the larger towns of southern and transalpine Germany, for example, there are numerous examples of prohibitions against disposing of waste in the city water supply and selling spoiled fish or meat. Some of these policies metamorphosed into effective public health legislation, and others contributed to negative social attitudes such as anti-Semitism and class envy. Negative and bizarre responses to the Black Death are well documented; the persecution of Jewish communities in the Rhineland provides a grisly example. But the horrors of plague also became a rich outlet for artistic and literary expression, from Boccaccio's *Decameron* to Grünewald's *Isenheim Altarpiece*. In retrospect, the Black Death deeply marked European consciousness for several hundred years, perhaps in much the same way as the Second World War and the Holocaust will mark both European and Jewish identities for centuries to come.

Female and Jewish Medical Practitioners

The final two chapters illustrate examples of individual responses to disease, focusing on the fascinating and ambivalent positions that female and Jewish physicians occupied within the medical profession and the urban social structure. Women were perceived as nurturers with natural healing abilities. Both literary references and archival records of female healers are predominantly positive, even though universities and many medical guilds excluded them in their attempts to gain a professional monopoly. In spite of such restrictions, many female healers learned their trade under male physicians, who were often members of their families. Jewish physicians exerted a considerable influence on the Western medical profession, even though religious and racial discourse pervaded popular perceptions of their work in the medieval urban community. Yet municipal and clerical authorities occasionally engaged the services of Jewish physicians, and Jewish doctors often treated Christian patients. Interestingly, many Jewish healers were also women. The roles of female and Jewish medical practitioners illustrate tolerance as well as prejudice, just one aspect of the ambiguity that characterizes medieval views of health care and disease.

Conclusions

In spite of elaborate attempts to explain plague in naturalistic or theological terms, the illness forever diminished confidence in Western medical tradition, as characterized by the Galenic theory. Dissatisfaction with the capabilities of medicine helped drive curiosity about the mode of infection, building on the existing rudimentary contagion theory. Intellectual curiosity in many ways threatened the medical establishment, which depended on the synthesis of older ideas rather than the discovery of new ones. Naturalistic explanations, originally motivated by belief in an all-powerful God, led to a more direct concern with the human body and its function. These developments paved the way for the modern scientific and empirical approach to medicine.

Such change was not necessarily progress. In fact, some things about it were very negative. Unfortunately, the institutionalization of public health on the municipal level often went hand in hand with the more negative aspects of social hygiene. Public health developments often degenerated into unfair and restrictive legislation against the unsightly, disease-ridden poor and the Jews, the scapegoats of European society. Even Christian charity in some ways became a reflection of increasing antagonism toward the poor, and a need to control them by means of institutions like hospitals. The original motivations behind public welfare and public heath, Christian piety and communal responsibility, sometimes degenerated into hostility toward the very members of society they were supposed to protect. Fear of contamination intertwined with a pious sense of duty affords some of the deepest contradictions in medieval urban society.

During the time period considered, the medical profession in England and Germany progressed from an informal system with only a handful of university-trained practitioners to a profession licensed and regulated by the Church, civic authorities, and independent guilds. The new self-consciousness of the medical profession inevitably led to protectionist tendencies, resulting in attempts to exclude traditional and informal healers. As early as the 12th century, a Salernitan regimen, *Flos medicinae*, had proclaimed: "The unlettered, the empiric, the Jews, the monk, the actor, the barber, the old woman—each pretends to be a doctor, as does the alchemist, the maker of cosmetics, the bathkeeper, the forger, the oculist. While they seek profit, the power of medicine suffers."[1] The gradual process of excluding these unwanted practitioners from the "respectable" profession of medicine took several centuries, but it was one step in the creation of a common licensing system for physicians, a system that we take for granted today. Such a formal system is exclusionary by nature. But ironically, the very system that shut out women and Jewish doctors in the Middle Ages ultimately metamorphosed into something like a meritocracy, accepting the qualified regardless of gender, race, or creed. The development of a uniform education and licensing system for physicians in the Middle Ages helped produce the elevated expectations of medicine that characterize contemporary Western societies.

The informality and deregulation of most health care attests to the great variety of needs and expectations in medieval society. Subject to licensing, regulation, and standardization,

medical practice ultimately became more responsible, and malpractice prosecutions had become commonplace as early as the 14th century.[2] Between 1250 and 1450, European medical services shifted from the sphere of Christian charity to the domain of the marketplace. On one hand, the medical establishment sought an exclusionary formalization of education and licensing. On the other hand, many potential patients resisted the systematization of their health care options, seeking treatment based on a wide variety of factors—skill and success level, fees, and local availability. If the cure seemed worse than the disease, people did not flinch from finding a theologically questionable doctor, if this offered them some hope of a cure less invasive and painful than those offered by Christian lay physicians and more certain than those promised by the saints.

Medieval charitable institutions, the beginnings of public health, and the contributions of minority medical practitioners came together to shape early modern attitudes toward compassionate care. The gradual shifting of public charity and social responsibility from the Church first to private citizens and then to governments has enabled secular societies to retain a strong ethic of caring for the sick and helpless. The benefaction of hospitals and the existence of charitable organizations are dependent on this ethic, and not exclusively on religion. Ultimately, medieval Christianity helped provide valid foundations for the exercise of charity in a philanthropic context, rather than a dogmatic one. As medieval Christians knew without a doubt, bodily and spiritual welfare are closely intertwined; the best caregivers are those who can provide spiritual strength and comfort in addition to alleviating physical ills. In this study, I have described various attempts to achieve the enduring values of life and health within the framework of medieval society. Such endeavors, both social and individual, delineate the philosophy of ethical caregiving, which is the proper goal of medicine in all times and places.

Endnotes

[1]Quoted in Park, p.76
[2]Shatzmiller, p.80

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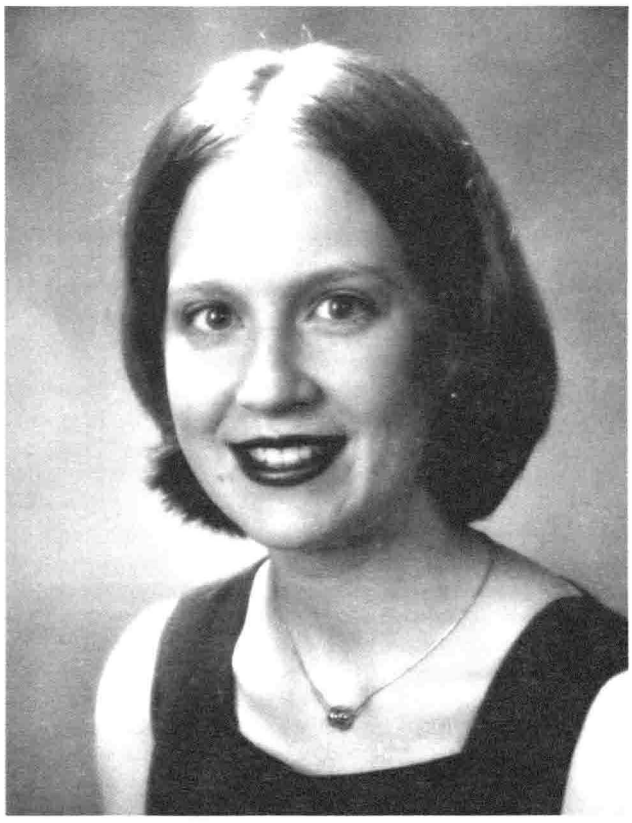

Anna Terry

Faculty comments

Mark Cory, Professor of German and director of European Studies, functioned as Ms. Terry's faculty mentor for this project. He had high praise for Ms. Terry's work. In his letter of recommendation, he said:

> As became clear from her selection this year as a Rhodes Scholar, Anna is an intellectually ambitious, superbly accomplished student. With her years of musical training and her orchestral experience here and abroad, Anna could become a professional musician. With her twin majors in German and European Studies, she could pursue graduate study in either of those fields. For the four and a half years I have known her, however, she has held firmly to her goal of becoming a physician. The article selected last year for the premier issue of *Inquiry* reflects her accomplishments in the BS program in biochemistry central to her pre-med preparation. I have no doubt that she will reach this goal, although she will spend the next two years reading for the M.Phil. in Economic and Social History under the auspices of Oxford's Wellcome Unit for the History of Medicine.
>
> The study abstracted here is preliminary to her course of study at Oxford. Intrigued by public health issues and by the way late medieval Europe responded to the challenges of ever greater urbanization, she has chosen for her senior honors thesis a consideration of the way early modern attitudes toward compassionate care were shaped by the Church in general, and by the contributions of minority practitioners (women and Jews) in particular. She has both the scientific and humanistic training for an interdisciplinary project of this sort. Her year of study and travel abroad in Europe has given her first-hand experience with the palpable legacy of medieval societies. She can read German source materials in the original. Her record gives every confidence that the product of her undergraduate research will be solid, literate and persuasive. Measured against the enormous pressures exerted in virtually every curriculum towards fragmentation and specialization even at the undergraduate level, the attainment of a genuinely well-rounded education at the highest levels of performance is nothing short of an outstanding intellectual endeavor. Most students at her point in their studies are driven to begin medical school immediately, perhaps because they have set their sights on beginning their careers. Anna's focus is on the quality of her journey, rather than on the punctual arrival at a given destination. The study she proposes

will add great value to her journey, and ultimately to the kind of contribution she makes as a physician. She understands, accepts and acts on the oft-cited wisdom that our best physicians must be more than superb technicians, but rather they must be mature and complex individuals with interests and experiences as varied and filled with highs and lows as those of their patients. I predict that a future biographer will one day reflect on the notable career of Anna Terry, Surgeon General of the United States, and observe that the intellectual reach of her two submissions to *Inquiry* marked the real beginning of a remarkable career.

Lynda Coon, historian and Director of the Humanities Program, had Ms.Terry in several classes. She is equally enthusiastic about Ms. Terry's abilities. In her letter, she commented as follows:

> In 1996, Ms. Terry won a prestigious four-year grant (Sturgis Fellowship, Fulbright College, University of Arkansas) for which students compete throughout the South, Midwest, and West. I met Ms. Terry when she was a first-year student in a team-taught, Honors Humanities Project (Fall 1996-Spring 1997). This National Endowment for the Humanities-supported course is a four-semester sequence integrating core courses in world history, world literature, and the visual arts, and only four-year honors scholars with superior ACT scores (above 31) enroll in this interdisciplinary program. The teaching teams for the first and second years agreed that Ms. Terry was *the* top student in the course--an amazing fact considering that students in this course won all the major University-wide academic awards at the 1999 Honors Banquet. In the Honors Humanities Project, Ms. Terry wrote a number of papers for me, but the one that sticks out in my mind (even though it was completed over three years ago) was her brilliant analysis of the Gothic church of Ste.-Chapelle and its inventive visual re-creation of the most pressing theological (sacred kingship) and militaristic (the Crusades) issues of the period.
>
> More recently (Fall 1999), Ms. Terry enrolled in my upper-level course on late medieval Europe. Again, she was by far the top student in the course (superior to the graduate students!). She never came to class unprepared, and her enthusiasm for the subject matter was so infectious that she often induced more reticent students to join in the dialogue. Her best paper in that particular course involved a detailed analysis of the c.1080 material culture source for the Norman invasion of England, the Bayeux Tapestry. Specifically, in her paper, she argued that Biblical exegesis informed much of the artistic work of the Tapestry. Furthermore, she examined how historical "memory" is continuously re-written by each successive generation, and, that in this case, even only twenty years after the conquest, politics and ideological concerns of the post-conquest generation were ingeniously interwoven among the obvious "facts" of William I's victory over the Anglo-Saxons. This was a highly sophisticated work--much more the kind of meticulous exegesis I would expect from a graduate student. Furthermore, because Ms. Terry has traveled widely in Europe, she was the only student to have made the pilgrimage to Bayeux to see the Tapestry firsthand.

I find Ms. Terry's Honors Thesis research to be equally impressive. The topic of medical history in the medieval period currently is a hotly contested one, particularly regarding the intersection of magic, philosophy, theology, and medical practice. Furthermore, as Ms. Terry's research indicates, there are many provocative related issues to the academic pursuit of medieval medicine, including the relationship of gender and ethnicity to scientific knowledge (Ms. Terry intends to examine sources that deal with women and medicine as well as Judaism and the urban medical community in Southern German towns, c. 1400-1500 CE). Ms. Terry not only possesses the requisite oral and written skills to carry out a research project that requires a great deal of reading in the German language (she has passed the difficult *Deutsche Sprachprfifungfifir den Hochschulgang*), she has already proven that she can do top-level academic research at one of the most renowned places in the world for medieval studies, the Institute of Medieval History, Munich. Next year, as a Rhodes Scholar at Oxford's Welcome Unit, Ms. Terry will begin an M. Phil. in Economic and Social History with a sub-field in the Social History of Medicine. A degree from this prestigious program accommodates both Ms. Terry's Humanistic research interests and her career goal to become a practicing physician with a special interest in pain management theory.