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Provision and access to healthcare  
in a historical perspective

Editors

Martin Dinges, Jan Sundin and Sam Willner

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# Preface

Sam Willner

**W**e are very pleased to be able to present this thematic issue of *Hygiea Internationalis* and to welcome guest editor Professor Martin Dinges from the Institute for the History of Medicine of the Robert Bosch Foundation in Stuttgart, to introduce the selected articles. This issue deals with the provision of and access to health care in different historical contexts and is based on selected contributions to a conference on “Health and Health Care between Self-Help, Intermediary Organizations and Formal Poor Relief (1500–2005)” which took place in Braga Portugal in July, 2004. We would like to express our sincere thanks to Professor Dinges and the authors contributing to this interesting volume.

The next two special issues of the journal (which are planned to be released during spring 2007) will contain articles on policy and cultural history of public health respectively, largely based on selected conference papers. Our intention is to publish *Hygiea Internationalis* more regularly in the future, producing at least two volumes each year. To make this possible we are to a large extent dependent on the contributions from our readers. Thus we invite you to submit articles, dealing with the history of public health, for coming issues of *Hygiea Internationalis*.



# Introduction to the Volume:

## Situating Health-Care: An Historical Perspective

Martin Dinges

Where healthcare is provided and accessed are the two questions discussed in this volume – from a historical perspective. Today healthy persons in wealthier countries are more and more occupied with practices supposed to keep themselves in good health: in a society with many people working in sedentary occupations regular physical exercise is one topic; the choice of a healthy not too abundant nutrition another; and avoiding smoking or excessive drinking a third issue. The general diffusion of preventive health care is – considered from a historian's point of view – a rather late achievement. No doubt, antique dietetics and its rediscovery since the Renaissance provided some of this knowledge in an earlier form, but the current interest in regular preventive health practices is partly linked to new bodies of knowledge, partly to increasing wealth and to a certain extent to the result of hygienists' impact on the everyday life of people from all social strata since the end of the 19<sup>th</sup> century.

Self-medication now plays an important and often underestimated role – some medical sociologists attribute an important share of the market for pharmaceuticals ranging from one fifth to one half of the sales in different post-industrial societies to this practice – without counting the variety of esoteric and other “pseudo-medications”. Self-medication was even more important when professional medical care was not at the disposal of the majority of the population – as is presently the case in many countries of the so-called “developing countries”. Nevertheless, under the recent austerity measures in several welfare states, people reconsider whether to attend the physician and obtain a prescription or to decide on their own about another – directly accessible – medication. In Germany, at least during the last few years, the market share of self-medication has grown significantly under these financial pressures.

Considering the other side of the coin, the provision of health care, the present debate reconsiders the hyper-professionalisation of health care and its side effects, mainly high and fast growing expenditure. For more than a generation, the growth rate of the medical market has been faster than almost any other sector in nearly all “industrialized” countries. Together with an ever aging population this is begin-

ning to overstretch the affordability for medical care in these societies.<sup>1</sup> This situation has encouraged public debate about the possible role of voluntary, non professional aid and about other – often supplementary – actors in the medical market beyond general insurance and/or national health care schemes. Financial considerations were, and still are, predominant in these debates; questions of the quality of care unfortunately play still too little a role.

This critical public debate was the incentive for us as historians to organize a conference on “Health and Health Care between Self-help, Intermediary Organizations and Formal Poor Relief (1500–2005)”, which took place in Braga, Portugal, 2–4 July, 2004. It was co-organized by Prof. Marta Lobo de Araújo of the Universidade do Minho in Braga and Prof. Martin Dinges from the University of Mannheim and the Institute for the History of Medicine of the Robert Bosch Foundation, Stuttgart, Germany, under the auspices of the PhoenixTN (European Thematic Network on Health and Social Welfare Policy), and its coordinator Prof. Laurinda Abreu, Evora, Portugal, who also participated in the scientific committee. The more precise aim of the conference was to reconsider the dominant historiographical interpretation of the development towards the welfare state by exploring a new and fresh approach based upon local experiences in various European countries – as this is the particular opportunity provided by such a European Thematic Network.

The traditional narrative of the inter-relatedness of self-help, intermediary organizations and formal institutions was formulated, until recently, in the following way: when, in the time of late medieval cities, self-help failed to cope with health and care problems, mutual help was a partial substitute which led to the creation of intermediary institutions. These institutions were overburdened by rapid population growth, mainly since the sixteenth century, which in turn led to an ever growing commitment of the early modern city and – later – the territorial „state“ in this field, aiming to take over the guidance of the entire health care sector. National health-care insurance systems of the European type were the epitome and the definite result of this long-lasting historical process. In consequence, informal institutions are supposed to have played an ever more marginal role.<sup>2</sup>

It is only since the debate about the crisis of the welfare-state and more precisely of its healthcare budgets that new considerations of the relative role of self-help, informal and formal institutions have found their way to a wider audience. These ideas changed the agenda of historical research. Since the 1980s, the linearity of historical development and its irreversibility are under discussion. The relative role

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1 Dörner, 2004, 25–33, 45–52.

2 Some of these questions were addressed in an earlier conference of PhoenixTN (European Thematic Network on Health and Social Welfare Policy), and are published in Abreu, 2004, cf. the section introduced by Dinges, 2004a; Dinges 2004b.



of self-help, informal and formal institutions and their interrelatedness is now considered in a more open-minded way: Informal solutions may indeed be better solutions for certain health-problems than solutions by formal institutions. European history provides plenty of examples for different ways of inter-relating the three above-mentioned sectors.

In consequence, one important aim of this conference was to reflect upon the interrelatedness of the three levels of health-care throughout the ages. In the call for papers we stated: “Many perspectives are possible. Here are some examples, such as the patient’s point of view: patients’ attitudes or practices from a particular sector may have an impact on other levels of health-care. From an institutional point of view it may be interesting to look at the users – as for example ill children – who may get into an institution, then return to the family and finally go back to the institution. Patients’ recommendation of specific types of healers may influence the medical market as behaviour and recommendations of the providers of health-care may have effects on individual decisions.

For an analysis of health concerns and practices it is the individual who must be the starting point. Health is intimately linked to healthy and unhealthy lifestyles. These lifestyles were always based on a certain body of knowledge, which circulated between the oral tradition of any given community and the literature of hygiene. Since the invention of the printing press and especially since the general diffusion of the periodical press, an enormous growth of information on healthy lifestyles has developed.

Therefore, healthcare as an individual or collective practice changed during the centuries in relation to the available body of knowledge. The forms and results of these everyday practices are still largely unknown: an entire field of research covering healthy nutrition, smoking habits, the intake of drugs and the various forms of sports are part of it. Concerning more medicine-related practices, self-medication is an important issue: recent studies show the large impact of this practice on the pharmaceutical market.

Self help in health matters is practised within the family – be it a nuclear or an enlarged family, in households, neighbourhoods, and other networks, as for example networks of friends. Working relations and even relationships based on accommodation may play a role. All these person-based relationships play an important role in patients’ choice of medications, healers, lifestyles, and health-care institutions. It is important to acknowledge this essential role of self-help in health and healthcare.

Healthcare is secondly in the hands of more or less informal intermediary organizations such as religious associations or other brotherhoods, during later centuries in other self-help organisations such as labour-unions, charitable associations, friendly societies or other types of non-profit organisations. Their specific motivation often shapes the kind of health care priorities. It makes, for instance, a

difference, whether denominational competition is at work or not. It also matters whether upper class people – as for example entrepreneurs – have the intention to help third persons or whether workers want to help themselves and their families by founding friendly societies. These different informal institutions “invent” therefore different health care needs. They prefer solutions that suit their political and social goals.

The bulk of research focuses on formal institutions as an important provider of healthcare. Hospitals, insurance companies, and healthcare schemes of national states are the typical examples of these institutions. Even inside these formal institutions, the interrelatedness between self-help and help by third persons can be traced. One example could be a patient’s attitude to nursing.”

To have cited the call for papers for the conference in Braga so extensively, serves here to illustrate the large scope of issues, which was suggested to the participants. Only a part of these proposals has been taken up and reshaped by the authors according to the actual state of their research.

The contributors of this volume are mostly established scholars; some are just finishing or have just finished their Ph.D. We preferred to present here a small choice of the papers of this conference.<sup>3</sup> Functioning as a European Thematic Network, the geographical and thematic scope of the volume is large. The authors address the above developed issues for four European countries: Germany, Malta, Spain, Switzerland. Fortunately some of these papers concern so-called smaller countries, which are ordinarily not sufficiently taken into account in the international debate about the roots of the Welfare State. No doubt, it is one of the positive results of the recent cooperation in the human sciences under the auspices of the European Union that the specific experiences of these countries are ready to be more and more integrated into a more differentiated vision of the continent’s history. This choice intends to add to this development.

To put patients’ choices to the foreground, it is appropriate to start with a paper about an individual experience, Susanne Hoffmann’s „Illness and Self-Help in Late Eighteenth-Century Rural Switzerland: the Strategies of Ulrich Bräker (1735–1798)“. Bräker presents an exceptionally well documented life history representative of the large population of small peasants in Europe, we know so little about. As he left more than a 1500 pages of (a recently printed) diary he allows rare insights into the medical behavior and preferences of such a peasant family, active in small-scale trade inside the Swiss canton of St. Gall: most of the medical aid was organized internally in the household and within the wider network of family and friends. Together they provided the material, economic and immaterial resources to cope with ill health. The help of medical professionals was sought in less than three percent of illness episodes. Hoffmann reconsiders the reasons for these

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3 A larger choice of papers is in press: Dinges 2006.

choices proposed earlier by McCray Beier and underlines the partial overlapping of formal and informal aid.

Even if the role of self-help was not as predominant in the city as it was on the country side, Philip Rieder nevertheless shows in his article on „The Poor and the Patient: Protestant Geneva in the Early Modern Period“, the extent to which this municipal medical market and its rural surroundings were dominated by the patients' demand. His example is particularly significant, because Calvinist Geneva must be considered as a paradigm of a „well-policed“ city. Lay suspicion of all sorts of healers guided not only individuals, but also the public authorities, who tolerated and even funded the services of non-regular healers – notwithstanding legislation regulating the opposite. Introducing the category of class, Rieder shows that the rich had more affluent ways to choose, but it seems that the poor possibly received in the end the same kind and quality of medical care as the better-off citizens.

John Chircop addresses in his paper “Old age coping strategies of the Ionian and Maltese poor, 1800–1865” the question of how people could get the resources for health care and survival when getting old, ill, partially disabled and consequently (partially) unemployed. In his inspiring case study he follows their tactics to bring together aid from all three aforementioned societal levels considered in this publication: the household and the neighbourhood, the intermediate organisations and the state. He underlines to which extent these elderly poor have to be considered as active players, who tried to safeguard a certain independence by avoiding exclusive reliance on only one or two of these providers of aid.

Pilar León Sanz turns her attention to „Professional Responsibility and the Welfare System in Spain at the Turn of the 19th Century“. As in other European states around 1900 the Spanish physicians had to make up their minds about the emerging system of public health in which a general or national health insurance scheme was often a matter of debate. The tempting option to enlarge the access to healthcare to the entire population was here as everywhere linked to the less attractive side of the coin, which was more influence for assurance companies. Sanz analyses the arguments of the Spanish physicians, who reacted with a certain time lag as compared to the European debate, but beyond corporatist reflexes they showed in general a positive attitude to the new opportunities and challenges.

The impact of public debate and political interests on institutions dealing with health is particularly evident in the case of hospitals, which form the topic of the third section „Hospitals as a Result of Medical Choices“. Fritz Dross strongly makes his case of this perspective in his „The Invention of a Medical Institution? The Discussion of Hospitals Around 1800“. Insisting on the one generation-long debate about the advantages and disadvantages of a municipal hospital in the Rhenish town of Düsseldorf as an alternative to the traditional home-care, he makes clear the extent to which a hospital represents a negotiated form of order.

Such an institution which seems to us from the perspective of the 21st century – and having the consequent development of the clinic as the pivotal institution of medical modernity in mind – as completely self-understanding, was the result of choices not necessarily as evident for the contemporary perspective of the early 19th century.

All these papers invite further research, which could and should first try to take the results obtained by research about earlier periods as a starting point for research about later moments in history and vice versa. This could sharpen the sense for continuities and discontinuities in the field of healthcare and might add to a better understanding of some of the solutions and problems in the so-called developing countries. Secondly, one could and should focus on the very specific circumstances and conditions of these almost national, regional or local experiences and developments. Enlarging such an approach might lead to a better understanding of European communalities, time lags and mutual inspirations. If this choice of contributions from very different strands has contributed to open the attention of the scholars to such comparative research – as the conference itself did for the participants – it has already attained a part of his objectives.

I want to express my special gratitude to Dr Mickey Chopra, Director of the Health Systems Research Unit of the Medical Research Council in Tygerberg, South Africa, who has done an excellent job in copy-editing the contributions for this book.

*Martin Dinges* is Deputy Director of the Institute for the History of Medicine of the Robert Bosch Foundation, Stuttgart, Germany and Adjunct Professor of Modern History at the University of Mannheim, Stuttgart, Germany.

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# Illness and Self-help in Late Eighteenth-Century Rural Switzerland

## The Strategies of Ulrich Bräker (1735–1798)

Susanne Hoffmann

In a representative survey on health care in Germany just 35 percent of the interviewees over 16 years recently maintained that they immediately consulted a doctor when they felt ill – in other words: 65 percent trust in self-help.<sup>1</sup> In comparison, self-help constituted an even more important strategy in early modern times to restore one's health and cope with hardships caused by illness (or other incidents during the course of life).<sup>2</sup> We know from Lucinda McCray Beier's work on Ralph Josselin (1616–1683), the then Vicar of Earls Colne in Essex, that he and people close to him, as he reported in his diary, consulted professional healers only in 2.8 percent of all cases of illness.<sup>3</sup> A similar pattern of health behavior can be seen in Ulrich Bräker's writings.

The Swiss Ulrich Bräker (1735–1798), married to Salome Ambühl (1735–1822) with whom he had seven children, spent most of his life in the rural Toggenburg area (located in the present-day canton St. Gallus).<sup>4</sup> The family owned a house in a

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1 Psychonomics AG, *Health Care Monitoring 2004*, quoted in Heike Krüger-Brand, "Vom Arzt zum Apotheker", *Deutsches Ärzteblatt, Praxis* 101 (2004), 4, p. 4.

2 Cf. Robert Jütte, *Poverty and Deviance in Early Modern Europe* (Cambridge et al., 1994), p. 83. In what follows the term "self-help", as opposed to outside or formal help, will be used for "the ability of individuals to endure a period of poverty or distress beyond the short-term logic of the market economy without asking for assistance", Martin Dinges, "Self-Help and Reciprocity in Parish Assistance: Bordeaux in the Sixteenth and Seventeenth Centuries", in Peregrine Horden and Richard Smith, eds., *The Locus of Care: Families, Communities, Institutions, and the Provision of Welfare since Antiquity* (London, 1998), p. 113.

3 Lucinda McCray Beier, *Sufferers & Healers. The Experience of Illness in Seventeenth-Century England* (London/New York, 1987), p. 198 et seq.

4 Cf. Holger Böning, *Ulrich Bräker: Der Arme Mann aus dem Toggenburg – Eine Biographie, überarbeitete und ergänzte Neuauflage* (Zürich, 1998) for Ulrich Bräker's biography. If not otherwise indicated biographical information (birth and death) of persons in Bräker's surrounding quoted according to Christian Holliger et al., *Chronik Ulrich Bräker: Auf der Grundlage der Tagebücher* (Bern/Stuttgart, 1985), pp. 522–543.

place called Hochsteig close to the village Wattwil and the town of Lichtensteig.<sup>5</sup> Although Bräker tried hard to earn his own and his family's living by spinning, weaving, or trading in cotton in the aspiring textile sector, the family was usually short of money or even in debt – in a word poor.<sup>6</sup> Yet, not least influenced by his pietist background, Ulrich Bräker had taught himself how to read and write, and finally even became a member of the local reading society.<sup>7</sup> Between 1768 and his death he almost continuously kept a diary and in the early 1780s he also wrote an autobiography (published in his lifetime under the title “Lifestory and Real Adventures of the Poor Man of Toggenburg”).<sup>8</sup> In both writings much attention is given to health and health care. Whereas Bräker mentioned a total of 586 cases in his diaries, in which he himself, his wife, children, neighbors, friends, or kin fell ill, he reported only 16 cases, i.e. 2.7 percent, in which a professional healer (surgeon or physician) was consulted.<sup>9</sup> The following sections contain an analysis of the illness-related self-help strategies of Ulrich Bräker and his fellows based on Bräker's diaries and his autobiography as has been recently edited.<sup>10</sup> As there is no in-depth study of health care in early modern rural, and in particular lower-class, households apart from McCray Beier's work on Josselin, the case of Ulrich Bräker will provide us with rare insights into this issue relevant to the renewed history of the patient.<sup>11</sup> The

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5 Cf. Alois Stadler, “Haus und Landschaft bei Ulrich Bräker”, *Toggenburger Annalen*, 13 (1986), 71–80, p. 73 et seq.

6 Cf. Albert Tanner, “Das ganze Land eine ‘Baumwollenfabrik’: Ulrich Bräker als Garnhändler, Weber und kleiner Fabrikant”, *Toggenburger Blätter für Heimatkunde*, 36 (1985), 51–67, pp. 58–61. According to Martin Dinges the term “poor” refers to a status where someone can manage to live at subsistence level without having to call on outside or formal help. “Destitution”, on the contrary, designates a status in which subsistence can no longer be achieved by means of self-help, Martin Dinges, *Stadtarmut in Bordeaux 1525–1675. Alltag, Politik, Mentalitäten*. Pariser Historische Studien, vol. 26 (Bonn, 1988), p. 19.

7 Cf. Alfred Messerli, “Bräkers Schreibprogramme, Schreibmotive und Schreibpraktiken in seinen Tagebüchern”, in Alfred Messerli and Adolf Muschg, eds., *Schreibsucht. Autobiographische Schriften des Pietisten Ulrich Bräker (1735–1798)*. Arbeiten zur Geschichte des Pietismus, vol. 44 (Göttingen, 2004).

8 “Lebensgeschichte und Natürliche Ebentheuer des Armen Mannes im Toggenburg”.

9 Own calculation of author. Note that the initial figure does include a total of 243 references to troubles of mood and soul, most of them referring to Ulrich Bräker, thus the relative importance of formal medical treatment might actually be slightly underrated.

10 Andreas Bürgi et al., eds., *Ulrich Bräker. Sämtliche Schriften, vol. I Tagebücher 1768–1778*, rev. Alfred Messerli et al. (München, 1998); Andreas Bürgi et al., eds., *Ulrich Bräker. Sämtliche Schriften, vol. II Tagebücher 1779–1788*, rev. Heinz Graber et al. (München, 1998); Andreas Bürgi et al., eds., *Ulrich Bräker. Sämtliche Schriften, vol. III Tagebücher 1789–1798*, rev. Andreas Bürgi et al. (München, 1998); Andreas Bürgi et al., eds., *Ulrich Bräker. Sämtliche Schriften, vol. IV Lebensgeschichte und vermischte Schriften*, rev. Claudia Holliger-Wiesmann et al. (München, 2000). In the following Bräkers writings are quoted by date of entry/“overview”/“lifestory”, (volume), page. All translations by author.

11 Cf. Christian Holliger, “Aus Ulrich Bräkers Hausapotheke”, in Helmut Holzhey and Urs Boschung, eds., *Gesundheit und Krankheit im 18. Jahrhundert: Referate der Tagung der*

main focus of the discussion below will include four thematic aspects: self-treatment, thematic networking, taking care of the ill, and economic support.

## Treating Oneself: Self-Medication and Self-Surgery

Ulrich Bräker regularly performed self-treatment in the form of either self-medication or self-surgery when he or somebody close to him fell ill. However, rather seldom Bräker mentioned the type of drugs he relied on for self-medication. Thus, we can only learn from his diary that in 1779 he “took some medicine and let blood”.<sup>12</sup> Likewise the reader is left in the dark about the nature of the “comforting powder” which Bräker gave his neighbor, Luncie in the same year to help him get over his everyday worries.<sup>13</sup> Anyway, there is good reason to believe that in the Toggenburg area everyday items were used as regular remedies, resulting in a rather fluid boundary between foodstuff and drugs and, obviously, moderate costs for treatment (although Bräker did not explicitly comment on the latter).

Foodstuff used to be major remedy in treating Ulrich Bräker’s recurring migraine in summer 1784. As Bräker’s response also provides an interesting insight regarding the relationship between self-help and outside help, a detailed chronology of events is given here. In the first week of August 1784 Bräker suffered from severe headache which he diagnosed as “the so-called migraine”.<sup>14</sup> Bräker immediately considered either taking a bath or letting blood (both were still common medical practices in Eastern Switzerland at that time), but he dismissed these plans soon as he was busy in his job at that moment.<sup>15</sup> Two days after his first reference to migraine and still suffering from “the ever most splitting headache”, Bräker walked to the town of Herisau (a distance of roughly 25 kilometers) for business reasons.<sup>16</sup> In the evening he took a bath there which “did good”.<sup>17</sup> Nevertheless, the “furious migraine” recurred the next day and bothered him on his way back home. Thus, he let blood as soon as he had arrived in town (presumably in Lichtensteig) which brought tem-

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*Schweizerischen Gesellschaft zur Erforschung des 18. Jahrhunderts Bern, 1. und 2. Oktober 1993. Clio Medica, vol. 31 (Amsterdam/Atlanta, GA., 1995) for an earlier, brief overview over health care at Ulrich Bräkers’.*

12 “habe etwas medicin gebraucht und adergelassen”, April 27th 1779, (II), p. 77.

13 “trostbülverle”, June 16th 1779, (II), p. 105.

14 “das sogenandte migrenie”, August 8th 1784, (II), p. 473.

15 Ibid. Cf. Sebastian Brändli, *‘Die Retter der leidenden Menschheit’: Sozialgeschichte der Chirurgen und Ärzte auf der Zürcher Landschaft (1700–1850)* (Zürich, 1990), pp. 83–87 with regard to surgical practice; and Urs Gantenbein, *Schwitzkur und Angstschweiß: Praktische Medizin in Winterthur seit 1300*. Neujahrsblatt der Stadtbibliothek Winterthur, vol. 327 (Zürich, 1996), pp. 45–53 with regard to bathing.

16 “rassentensten kopfschmerzen”, August 12th 1784, (II), p. 473.

17 “es that mir gut”, ibid.



porary relief.<sup>18</sup> Bräker rested for two days after blood-letting and felt quite well.<sup>19</sup> For the next roughly six weeks Bräker did not say a single word about his migraine, and it was only on Friday, October 28, that he reported on being “again seddled with a furious migraine – or however the disease was called – which [did] make [him] very ailing and weak”.<sup>20</sup> The illness forced him to stay in bed for the whole week, and so he planned to consult a doctor the next day (a market day) and follow the doctor’s advice, qualifying that he would be only compliant if the physician’s suggestion pleased him.<sup>21</sup> The following afternoon Bräker walked in fact to Lichtensteig and asked Dr. Wirth for advice who recommended him to bleed. Thereafter, the suffering Bräker spent the whole Sunday at home looking forward for the surgeon to arrive at his place.<sup>22</sup> (Unfortunately Bräker did not comment on the expenses for the professional treatment he had received). And although the blood-letting had brought again temporary relief, the pain recurred the next Monday and was even worse than before. In that situation Bräker eventually fell back on food-stuff: he applied a compress made of egg-white, flour, and spirits to his artery, and used a so-called “foot water” in addition.<sup>23</sup> These two measures finally showed their desired effect and Bräker’s pain slowly decreased. The following Sunday Bräker stated that the “worm in [his] head was still gnawing every day – but only very gently”, and he never mentioned suffering from migraine again.<sup>24</sup> As this chronology of events shows, Ulrich Bräker treated his migraine by relying on a combination of self-help and outside help, while he sought professional assistance (from a bathmaster, a surgeon, and a medical doctor) four times in the aggregate. It is interesting that self-treatment completed a sequence of unsuccessful professional therapeutic interventions; however, it seems as if no other lay person, except Bräker, did provide informal support. In addition it is worth noting that not only informal and formal aid but also different kinds of medical services drew upon each other because, against the background of the surgeons’ monopoly on blood-letting, Dr. Wirth did not perform the proposed bleeding himself, but it was carried out the next day by a surgeon instead.<sup>25</sup>

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18 “wüthende migreine”, *ibid.*, p. 474.

19 August 15th 1784, (II), p. 474.

20 “habe das wüthende migrenie – oder wie diese krankheit heissen mag – wieder am hals – welche mich gantz marode und kraftlos macht”, October 28th 1784, (II), p. 487.

21 *Ibid.*

22 November 2nd 1784, (II), p. 488.

23 “fußwaßer”, November 2nd 1784, (II), p. 488. According to Grimm’s dictionary the term “Fuszwasser” refers either to a foot bath or, especially in Switzerland, to water in one’s shoes, *Deutsches Wörterbuch* (rpt. München, 1984–1991), vol. 4.1.1., col. 1058.

24 “der wurm im kopf nagt noch alle tage – aber auch gar gelind”, November 7th 1784, (II), p. 488.

25 Cf. Brändli, (1990), p. 57.

Coming back to foodstuff, Ulrich Bräker appreciated both alcohol – in particular wine and spirits – and tobacco for curing head- and toothaches not least because of their analgesic effect. However, he was very particular when making a detailed entry in 1795, in that he pointed out the physical and moral dangers of spirits and that from then the only reason for him to have spirits – such “stinking water” – in his household would be their potential usefulness “as a medicine in certain cases”.<sup>26</sup> And the fact that it used to be a heavy toothache which offered adolescent Bräker the excuse to smoke in public for the first time points out the tobacco’s medical reputation in the vicinity.<sup>27</sup> In this context it is interesting to note that Bräker also occasionally applied coldness (or snow respectively) as external pain killer.<sup>28</sup>

Coffee, the consumption of which became popular in industrializing Toggenburg, was valued by Ulrich Bräker and his fellows because of its invigorating effect.<sup>29</sup> Thus, in Mai 1783 weak Bräker was served some cups of coffee by the local pastor after he had fainted and vomited as a result of a surgeon having cupped him to cure his painful toothache. The coffee eventually restored Bräker’s health though.<sup>30</sup>

In 1793 Bräker reports in his diary the story of a man who had just died although he had been served “tea or whey” by his spouse while lying in bed and suffering from nausea after excessive agricultural work.<sup>31</sup> Bräker’s reference to whey applied for the respective purpose is highly reminiscent of Simon-Andre Tissot’s (1728–1797) widely circulated “Avis au peuple sur sa santé”; probably, this was not accidental as Ulrich Bräker had already read this paradigm work of the Enlightenment era focusing on medical education of common people in those times.<sup>32</sup> Therefore Bräker’s literacy must be considered as a resource for self-help, facilitating access to health-related information. It is interesting to note in this context that, apart from “Avis”, he had not only read other works of Tissot, but

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26 “stinkwasser”, “in gewüssen fählen als artzney”, November 1795, (III), p. 594. Cf. also July 7th 1783, (II), p. 414; and September 2nd 1783, (II), p. 425.

27 Lifestory, (IV), p. 395; cf. also January 7th 1780, (II), p. 131.

28 January 7th 1780, (II), p. 131.

29 Cf. Rudolf, Braun, *Industrialisierung und Volksleben: Veränderungen der Lebensformen unter Einwirkung der verlagsindustriellen Heimarbeit in einem ländlichen Industriegebiet (Zürcher Oberland) vor 1800* (Göttingen, 1979), p. 95 et seq. for consumption of coffee in rural Zurich; and Edith Heischkel-Artelt, “Kaffee und Tee im Spiegel der medizinischen Literatur des 17. bis 19. Jahrhunderts”, *Medizinhistorisches Journal*, 4 (1969), 250–260, pp. 250–254 for attitudes towards coffee in contemporary medical theory.

30 May 1st 1783, (II), p. 392; cf. also April 21st to 25th 1798, (III), p. 747.

31 “thee oder schotten”, July 4th 1793, (III), p. 447.

32 Bräker directly referred to Tissot’s “Avis” as early as March 30th 1787, (II), p. 549. For Tissot’s advice to use whey cf. Holger Böning, “Medizinische Volksaufklärung und Öffentlichkeit. Ein Beitrag zur Popularisierung aufklärerischen Gedankengutes und zur Entstehung einer Öffentlichkeit über Gesundheitsfragen. Mit einer Bibliographie”, *Internationales Archiv für Sozialgeschichte der Literatur*, 15 (1990), 1–92, p. 25.

also Cornelius Bontekoe's "Kurze Abhandlung vom menschlichen Leben" as well as Johann Georg Zimmermann's "Von der Erfahrung in der Arzneykunst", two popular books on medicine in the eighteenth century.<sup>33</sup>

It is quite clear though that Ulrich Bräker used all kinds of natural resources which the Toggenburg landscape provided for self-medication. Nevertheless he remains rather silent about any details in his writings, possibly because this knowledge seemed to be too obvious to Bräker. Yet in the 1770s Bräker entered several prayers into his journal in which he praised God particularly for having created herbs, plants, and animals not least as medicine.<sup>34</sup> And above all, when summarizing the year 1771, he casually mentioned that "the wise herbs, like caraway lamb's lettuce nettles, were eagerly collected".<sup>35</sup> Finally, we know from Bräker's autobiography that learning from fellows used to be one way of acquiring such kind of 'pharmaceutical' knowledge; Bräker learned about various plants from his fellows when he was a young herdsboy.<sup>36</sup>

Also animal products served as cheap means for self-help, and in particular animal fat used as an ointment. When "the poor man of Toggenburg" (so the corresponding title) went again on a journey to the general vicinity in summer 1789 and "[his] feet again happened to itch and burn dreadfully", he asked in an inn for "some tallow to rub in [his] feet" which he extensively applied to feet, socks, and shoes.<sup>37</sup> Moreover, in the first half of the eighteenth century animal excrement was proposed as a cheap drug for self-medication in popular pharmacopoeia, for instance in Christian Franz Paulini's widely circulated "Heylsame Dreckapotheke".<sup>38</sup> Ulrich Bräker described its application in two passages of his autobiography (written in the early 1780s), and in particular when he recalled his grandfather's death some 40 years before. Several months before he passed away the old man had dressed a wound on his thumb with "fresh warm cowpat".<sup>39</sup> Unfortunately he used water from a well to wash away the excrement which resulted, at least in the grandson's interpretation, in a lethal dropsy.<sup>40</sup> However, as Bräker never mentioned such treatment with animal excrement again in his diaries (reporting on the years 1768–

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33 Cf. the summary in (I), p. 719.

34 Cf. October 18th 1772, (I), p. 444; August 19th 1773, (I), p. 534; and April 12th 1774, (I), p. 633.

35 "die weisen kreüter, als kümekrut rabüntzle neßlen, wurde fleisig aufgesucht", Overview 1771, (I), p. 261.

36 Lifestory, (IV), p. 387.

37 "fiengen seine füsse wieder an entsezlich zusausen und brennen", "ein bisgen unschilt seine füsse zuschmieren", July 1789, (III), p. 201. "Unschilt" or "Unschlitt" respectively used to be a kind of tallow, that is an animal fat of harder consistency, cf. "Pinguendo" in *Lexikon zur Arzneimittelgeschichte* (Frankfurt, 1968–1974), vol. 1, p. 58.

38 Cf. Böning, (1990), p. 6, n16.

39 "frischwarmen Kühmist", Lifestory, (IV), p. 372.

40 Ibid. Cf. also Lifestory, (IV), p. 385.

1798), this description presumably represents first and foremost a retrospective idealization of his childhood rather than a still-practiced means of self-medication.

Apart from internal and external self-medication also minor surgeries were carried out at Bräkers' to restore the health of family members. So in Ulrich Bräker's childhood, for instance, his father once "dugged up [...] with a knife" a burning and hurting wound filled with moss and grass in one of the boy's soles.<sup>41</sup> Interesting in the context of illness and self-help is also the following episode reported by Bräker on 27 April 1780, although he did not consciously make any efforts to cure his "stinking rotting fever", his toothache, and the "ulcer in [his] mouth".<sup>42</sup> Bräker reported that several times he had been close to stab up the ulcer with a knife – a surgery which had been carried out on him by two local medical doctors (father and son Mettler) some 30 years earlier.<sup>43</sup> This illness episode therefore exemplifies the interaction of self-help and professional medical aid, in that therapeutic knowledge diffused literally by means of 'learning-by-experience'.

## Thematic Networking

Bräker's fifth-born Jacob (1769–1787) suffered from a "consumptive disease" for most of his life which eventually caused his early death at the age of 17 in 1787.<sup>44</sup> On 23 June 1779 Bräker entered the following episode in his journal:

I visited a sick person in Schwellbrun who is suffering from the same disease as my Jacob: visited him 5 weeks ago as well, and it is everytime the same. he tries to heal his disease constantly, not does my boy; either he is wrong or me, the outcome will show it; I am looking very much forward to seeing him again.<sup>45</sup>

At the first glance this passage does not appear to be a well chosen example for discussing medical aid in general or self-help in particular, but it rather seems to be a demonstration of medical fatalism, as Ulrich Bräker frankly admits that he had just stopped treating his ill son waiting for whatever happened. Bräker's seemingly passive attitude towards Jacob's illness is though qualified, as he had obviously consulted various healers about his son's health condition.<sup>46</sup> But still there seems to be no reference to any measure of informal aid; however, on closer inspection this episode reveals a kind of self-help other than treatment, which will be called 'thematic

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41 "grub mir's mit einem Messer heraus", Lifestory, (IV), p. 385.

42 "stinkendes faulieber", "geschwürr im mund", April 27th 1780, (II), p. 152.

43 Lifestory, (IV), p. 475.

44 "auszehrendenkrankheit", January 11th 1787, (II), p. 524.

45 "jch besuchte einen kranken in Schwellbrun welcher die nemliche krankheit wie mein Jacob hat: habe ihn vor 5. wochen auch besucht, und immer ists gleich. er doctert immerfort, und mein knabe nicht; entweder fählt er oder ich, der ausgang wirds weisen: bin sehr wundergirrig bis ich ihn wieder sehe.", June 23rd 1779, (II), p. 108.

46 Cf. January 11th 1787, (II), p. 523.

networking' in the following. Apparently, Ulrich Bräker took the trouble several times in that year (from his description above we can infer at least three occasions) to walk to Schwellbrunn (located approximately 20 kilometers north-east of Bräker's place) to visit somebody whom he only refers to as a "a sick person [...] suffering from the same disease as [...] Jacob".<sup>47</sup> Therefore, Bräker's main reason for these trips was obviously a medical one, i.e. comparing the men's therapeutic progress to that of Jacob over time. As can be seen from the text, the only apparent reason for these otherwise unrelated strangers – obviously they were neither neighbors nor relatives – to socialize with each other was their respective affectedness with a specific disease. And within this lay network consumption-related experience, knowledge, and information could easily be exchanged. Seemingly, only two households were involved in 1779. However, in early January 1788, i.e. almost exactly one year after Jacob's death, Ulrich Bräker happened to report again (unfortunately in less detail than before) that he had just visited two men who were suffering from consumption at that time. One was a "delicate youth" from Bräker's hometown Wattwil, the other lived at Moossegg (approximately 20 kilometers far away) where Bräker had stopped by on his way back home from a business trip.<sup>48</sup> It might be presumed that thematic networking was a major issue of these visits as well.

## Taking Care of the Ill

In 1788 Ulrich Bräker entered the following (assumed) soliloquy of his new neighbor, Hildebrand into his diary, a tailor who had been "bothered" by his wife, a "nasty, roguish woman – in poor health", before she passed away:<sup>49</sup> thank heavens – it's over – I have borne it – stood by my post – how would I regret it now – if I had followed some people's advice – left her – crept away – no – my heart told it to me – stand by your post – and that's what I did – and I am glad that I did it – nevertheless it seems wistful to me – that I have to shed light teardrops over her – but how would I have to tear out my hair now – if I had left her – let her dying helpless and at a loss – good people would have looked after her – but it was my duty – of course, I got frustrated with her – a great deal of effort and work – [...].<sup>50</sup>

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47 Cf. n45.

48 "zarten jüdling", January 3rd 1788, (II), p. 631; cf. also January 6th 1788, (II), p. 633.

49 "von einem bösen, schalkhafften – kränklichen weibe geplaget", April 13th 1788, (II), p. 701.

50 "gottlob – sist überstanden – ich habe ausgehalten – ausgeharrt – wie würds mich iez reühen – wenn ich einicher leüte rath gefolgt hete – sie verlassen – mich davon gemacht hete – nein – mein hertz sagte mirs – harre aus – und das that ich – und bin froh das ichs that – s komt mir gleichwol noch so wehmüthig vor – das ich die helen tropfen um sie weynen muß – aber wie müst ich ietzt nicht die haare ausrupfen – wen ich sie verlassen hete – sie hülff u. rathlos hete

In several ways these thoughts refer to the way health care was organized in Bräker's Toggenburg. First of all, they emphasize the fact that nursing was considered to be the duty of the immediate family, i.e. of the spouses, parents or siblings living together in one household.<sup>51</sup> Only if this aid was either insufficient or no longer available, the broader kin was involved. The Bräker family experienced such urgent situation in fall 1771 when an epidemic of dysentery was rife in the area. Within some few days Ulrich Bräker's two oldest children – Johann Ulrich (born in 1763) and Susanna Barbara (born in 1762) – died and Ulrich Bräker himself as well as all his remaining three children fell ill, too. And although Bräker's wife Salome, who remained in good health, albeit she was seven months pregnant, took care of her suffering family members, her unmarried sister came to support her “as she couldn't serve all that”.<sup>52</sup> Sometimes formal intervention was also necessary to guarantee kinship support. Thus, Ulrich Bräker witnessed in the course of one of his trips close to Lake Constance, how the local pastor had to ask a young lunatic's “next relatives” to take care of the mentally ill girl after her sister, under whose surveillance she used to live, had passed away.<sup>53</sup>

Neighborly support constituted a further source of lay aid to cope with acute illness. That is why Ulrich Bräker did his duty when in 1787 one of his neighbors, the miller Hans Jacob Bösch (1752–1795), went “crazy in his head – speaks all kinds of insane things, from time to time coarse – obscene things”.<sup>54</sup> Bräker helped keeping Bösch under surveillance for at least two nights, assisted in chaining him up, and went several times to Bösch's because, for some reason, the mentally ill appreciated talking to him. And Bräker's comment “Bösch, gives the whole neighborhood bother” indicates above that he was not the only one to provide such neighborly support.<sup>55</sup> Yet in Bösch's case it turned out that informal health care was insufficient and professional medical treatment became necessary instead. Therefore, the sick miller eventually (after some four weeks or so) got handed over to a physician named Dr. Forrer who took him to his nearby place where he chained him up and

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sterben lassen – doch heten gute leüte – sich jhrer angenohmen – aber es war meine pflicht – freylich, hate sie mir viel verdruß – viel saure müh und arbeit gemacht – [...]”, *ibid.*, p. 701 et seq.

51 Cf. January 11th 1787, (II), p. 522 for mother, and September 21st to 26th 1790, (III), p. 340 for siblings.

52 “da sie nicht allem abwarten konnte”, *Lifestory*, (IV), p. 493. Salome originated from a village close to Wattwil, and two of her sisters were unmarried in 1771, that is Anna Katharina Ambühl (born in 1747) and Verena Ambühl (born in 1750), cf. Holliger et al., (1985), p. 66.

53 “nächsten anverwandten”, September 21st to 26th 1790, (III), p. 340.

54 “verrückt im kopf – redet allerhand verirrt sachen, biswilen grobe – unflätige sachen.”, October 17th 1787, (II), p. 609.

55 “Bösch, macht der gantzen nachbarschafft mühe”, October 28th 1787, (II), p. 609.

successfully treated him with humoral therapies such as purging, vomiting, and bleeding.<sup>56</sup>

Both the tailor's monologue and the behavior of the lunatic's relatives indicate how taking care of the ill (like the provision of informal aid in general) could become a burden. Therefore, potential caregivers tried to shirk their social obligation at times. This is quite well exemplified by Ulrich Bräker's behavior that day his son Jacob eventually died from consumption in 1787: while Bräker's wife Salome performed her "tender service" on the fatally ill boy (who passed away in her arms), Ulrich Bräker was absent.<sup>57</sup> The father had left early that morning to Herisau seemingly to pursue his business at the local market although he admitted later – half justifying and half excusing his own deed – that he had felt "the secret wish in [his] chest [...] not having to look at him passing away".<sup>58</sup>

So far we have seen how in Bräker's Toggenburg the care of physically or mentally ill and dying persons was usually organized within informal social networks involving not only the immediate family but also the broader kin and neighbors. In April 1779 though "the attendant of the ill Mrs. Liberherr" (Sara Lieberherr-Bösch, 1726–1779), who was by then suffering from a "long very painful disease", rushed into Bräker's house to call for the surgeon who happened to be present at Bräkers'.<sup>59</sup> However, in lack of any further information concerning the "attendant's" nature it is at least worth speculating that she might have provided some kind of formal health care, which she got paid for. Above all it is interesting to note in this context that Bräker did not mention whether or not his wife experienced any support from a (professional) midwife when she gave birth (three of their children were born during the time when Bräker kept his diaries).<sup>60</sup>

## Supporting the Ill Economically

Ulrich Bräker called his autobiography, not without good reason, the "Lifestory and Real Adventures of the Poor Man of Toggenburg", a quite suitable characterization of his lifelong economic situation as already mentioned in the introduction. And

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56 November 18th 1787, (II), p. 613. Bundt was located close to Bräker's place between the town of Lichtensteig and Wattwil. Compare in this context the similar case of Bräker's sister-in-law Anna Elisabeth who committed suicide before February 26th 1784, (II), p. 457 et seq., obviously neither Ulrich nor Salome Bräker were involved in caring for her though.

57 "zärtlicher wartung", January 11th 1787, (II), p. 522.

58 "der geheime wunsch in meiner brust entstanden seyn, sein hinscheid nicht mit anzusehen", *ibid.*

59 "die wärterin der kranken frau Lieberherrin", "lange sehr schmerzhafter krankheit", April 27th 1779, (II), p. 77.

60 Cf. November 17th 1771, (I), p. 370; June 30th 1773, (I), p. 525; and Lifestory, (IV), p. 535.

although he was never destitute, it is not difficult to imagine against such a background that financial and material questions were particularly pressing in times of illness or old age. To Bräker this topic came up for the first time in 1782 when his brother Johannes (1748–1782) died after one year of severe physical decline, loss of sight, and his resulting inability to work. In this particular case the financial burden of illness mainly rested on the shoulders of Johannes' family and, in particular, his siblings (apart from Johannes five brothers and sisters including Ulrich were still alive at that time), and Bräker thus maintained that “the help of mine a[nd] all of his poor brothers and sisters is not enough – and is wearied soon”.<sup>61</sup> Bräker's initial comment that Johannes was someone “in need of our and of other people's help” does indicate that help might have been additionally obtained from other agents outside the core family.<sup>62</sup>

The argument that Ulrich Bräker had with his own and his brother's wife regarding the acceptance of “two oertli” which the local “officer of poor relief” had offered to Johannes and which both women agreed to refuse (allegedly because taking the money would have forced them to cut expenditure on clothes), points out the fact that at least some kind of formal assistance did exist in Toggenburg to ease the worst financial hardships illness brought about.<sup>63</sup> The amount of money distributed here, i.e. “two oertli” corresponding to a quarter of a florin or 15 kreutzer, was apparently only meant to supplement informal efforts, thus resulting in a temporal interaction of informal aid and formal assistance.<sup>64</sup>

Financial support within informal networks could easily lead to social tensions, a circumstance which is not only highlighted by Bräker's furiousness over the two women's attitude towards poor relief. Moreover, Ulrich Bräker accused his brother of insincerity and feigning his fatal illness. In his point of view Johannes only “did as if he died soon – the people believe it – and his little woman believes it, too, and

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61 “die hülff, meiner u. aller seiner armen g'schwister langt nicht zu – und ist bald müde”, January 23rd 1782, (II), p. 257.

62 “unser und frömder leüte hülfe nöthig hat”, *ibid.*

63 “zwey örtli”, “armenpfleger”, *ibid.* In Bräker's lifetime there were no unified rules for official poor relief in the Toggenburg. However, most villages and towns somehow supported their poor by means for instance of ecclesiastical property which they had obtained in the course of Reformation, cf. Paul Wernle, *Der schweizerische Protestantismus im XVIII. Jahrhundert: Erster Band. Das reformierte Staatskirchentum und sein Ausläufer (Pietismus und vernünftige Orthodoxie)* (Tübingen, 1923), pp. 67–71. Although not directly related to illness compare in this context Lifestory, (IV), pp. 398–399. where Ulrich Bräker remembers the fact that in 1754 the heavily indebted family shared a house with a likewise poor woman living on alms, cf. Böning, (21998), p. 43.

64 Cf. Holliger et al., (1985), p. 476 for denominations. In October 1782 Bräker reported that a drama was staged in Lichtensteig by a traveling group which he had attended several times, and the tickets were 15 kreutzer (1st category), 8 kreutzer (2nd category), and 4 kreutzer (3rd category). Thus the amount of two oertli approximately equalled the value of two drama tickets in the best category or seven in the worst respectively, cf. October 20th 1782, (II), p. 323.



advises him pretty well”.<sup>65</sup> Several circumstances aroused Bräker’s doubts, and shortly after Johannes’ death he admitted full of remorse:

– forgive – I did you an injustice; although I hid it – but by myself – in assumption I did you an injustice – thought – because you did not complain, and always slept – so I did think, you lost nothing but face: otherwise it was mostly laziness.<sup>66</sup>

Especially Bräker’s last accusation – “laziness” – emphasizes the economic dimension underlying his rage. However, it is interesting to note in this context that Bräker in fact never used the term ‘illness’ when referring to Johannes’ health status. Instead he spoke of a “strange condition”, a “curious case”, or a “seldom case”, thus implicitly denying the legitimacy for receiving any support.<sup>67</sup>

For Ulrich Bräker the issue of economic support became acute again only towards the end of his life cycle, but in contrast to the aforementioned case it was now him who, against the background of his just impending bankruptcy, had to rely on material and financial aid. While suffering from various physical complaints accompanied by a weakness which rendered physical work more and more impossible, he still contentedly evaluated his own situation as follows:

– what advantages I enjoy – belonging like other human beings – to the class of the poor – who quite often without service – pass away on straw and own excrement and filth without any service and the most important necessities for life – I have the best service and nursing though – I don’t lack any important necessities for life – my good genius always provides me with charitable people who don’t let me lack anything – just now I received from a philanthropist my only one from St. G. necessary foodstuff for lots of weeks – whom God shall repay it.<sup>68</sup>

Amongst these “charitable people” were not least Bräker’s neighbors who provided him with both financial and material resources: “the neighbors, too, never looked upon me more favorably – and do give me money and pleasant words they

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65 “thut als wenn er bald sterben werde – die leüthe glaubens – und sein weibchen glaubts auch, und berath ihn gar gut.”, March 16th 1782, (II), p. 263.

66 “verziehe – jch thate dir unrecht; zwar hab ichs verbissen – aber bey mir selbst – in vermuthungen that ich dir unrecht – dachte – wil du nichts klagtest, und immer schliefest – so dachte ich, es fühle dir nichts, als das gesicht: sonst sey es meistens faulheit.”, March 24th 1782, (II), p. 267.

67 First two quotes “seltsamen zustand” and “curioser fahl” both taken from March 16th 1782, (II), p. 263; last quote “seltener fahl” taken from March 24th 1782, (II), p. 268.

68 “– welche vorzüge genieße ich – der ich ein mensch wie andere – in die classe der armen gehöre – welche gar oft ohne wartung – im stroh und eigenem kot und unrath dahin sterben aus mangel an wartung und der nöthigsten lebensbedürffnuße – ich aber habe die beste wartung und pflegung – mir fehl an keinen nöthigen lebensbedürfnußen – mein guter genius verschafft mir immer wohlthätige menschen die mir nichts mangeln lassen – eben iezo erhalte von einem menschenfründ meinem einzigen von St. G. nöthige lebensmittel auf viele wochen – dem gott vergelten wolle.”, July 22nd 1798, (III), p. 788 et seq.

wouldn't have given me otherwise – goat milk and such".<sup>69</sup> Hence there is no reason to believe that Bräker's standing somewhere on the fringes of the village community due to his self-educatedness and his social upward mobility did have any negative consequences with regard to neighborly help.<sup>70</sup> Above all it is interesting to note incidentally that Bräker then experienced indirect economic support from his wife's kin, too, since his impending bankruptcy was only averted as long as his spouse's relatives stood surety for his debts.<sup>71</sup>

Ulrich Bräker's most active supporters in the months prior to his death, however, were his friends from St. Gallus – not only in moral, but also in economic terms.<sup>72</sup> These friendships were both a sign and an outcome of his social mobility, which finally resulted in a socially and geographically extended helping network. The so-called "philanthropist" from "St. G." whom Ulrich Bräker referred to in the passage quoted above used to be the wealthy bourgeois and banker Daniel Girtanner (1757–1844) living in St. Gallus with whom he had been close friends since 1791.<sup>73</sup> Ulrich Bräker was in frequent receipt of both material ("foodstuff for lots of weeks" as cited before) and financial aid from Girtanner. And thus it happened that the last event Bräker entered into his diary was that Girtanner had just sent him "a whole box of necessities sugarsweet things".<sup>74</sup> The theologian Gregor Grob (1754–1824), too, member of the same reading society like Bräker, private tutor in St. Gallus, and a mutual friend of both Girtanner and Bräker, did support the ill and elderly Bräker. Yet it was Ulrich Bräker who took the initiative in summer 1798 and wrote a letter to Grob in which he "asked [him] for putting in a good word for him in some other houses – to get some support".<sup>75</sup> In fact, only three days later Bräker received a letter from Grob containing the reasonable amount of one luisdor (which

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69 "auch die nachbarn sind gefählicher als sonst – und geben mir um gelt und gute wordte was sie mir sonst nicht gegeben hätten – geißmilch u.d.g.", July 12th 1798, (II), p. 782.

70 In his journal Bräker occasionally reported on hostility of his surrounding, for instance on April 4th 1788, (II), pp. 695–698; and March 22nd 1789, (III), 73 et seq. Cf. Holger Böning, "Gelehrte Bauern in der deutschen Aufklärung," *Buchhandelsgeschichte. Aufsätze, Rezensionen und Berichte zur Geschichte des Buchwesens*, 24 (1987), 1–24, pp. 17–18; and Hans-Jürgen Lüsebrink, "Die Einsamkeit des Autodidakten", in Aleida Assmann and Jan Assmann, eds., *Einsamkeit. Archäologie der literarischen Kommunikation*, vol. 6 (München, 2000), pp. 282 / 284.

71 Cf. April 28th 1798, (III), p. 749.

72 Cf. Hans Amann, "Ulrich Bräkers St. Galler Freund und Wohltäter", *Bodensee-Hefte*, 45 (1995), 22–26.

73 Cf. Samuel Voellmy, *Daniel Girtanner von St. Gallen, Ulrich Bräker aus dem Toggenburg und ihr Freundeskreis: Ein Beitrag zur Geschichte der Aufklärung in der Schweiz in der 2. Hälfte des XVIII. Jahrhunderts* (St. Gallen, 1928), p. 70.

74 "eine gantze schachtel voll notwendige bedürffnuße zukersüße sachen", August 14th 1798, (III), p. 797.

75 "– und ersucht in ein paar heüsern ein – gut wordt vor mich ein zulegen – um etwas unter stützung zuerhalten –", August 12th 1798, (III), p. 797.

equals 5 thaler or 10 florin or 40 oertli).<sup>76</sup> In addition, a second letter reached Bräker after several days, containing “a whole pile of thaler – from my f.[riend, S.H.] Grob collected in the Gontzenbach household from the family” (whom Grob was tutoring for).<sup>77</sup> The interaction of the two friends illustrates that, on a very practical level, not only Bräker’s ability to read, but also his ability to write constituted an important resource facilitating access to informal support, and besides that receiving support in urgent situations demanded for active measures on the side of both the person in need and of those who wanted to help. Grob’s fund-raising finally demonstrates how informal aid was even obtained beyond the borders of one’s immediate circle, for instance from indirect acquaintances or employers of a friend respectively.

Bräker’s consultations of Dr. Sulzer in the year of 1798 show how informal support in an extended social network of friends could eventually procure professional medical treatment.<sup>78</sup> Hans Heinrich Sulzer zum Adler (1735–1814) used to be a friend of Daniel Girtanner, the city physician of Winterthur, or in Bräker’s words “a skillful medical doctor – and recommended to me by my dearest Mr. G.”.<sup>79</sup> And although Bräker did not explicitly comment on whether or not he was charged for the doctor’s advice, the plaster and the medication he had received, it is very likely in view of Bräker’s then economic situation, that Dr. Sulzer treated him free of charge or Girtanner paid Sulzer. Therefore, this episode illustrates how the boundaries between informal self-help (here with regard to economic aspects) and professional medical aid (here in terms of treatment) occasionally blurred.

## Conclusion

Starting with quantitative evidence suggesting that self-help instead of asking for professional medical assistance used to be the most common answer to illness in early modern times, the preceding discussion has scrutinized how informal health care worked in everyday life in the late eighteenth century. Through Ulrich Bräker we have gained an insight into the way how lower-class households, in particular in rural areas, handled illness-related challenges. However, dietetics as a means of both preventive and curative self-help has not been the subject here. The sections below focus on the main results regarding three central issues for our understanding of

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<sup>76</sup> Ibid.

<sup>77</sup> “ein gantzes pak thaller – von meinem f. Grob aus dem Gontzenbachischen hauße von der familie gesamlet”, August 13th 1798, (III), p. 797.

<sup>78</sup> Cf. April 24th 1798, (III), p. 747; Mai 29th 1798, (III), p. 761; and June 20th 1798, (III), p. 770.

<sup>79</sup> “der ein geschikter arzt – und mir von meinem besten h. G. empfohlen ward”, Mai 29th 1798, (III), p. 761. Cf. Voellmy, (1928), p. 183 for friendship of Sulzer and Girtanner, and Gantenbein, (1996), pp. 158–163 for Sulzer’s biography.

self-help strategies: Firstly, who were the agents involved in informal self-help? Secondly, which were the resources for self-help? And thirdly, who were the agents providing formal medical service, and to what extent did the interaction between informal self-help and these offers take place?

In Ulrich Bräker's surroundings, like elsewhere in early modern Europe, support for the ill was obtained within wide informal social networks centered around the person in need.<sup>80</sup> To the extent possible, this aid was mainly organized within the core family or the household, and in this context spouses, parents and siblings were of particular significance. Such aid could also be expected from the broader kin, and in Bräker's context especially grown up siblings (as seen in the case of dysentery in 1771 as well as in the course of his brother Johannes' illness) played a significant role, however also neighbors and friends. Considering Ulrich Bräker's social upward mobility there is, hence, no reason to believe that it came out against him in terms of neighborly help, as he reported on both providing (e.g. surveillance for Bösch or medicine for Luncie) and receiving such (esp. economic aid in old age). On the contrary, his social mobility did actually add further powerful agents (first and foremost his friends Girtanner and Grob) to his own network. In addition, also acquaintances of a different character – based either on mutual friends (think of Dr. Sulzer), on an employer-employee relationship of a friend (the Gontzenbach family), on shared interest (in the case of thematic networking), or on chance (like the landlady in a random inn) – occasionally contributed to health care. Reciprocity, that is the expectation of those who provide support to receive in turn some kind of comparable service in future, obviously constituted – unspoken though for most of the time – a key principle underlying the exchange of resources in those networks Bräker encountered.<sup>81</sup> Yet only when Ulrich Bräker accused his fatally-ill brother Johannes of dishonesty and exploiting people next to him, this seemingly self-evident truth was put in discussion.

Three groups of resources were at work in Toggenburg with regard to medical self-help and hence exchanged in those social networks: material, economic, and immaterial resources. Self-treatment at Bräker's drew first heavily upon everyday items, in particular upon foodstuff like wine, spirits, tobacco, coffee, egg-white, and flour. All kinds of natural resources which the landscape provided such as snow, water, herbs, plants, animal fat, and – mentioned at least in two passages of his autobiography – animal excrement were applied as remedy. The costs of all of these goods were moderate. In view of the only rudimentary system of poor relief in the late eighteenth-century Toggenburg, the economic support for people suffering from a severe illness turned out to be a central challenge for the people around, and for Bräker himself this was not least an issue of life-cycle. The corresponding eco-

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80 Cf. Jütte, (1994), pp. 83–86.

81 Cf. Dinges, (1998), p. 114 concerning reciprocity.

conomic resources could come in the shape of either cash, material goods, or in indirect form (e.g. Girtanner's recommendation of Bräker to Dr. Sulzer). But financial obligations were particularly suited for triggering off social tensions (as seen in the case of Bräker's brother Johannes). Finally immaterial resources, such as knowledge on the one hand, and time, attention, and energy on the other were essential to the provision of health care, whereas the latter resources were mainly involved in taking care of the ill. In this context Bräker's thematic networking represented a suitable behavior for sharing knowledge related to a specific disease (consumption in this case). Likewise, Ulrich Bräker's literacy did not only provide him with access to the knowledge of the medical literature, but also allowed him to get into contact with potential supporters not living in the vicinity.<sup>82</sup>

Apart from self-help Ulrich Bräker mentioned several agents in his writings, providing formal assistance. Occasionally (in less than 3 percent of all cases of illness as indicated in the introduction), Bräker and his fellows sought help from medical professionals – surgeons as well as medical doctors (e.g. father and son Mettler, Dr. Wirth, Dr. Forrer, Dr. Sulzer) – to ease their physical complaints. Lucinda McCray Beier suggested in her work on Ralph Josselin that the geographical distance to the next healer, expenses, and faith in God's providence and the Divine Physician in particular could be an explanation of this marginal role of professional medical treatment.<sup>83</sup> Compared to Ulrich Bräker's context, none of these explanations alone seems to be applicable, although economic aspects, in particular, should not be denied. However, also some kind of formal financial assistance did exist in Toggenburg to support the poor ill (as exemplified by the visit of an "officer of poor relief"). The above writings of Bräker revealed that outside aid and self-help interacted in various ways: in terms of actual medical treatment he reported on a temporary succession of both in either direction (think of Bräker's migraine or mentally ill Bösch). Yet informal and formal aid did also overlap, this could happen either in the shape of a diffusion of professional medical knowledge to everyday lay practice or by means of formal intervention initiating informal help (e.g. a pastor in case of the lunatic). And likewise, in terms of finance, those "two oertli" of poor relief offered to Bräker's brother Johannes were meant supplementary. Finally Dr. Sulzer's treatment of Ulrich Bräker on recommendation of Girtanner should remind us of the fact that the borders between outside help and self-help at times blurred.

*Susanne Hoffmann* is a Ph.D. student at the Institut für Geschichte der Medizin der Robert Bosch Stiftung in Stuttgart, Germany.

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82 Cf. Ginnie Smith, "Prescribing the Rules of Health. Self-Help and Advice in the Late Eighteenth Century", in Roy Porter, ed., *Patients and Practitioners: Lay Perceptions of Medicine in Pre-Industrial Society*. Cambridge Monographs in the History of Medicine (Cambridge, 1985), p. 254 for role of popular medical literature in England.

83 McCray Beier, (1987), p. 203 et seq.

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# The Poor and the Patient: Protestant Geneva in the Early Modern Period<sup>1</sup>

Philip Rieder

Recent research has demonstrated the usefulness of considering both the history of lay and professional practices from the patient's point of view. Issues explored include the interactions between the ill and contemporary healers<sup>2</sup>, between medical knowledge and lay expectations<sup>3</sup>, and between the ill person and his or her direct environment.<sup>4</sup> The results of these studies recognise the existence of a lay medical culture, although the importance of lay, informal healthcare and self-help remains difficult to assess throughout the Early Modern period. Moreover, the extant data are generally related to the more literate and prosperous spheres of society and little is known of what happens in less affluent environments. The poor – understood here not as vagrants who were generally driven away, but as recognised impoverished inhabitants of the city<sup>5</sup> – have left few or no manuscripts. The aim of this contribution is to make use of the exceptionally rich sources kept in Geneva's state and private collections in order to discuss available data on lay medical practices and reveal what general medical practices existed from the point of view of an ordinary or poor patient. It is important to stress from the out-set that medical practices are not reduced to acts performed by medical doctors alone, but understood to include self-help, informal counseling and any medical commodities or advice exchanged. The topic is as yet obscure and complicated by methodological issues pertaining to the difficulty of understanding the respective roles of different resources in a patient's efforts to retrieve or to preserve their health in the past. The following pages, by avoiding modern definitions and assumptions on efficiency and concentrating on practices, aim to assess how the patient used available medical commodities and services. Particular attention is paid to different strategies condi-

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<sup>2</sup> Garcia-Ballester, 1989; Faure, 1992; Pomata, 1998.

<sup>3</sup> Stolberg, 2003.

<sup>4</sup> Smith, 2003; Rieder, 2003.

<sup>5</sup> This is a common reality in early modern Europe. Vagrant poor frighten and are commonly repressed. Gutton, 1974, p. 103 et suiv.

tioned by the financial situation of the patient. Do those devoid of means enjoy only limited access to resources? Do the poorer members of society resort systematically to irregular practitioners? Addressing these questions is ambitious, given the nature of existing historical data. The first section of the paper contrives more modestly to map out both formal medical commodities and lay or informal services available in Early Modern Geneva.<sup>6</sup> The second section concentrates on self-help and informal healthcare organised by and around the patient. In the last section of this paper, a series of insights into understanding how the less affluent used medical commodities are suggested.

## Available Medical Services

Although the number and the nature of regular medical practitioners evolved during the rather long time span considered here, stretching from the Reformation to the French Revolution, a period of territorial and political stability for the Republic of Geneva, one permanent feature of Geneva's medical market is the global control exercised by the Republic's paramount political body, the Small Council (*Petit Conseil*). The role of the Council was particularly important in the direct aftermath of the Reformation when there was no established medical guild. During this period the town aldermen were overtly wary of the interests of established practitioners when it came to judging of the capacities of foreign healers seeking establishment within the city. In certain cases, aldermen overrode the advice of recognised and established practitioners in order to grant licences to particular healers, often prompted by patients' requests. Conditions of admission to practice remain flexible even after 1569, the year the first medical edicts (*Ordonnances médicales*) were implemented and the foundation of a guild (*Faculté*) encompassing physicians, surgeons and apothecaries.

Regular practitioners were comparatively numerous in Geneva during the entire period. High numbers could be related to the reformed denomination of the city as many practitioners, attracted to Geneva for confessional reasons, remained. Moreover, Protestants from France and nearby Swiss and German regions sent their children to be apprenticed to surgeons and apothecaries within the city. This probably boosted local trade and the overall number of healers. The last point is confirmed by particularly high numbers of practitioners present after each wave of protestant immigration, most explicitly following the Second Refuge in the late 17th century. In 1701, the medical density (counting both master surgeons and physicians) was approximately 1 practitioner for 500 inhabitants in Geneva. This was a period of crisis for providers of medical commodities and an effort was made to reduce num-

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6 See Revel, 1996.

bers in the following years.<sup>7</sup> Yet, as during the 16th and 17th centuries, the mean medical density remains above 1 practitioner/1000 inhabitants throughout the 18th century.<sup>8</sup> Overall, concentrations of practitioners appear to be higher than those found in contemporary France.<sup>9</sup>

High concentrations of practitioners may have been responsible for the lack of work and low prices, these were at least the complaints voiced by regular healers. More generally, the organisation of the medical marketplace can be depicted as revolving around the “patients” requests and desires throughout the period. This is largely due to the fact that the control of medical practice remained in the hands of the Small Council. Moreover, as elsewhere, even healers considered to be ignorant were accepted if they could count on patients’ patronage.<sup>10</sup> Healers expelled or formally banished from the city were sometimes readmitted, albeit on a temporary basis, in order to heal specific patients. In 1562, for instance, Jean des Vernaitz, a temporary resident suffering from a cataract, asked for permission for the surgeon Aymo Tissot, banished for repeated drunkardness, arrogance and lack of respect two years previously,<sup>11</sup> to be readmitted to the city in order to operate on his eyes. The decision taken was to allow Tissot to remain two months within the city walls.<sup>12</sup> Rulings in favour of the interests of the sick were common. The policies of the Guild tending to enforce its own monopoly were consistently frustrated by the City Council and lay requests. Even the edicts framing medical practices allowed provision for bone setters, operators of cataracts, of stones and other specialists to receive short term licences in order to practice as “the patient shall deem fit” on the condition that they operate in the presence of a regular practitioner.<sup>13</sup>

The edicts themselves were not strictly enforced. Notwithstanding the provision already mentioned which suggests that exceptions to the standard examinations or

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7 In 1701, the guild officially petitions in order to reduce numbers of barber-surgeon and apothecary shops within the city. BPU, Ms fr 2171–2186. Archives de l’État de Genève (hereafter : AEG), Santé F1, pp. 154–155.

8 XVIth century numbers are approximations calculated from administrative documents. The town then held between 10 to 18'000 inhabitants, with something close to 5 physicians and 10 barbers or surgeons available between 1536–1569. 18th century data stems from the guild’s records.

9 Jean-Pierre Goubert's overview concludes of the presence, in French towns of Geneva's size, of between 0.7 and 1.5 practitioners/1000 inhabitants in 1780. This is comparable to data found by François Lebrun for Anjou (1 physician/surgeon for 1400 inhabitants) and higher than densities calculated by Jean Meyer in his study of Brittany (1 physician/surgeon for every 4000–4500 inhabitant) although small active towns such as Nantes and Rennes boast a high rate of 1 practitioner for 1500–1700 inhabitants. Saint-Malo is even closer to the Geneva numbers with 1 practitioner for 1000–1200 inhabitants. Goubert, 1977; Lebrun, 1971, p. 218; Meyer, 1972, pp. 174–179.

10 Practical capacities are widely recognised: Ruggiero, 1981, p. 170.

11 AEG, Livre du Conseil des affaires criminels et consistoriaux, 15/10/ 1560.

12 AEG, Registre du Conseil (hereafter: R.C.), f. 32, 2/4/1562.

13 Gautier, 2001, pp. 610–618. For the 18th century, see: Louis-Courvoisier, 2001.

professional credentials were to be demanded by the patient and limited in time, less than 10 days after the formal acceptance of the edicts, Antoinette Deserre requested “permission to treat those suffering from ruptures of which she had previously cured more than one”. Antoinette Deserre is clearly a specialised lay healer and her pretensions are based on previous success. She shares this profile with many contemporary and subsequent lay healers. The fact that the Council grants her request, conferring thereby an indefinite licence to a lay healer without consulting the medical corporation, illustrates the accepted presence of lay healers even after the implementation of the new guild’s formal monopoly.<sup>14</sup> Although it is not yet possible to establish comprehensive lists of lay practitioners, there are many traces suggesting the regular presence of lay healers within and in the neighbourhood of the city. Local lay healers, both men and women, are associated with occult powers both to harm and to heal; many are suspected of performing “miracle” cures and not conforming to orthodox Protestant worship patterns. As such, some are called before Geneva’s Consistory court<sup>15</sup>; others are tried in the Geneva witch trials or in criminal proceedings when their activities are suspected of having regrettable effects on their client’s health.<sup>16</sup> Over time the status of established lay healers changes. They no longer receive definite official licences to practice in the 17th and 18th centuries when only itinerant specialists obtain provisional licences to practice, although native lay healers seem still to be widely tolerated – in fact, healing practices were commonly presented by suspected fortune-tellers as a justification to their activities.

Understanding how and why such healers were tolerated is a key issue in clarifying the reality of the Early modern medical marketplace. Possible explanations are numerous. Lay healers may not have charged, or charged only little, therefore encroached only superficially on the practices of more “professional” healers. On the other hand, their healing practices could be seen as related to domestic medicine, a sphere where established practitioners were rarely present. The most obvious reasons are that the overall control of the marketplace being in the hands of the Small Council, the stress was laid on organising medical practice around the patient’s needs, two elements which infer a tolerant attitude all-round. Even the more official activities of recognised practitioners are constantly jeopardised in the name of the same principal. At times, for instance, formal rules are relinquished in order to allow apothecaries and surgeons to prescribe medicines so that poorer patients may receive care without having to find the means to pay for a physician’s

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14 AEG, R.C. 64, ff. 74v & 80, 18/5/1569 & 27/5/1569.

15 The Consistory court is composed of the city ministers and 12 elders (deemed both godfaring and respectable) chosen from the Council of citizens (Conseil des CC) by the Small Council and 2 must be members of the Small Council. *Edits Ecclésiastiques*, 1576, art. LXIX et LXX. See Kingdon, 1995.

16 Monter, 1971; Monter, 1976, pp. 167–190; Broye, 1990.

bill.<sup>17</sup> It is probable, although difficult to prove, that as different categories of medical practitioners originated in specific social strata, their occupations were integrated into the social environments in which they were born. The 16th century is exceptional in this respect; medical occupations and social positions were then complicated by the fact that on one hand many migrant physicians lived in precarious conditions and on the other, certain irregular practitioners evolved in the higher spheres of Geneva society. This is the case, for instance, of Jaques Carre, a merchant and bourgeois of the city, who claimed in 1543 a right to heal because his father was a surgeon as was his father's father. He admits to healing "ruptures, dislocations and broken bones" and to preparing plasters of wax mixed with certain herbs, which he then uses in order to expel bad humours, but denies having ever given "brevet" or spells ("charmes"). In the 17th and 18th centuries social groups tend to be rigid, medical doctors and apothecaries were typically born in well-to-do families, surgeons stemmed from the middling sort and irregular healers came from popular environments. The social integration of practitioners is probably the first and the most useful outlet for their medical commodities, although observing common practice reveals that reputations and recognised capacities to heal tend to break down social barriers.

## Self-Help, Patient Culture

When it comes to describing who consults whom and why or, more simply, how one strives to remain healthy or retrieve lost health during the Early Modern era, it is important to start by stressing the idiosyncratic characteristics of patients' ills.<sup>19</sup> In written testimonials, each particular health story tends to be presented as unique. Starting from the humoral, physical and occupational characteristics either inherited or imprinted in childhood, each individual construes a singular relationship to his or her health. In this context, one is oneself the most able to

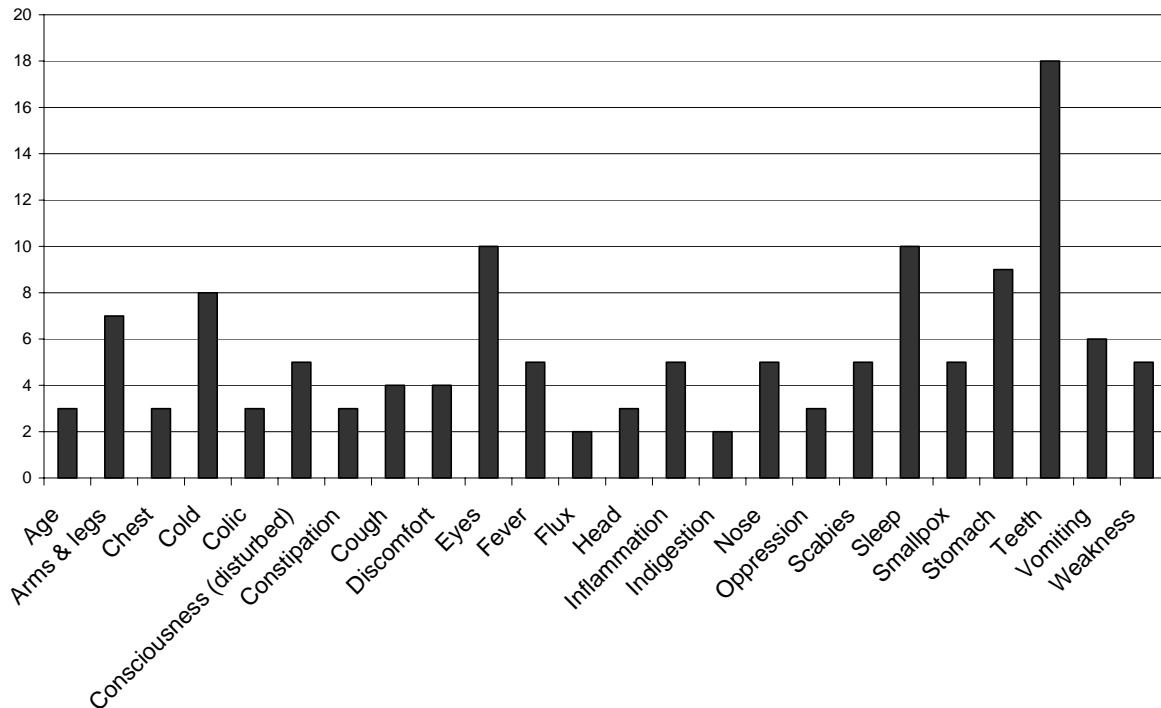
**Figure 1.** Common complaints. Théophile Rémy Frêne (1741–1804).

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17 This is particularly obvious when, after a revision of the edicts in 1658, Surgeons and apothecaries are "again" permitted to practice medicine after complaints by poor inhabitants of the cost of having to consult a physician in order to obtain a prescription. AEG, R.C., le 9 mars 1660, f. 25.

18 A bill on which figures or words are inscribed, used superstitiously in order to heal patients, see: Académie, 1694.

19 This explains difficulties encountered in understanding medical expressions today: Peter, 1971.



Source: Frêne 1993–1994.

Commentary: N= 124.

interpret the evolution of one's own health.<sup>20</sup> Jewson's much acclaimed model tracing the evolution of relations between patients, practitioners and medical knowledge is certainly correct in at least one respect: during the Early modern period the patient tends to control his or her own medical story and therefore the meaning of illness.<sup>21</sup> How then can one understand the aches, pains and diseases of which patients suffered in the Early Modern period? Some information about the ailments that most plague everyday life can be found. Books of family recipes, for instance, offer some insights.<sup>22</sup> The vast quantities of medicines destined to relieve stomach and digestive troubles may reflect difficulties met in procuring water of a good quality and in preserving food. Other ills are related to behaviour. Bad teeth incur many medical preparations and are reputedly an 18th century problem, due to changes in dietary habits (more sugar). Painful teeth figure among the most frequent ills which plague some patients for years: in the diary kept by Théophile Rémy Frêne (1727–1804), decayed teeth and subsequent pains cause the most numerous complaints. Eye problems are also common in 18th century, as described in the registers of Geneva's hospital.<sup>23</sup> The list of complaints the most commonly

20 Such interpretations are based on ancient hygiene, i.e. the 6 non-naturals: Pilloud/Louis-Courvoisier, 2003.

21 Jewson, 1976.

22 On secret remedies, see Ramsey, 1982a; Ramsey, 1982b; Ramsey, 1988.

23 Louis-Courvoisier, 2000, p. 45.

found in diaries confirm the symptom orientated medical culture of the patient as does the rare occurrences of named diseases – in Frêne's case, only scabies and smallpox appear regularly as ontological entities.<sup>24</sup>

Beyond examples such as those offered by diaries, there are few means of knowing how recipes were used and this is in part due to the fact that they are usually made up of common ingredients found in most kitchens. Traces in account books enable one to get a pretty clear idea of the availability of common ready-made medicines in households: Sirop de capillaire, Eau de carmes<sup>25</sup>, Eau de la reine de Hongrie<sup>26</sup>, Eau sans pareille, Eau cordiale, Panacée solutive, Beaume du Commandeur, Eau d'arquebusade<sup>27</sup>, and other all purpose medicines appear regularly in 18th century documents. The presence and the ready usage of some of these items are confirmed in particular circumstances. In 1761, as Antoine de Normendie (1713–1761) lies in pain on his bed, possibly poisoned by a badly confectioned enema, a neighbour comes to assist his wife and brings with her a bottle of Eau de carmes<sup>28</sup>. Overcome by weakness while visiting a friend, Théophile Rémy Frêne collapses and is offered by his host, in June 1779, true Venician theriac and tea in order to set him right.<sup>29</sup> The list could be pursued indefinitely, involving individuals from all strata of society.<sup>30</sup>

Important use of ready-made medicines may be an 18th century phenomenon, but documents left by Early Modern patients confirm important lay autonomy and regular self-medication, with more or less frequent counselling by different categories of healers. Data on the way the affluent use medical services is available.<sup>31</sup> The working classes tend to take their health problems into their own hands. In 1765, for instance, Benjamin Macaire, a 60 year old master watchmaker suffering from a swelling on his hip which is described as a tumour, consulted François-David Cabanis (1727–1798), a well established master surgeon. The plasters, pills and regimen prescribed did not resolve the tumour and some time later, a village surgeon named Lafon suggested to operate the swelling, arguing that it could be an abscess. Cabanis was against the idea, but Macaire decided to let Lafon operate.

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24 Others do appear in his diary, namely apoplexy, dysentery and measles, but do not affect him directly.

25 Contains balm alcohol, rosemary, thym, cinamon alcohol, etc. Invented and sold at the "Carmes" monastery in Paris: Franklin, 1892, pp. 218–219; Béclard and al., 1821–1822.

26 "Alcoolat de romarin" according to Franklin. Franklin, 1891, pp. 221–222; BÉCLARD et al., 1821–1822.

27 Used for wounds. Contains aromatic herbs and alcohol. Franklin, 1891, p. 217; Béclard et al., 1821–1822.

28 AEG, P. C. 10905: Deposition de Dame Antoinette De Chapeaurouge du 24 aoust 1761.

29 Frêne, 1993–1994, p. 1311.

30 Rieder, 2002, pp. 696–699.

31 Rieder, 2005.

Eight days after the operation, the patient died, but neither the patient on his death bed nor his widow thereafter felt the need to incriminate the surgeon: did he not convince the patient of the necessity to operate?<sup>32</sup>

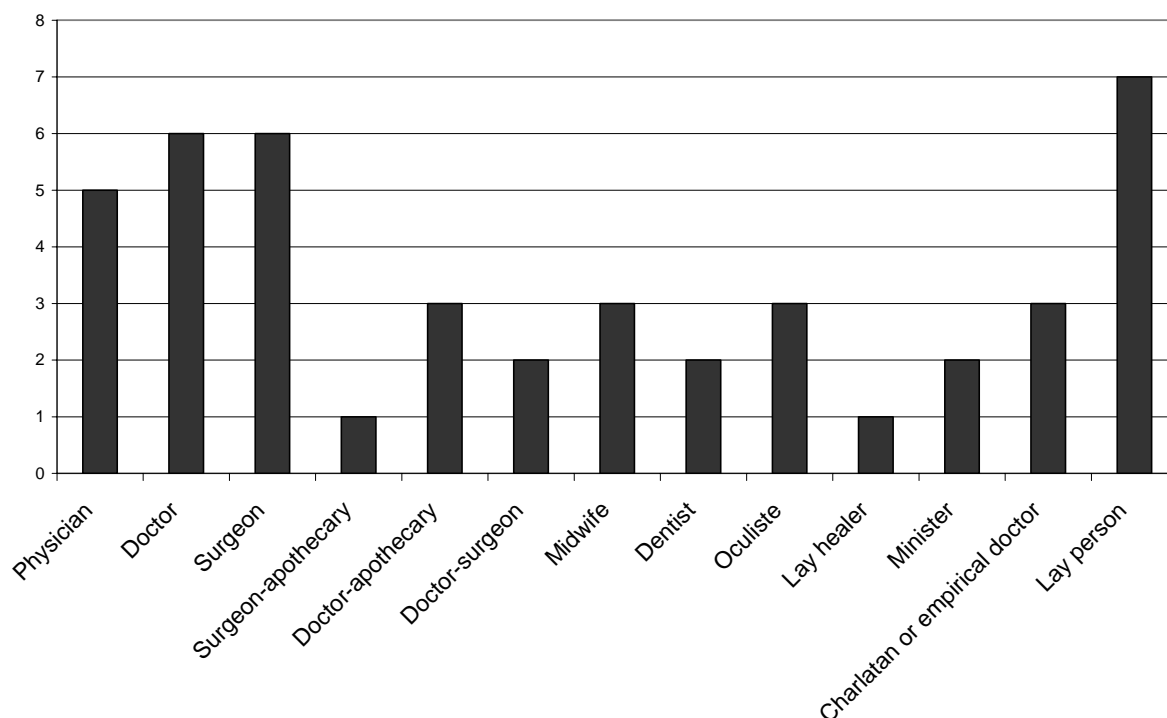
Macaire had consulted two surgeons with very different profiles: a famous city surgeon and a reputedly ignorant village surgeon. This is all that is known of three years of the patient's life as it is confined to the investigation report that the watchmaker's sudden death occasioned. More information is available a few steps up the social ladder, in middle class families. These people were poor in the traditional sense that they had to work to survive, but they most certainly did not consider themselves to be poor. Jeanne-Marie Bellamy Prevost (1725–1785), is a good illustration of this social category. Wife to the minister Abraham Prevost, she enjoys the help of two servants in order to perform her household duties and care for her two children. During the eighteen months in the years 1772 and 1773 of her diary, she mentions only two consultations. The first is a rather unofficial request presented to a physician attending her mother in autumn of 1772 and the second occurs in the following spring when she feels the need of phlebotomy. And yet during the entire period her state of health is a source of great anxiety. She undertakes on her own ruling a variety of medical measures, namely medicines such as changes of scenery, goat's milk, exercise and a powerful purgative made from rhubarb, which she consumes often. In Bellamy Prevost's case, domestic or self-administered remedies form the main part of her health program: the physician is clearly called in to counsel or confirm her own strategies. She does mention rather vaguely lay or common opinions on certain medical problems, suggesting that she does confer with others on such matters. In this respect, other diarists are more explicit. A contemporary figure evolving in the same social class, the already mentioned minister Théophile Rémy Frêne, details in his diary conversations with a variety of healers, including surgeons, village “notables”, neighbours, friends and physicians.

Frêne discusses medical questions with everyone and takes counsel from different types of healers (figure 2): he often resorts to lay advice or to help given by irregular healers, although he typically calls in a regular physician when he is seriously worried or considers himself or a member of his family to be “in danger”. He also indulges in some self-doctoring. On one occasion, in a self-prescribed preventive treatment for dysentery – rhubarb taken as a purgative – his wife falls seriously ill and he fears for her life. Frêne immediately writes to a physician, Friedrich Salomon Scholl (1708–1771), established in Bienne, a town some 15km distant. **Figure 2.** Origins of medical advice and medicine given to Théophile Rémy Frêne for his own health problems (1740–1804).

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32 AEG, P. C. 11723.





Source: Frêne 1993–1994.

Commentary: N=31. The table does not take into account the number of occurrences.

The physician cannot come immediately and the medicine he sends does not seem adequate to the husband who falls back on a recipe taken from Tissot's famous *Advice to people in general*<sup>33</sup> which he later judges to be at least partially responsible for his wife's recovery.<sup>34</sup>

As suggested by the proceeding examples, family medicine is probably the most common type of medicine. Individuals, male and female, often care for and nurse ill family members. In fact, in the context of Geneva's social discipline as it is enforced since the Reformation, nursing next of kin is a duty which incurs the formal disciplinary intervention of a minister or an elder if it is not respected. This applies to all social classes.<sup>35</sup> Recent research tends to suggest that family medicine and medical services exchanged in the neighbourhood constitute an important section of medical practices.<sup>36</sup> Such informal help is tolerated by the city and the guild: only practices arousing social protest or suspicion of superstitious or magical healing rituals get particular attention. Here most of the data appears to stem from

33 Tissot, 1993.

34 A more detailed account of these cases can be found in Rieder, 2002.

35 Among many examples: David Remond was rebuked for having left his ill wife alone on Sunday; Pierre Verna's son is admonished for not having visited his ill wife; Pierre Maupin is called for having abandoned his ill wife. AEG, R. Consist., vol. 2, f. 8, le 5 novembre 1545; vol. 58, f. 77, le 11 août 1659 et vol. 72, p. 107, le 3 novembre 1707.

36 Smith, 2003.

modest households, namely during the 18th century when the Consistory is wary of incriminating citizens evolving in the upper strata of society. Some irregular healers are well integrated within the neighbourhood and their offer of medical services may be standard practice. Scandals and conflicts sometimes reveal traces of such practices. On one occasion, for instance, in 1703, Lucresse Mermillon, unconvinced of the effects of a particular medication on her son's fever, demands repayment from her neighbour, Marguerite David, who had sold it to her for 18 sols – the price of a day's work for a farm hand<sup>37</sup>. The argument about payment is the only reason Marguerite David's practice came to the court's notice<sup>38</sup>. More often, incriminated lay healers protest that their sole goals are to be charitable and to do some good. Françoise Baud, married to Simoen Gilles master tanner, admits to having applied a plaster to a child's stomach "only charitably and without having been paid".<sup>39</sup> On one occasion, Mrs Chapuys, born Faure, offers a plaster to a young neighbour who might have been poisoned, the illegitimate son of Isabeau Du Boule, a cook ("rotisseuse"): the boy suffers from stomach pains. Chapuys reportedly also gathered some herbs ("Rote"), which she then applied onto the child's feet before, two hours later, throwing the same herbs into the Rhone and declaring the child to be bewitched.<sup>40</sup> The city executioner, an established irregular practitioner, is accused of confirming this accusation and could have been paid 18 sols for his opinion.<sup>41</sup>

Consulting irregular practitioners can lead the patient to be called before the Consistory court. The widow of Rolland, a baker, for instance, is questioned in November 1545 for having consulted a healer, sometimes called a witch, who is said to have given her some roots to heal her late husband. She admits having consulted Claude Verna<sup>42</sup> and to having received roots, but nothing else, i.e. she does not admit to "superstitious" practices.<sup>43</sup> Claude Verna seems to live within the city and is regularly involved in cases where suspected "superstitious" acts were performed. Patients calling on healers who chanted formulas or prayers, use magic spells or religious symbols, or more precisely, are suspected of such behaviour, are numerous. It is tempting to suggest that such healers, constantly present throughout the Early Modern period, are less expensive and treat primarily the poorest members of the community. A sociological study would be necessary to establish any degree of

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37 This may not be expensive for medicine, but a lot of money for a working family. A non-qualified manual worker earned about 20 sols per day in 1720 and one pound of bread then cost 4 sols. Piuz, 1985.

38 AEG, R. Consist., 71, 28/6/1703.

39 "Verbal de l'auditeur De la Rive, du 21 juillet 1728", P. C. 7564.

40 «Déclaration de Jean Marie Jaillet, femme Clejat, le 4 août 1728», P. C. 7564.

41 P. C. 7564.

42 Claude Verna, called "Bon Hérège" ("the good witch") comes from the nearby village of Challex (Ain). (cf. Consist. 3 & 10 avril 1544).

43 R. Consist. 2, f. 13v, le 26/11/1545.

certainty, but at this stage of research this seems quite improbable. Although many of the individuals mentioned as clients of irregular or reputedly “superstitious” healers are unknown and probably originated, like the baker Rolland’s widow, from the lower levels of the social ladder, this is not always the case. Gonget, described as a lark hunter, is regularly accused of healing by magic in the 1540’s. On one occasion, his alleged client was Jehan Lullin, a former member of the group of four leading the Small Council.<sup>44</sup> Two centuries later, Henri-Albert Gosse (1753–1816), born in an affluent family, does not hesitate to take his lame leg to a healer called Sisseran established in the Catholic village of Châtelaine, well beyond the city walls<sup>45</sup> and in the 1760’s, the wife of Charles Bonnet, member of Geneva’s aristocracy, is operated by an itinerant healing abbot.<sup>46</sup>

There is apparently a high degree of tolerance for irregular and lay medical practice, both by the Consistory, the guild and the Small Council. Even the hospital regularly sends patients to be treated by specialists. In 1549 and 1559, a lady called La Guyaz treats women ill with the ringworm (“teigne” or “rache”).<sup>47</sup> Two centuries later, the same institution continues to send its clients to lay specialists, namely epileptic patients.<sup>48</sup> Irregular medical practices are not systematically associated with superstitious doings. In the 17th and 18th centuries, suspicion of Catholic and superstitious healing practices is more often than not focused on areas beyond the town walls, places where the clergy of the Counter Reformation was active.<sup>49</sup> In short, the Reformation of the town had the effect of prohibiting certain religious healing practices, or more generally, healing through what appeared to the Reformers as superstitious or occult means. Many Protestant inhabitants of Geneva continued to access such medical services by simply walking either to the nearest Catholic village (a few miles beyond the city walls) or by visiting any known clerical or magical healer in the vicinity of the town. Such trips are triggered by the healer’s reputation, and sometimes by pressure applied by neighbours and family.<sup>50</sup>

Confronted by the variety of therapeutic issues available, it is difficult to understand how individual choices were made without a detailed study on each particular case. Nevertheless, overall, choices are better understood when one considers the medical marketplace not as expressing conflicting ideologies, but as seen by the patient, a place where a series of practitioners offer services and where, finally,

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44 Lambert, Watt, and McDonald, 2001, f. 30v, le 4 février 1546.

45 Plan, 1909.

46 BPU, Ms Bonnet 70 ff. 140–141: Charles Bonnet to Henri-Louis Duhamel de Monceau (copy), 28/1/1760.

47 Courvoisier, 1985, pp. 28–29.

48 Louis-Courvoisier, 2000, pp. 105–107.

49 On the importance of the Counter Reformation’s healing practices: Gentilcore, 1995; Gentilcore, 1998; Walsham, 2003.

50 See for instance: AEG, R. Consist. 70, f. 74, le 02/11/1702.

examples of successful healing are both the most common and the most convincing arguments for lay onlookers.

## Work and Charity

Up to this point, it is difficult to assess clearly what exactly is specific to the poor and what place domestic medicine took in dealing with their health. Present knowledge of urban poor in Geneva is limited to traces left in documents issued by the town administration, namely the hospital and the Council's records. Published research tends to confirm, as elsewhere, the presence of a high percentage of the population living close to the poverty line (8–10%) and many near enough to require assistance during any given family or collective mishap (30–60%).<sup>51</sup> Reasons causing working-class families to cross the boundary into poverty are numerous and comparable to those found elsewhere (loss of job, death or departure of parent, etc.).<sup>52</sup> Among these, illness is an important factor. Beyond the suggested existence of forms of informal help in both poor and wealthy neighbourhoods, the means by which the poor were able to help themselves are difficult to assess. The inadequacy of their means for extra expenses suggests very little possibilities to indulge in all but the simplest of medications, although, as it has already been mentioned, social pressure tends to enforce a minimum of solidarity among family members. What happened then, when poor people fell ill?

During the Early Modern period, for the working-classes (peasants and artisans), illness is not solely, as Carl Havelange puts it, “an internal transformation of the self, but a breach in one's capacity to survive”.<sup>53</sup> The ill poor are clearly recognised, from the time the distinction is enforced at the end of the Middle Ages, as “worthy poor”. When a bread-earner falls ill, early modern families are more often than not compelled to resort to charity.<sup>54</sup> Being ill and requesting help are here related to the incapacity to work: many clients are given relief for as long as they are ill.<sup>55</sup> This is particularly well documented thanks to the interesting case study undertaken by Anne-Marie Piuz on the family of Jean Vian, an immigrant labourer hired to work on the building of Geneva's fortifications in the 1710's.<sup>56</sup> Piuz details the continual recourse of Vian to Geneva's main charities, in spite of the fact that he is employed

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51 In 1698, more than 40% of the towns inhabitants required assistance. Wiedmer, 1990; Louis-Courvoisier, 2000, pp. 21–22..

52 Gutton, 1974; Wiedmer, 1990; Louis-Courvoisier, 1985

53 I am indebted to Micheline Louis-Courvoisier for this reference. Havelange, 1990, p. 142.

54 Wiedmer, 1990, pp. 140–141.

55 Louis-Courvoisier, 1985, p. 25.

56 Piuz, 1985.

regularly during his working life; she concludes, after having compared his salary to the price of foodstuffs and accomodation, that what he earns every day is just sufficient to feed himself and his family. As soon as illness or accident forces him to stop working, he is compelled to resort to charity in order to eat. Of course, and the case of Vian is quite explicit, the most obvious and common way of mapping health services used by the poor is to study charity records. The ill and deserving poor do regularly get food and medicines through Geneva's hospital. As previous authors have noted, purveyors of charity then gave out bread and other essential commodities, but also remedies destined to heal the ill poor. This is seen as a good investment as once healed, a poor patient can get back on his feet and return to work.<sup>57</sup> During the Early Modern period, there are regular healers attached to the General Hospital employed to treat the poorer inhabitants of the city, be they inmates of the hospital or beneficiaries of domestic support. As from the late 1530's, a surgeon (or barber, the terms are used indistinctly) is regularly employed and, since 1558, a physician is officially taken on by the hospital.<sup>58</sup> As the town grows so does the fixed medical personnel. By the XVIIIth century, there are two surgeons, two physicians and two apothecaries on the Hospital's pay role.

Keeping things as rational as possible, the Hospital tends to deliver aid directly to homes. This is also true for medical support. Access to charity health care is often an indicator of social isolation, but what kind of support could the beneficiaries get? Good quality food is automatically given to inmates of the hospital when they are ill, an important medical measure in regard of the importance of diet in the understanding of individual health.<sup>59</sup> All things considered, one may wonder if costly medicine is not accessible to poor patients. One deterrent may be the necessity to ask for help. In a society where the honour and the position of each family group are clearly placed on a social scale, asking for charity is not easy for all but the most destitute. Cases such as that of André Sauvan suggest that even the poor are able to negotiate with some groups of health carers, ultimately avoiding public help. In 1724, André Sauvan, complained of an intestinal hernia and consulted a group of itinerant operators «in the aim, he said, of being able to improve later his capacity to work» reports his widow a few days later.<sup>60</sup> Such cases suggest that as the Hospital governors, the poor are prepared to engage in expensive treatment in order to get back to work. They are probably encouraged to do so by the undertakings of the operators themselves not to ask for any money before complete recovery.<sup>61</sup> In

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57 See for instance: Louis-Courvoisier, 1985, p. 28.

58 AEG, Registre du Conseil, 21 mars 1558, f. 126v.

59 Wiedmer, p. 155.

60 AEG, P. C. 7169: Déclaration d'Isabelle Sauvan, née Noblet du 19 mai 1724.

61 Many other examples suggest that among modest healers, the practice of health contracts as described by Gianna Pomata, prevail untill the end of the 18th century. Pomata, 1998 (1ère éd. italienne 1994).

their statements, the operators justify having contravened the town's edicts and operated on Sauvan within the town and without a licence, because Sauvan had declared that "he was a poor man and could not afford to board at the inn where the two men were staying" in a nearby village (Grange-Canal).<sup>62</sup> This and other similar cases, suggest that even the patients as devoid of means as Sauvan tended to evolve their own strategies in order to retrieve their health. They typically take responsibility for the therapies chosen, and Sauvan's widow, as others, declared that on his deathbed, her husband had not accused the men who had operated on him, considering that they had done the best they could.<sup>63</sup>

It is difficult, due to the lack of documents, to ascertain what kind of family care and medicine the poor resorted to outside institutional care. Neighbours and family were probably the most obvious and accessible sources of help.<sup>64</sup> Indeed, as has been suggested above, some men and women actually perform particular medical services in their neighbourhood. Among them are journeymen and possibly servants working in surgeon's shops<sup>65</sup>. Even famous charlatans<sup>66</sup> and travelling operators undertake free operations on the poor.<sup>67</sup> What is more, the physicians themselves offer free consultations for those devoid of means – in fact they have a social obligation to do so. As the medical edicts put it: "For the love of God, the physicians (docteurs-médecins) will, each in his district (quartier), care for the poor who solicit them, on the condition that the poor themselves be not taken care of by the hospital or one of the poor chests (bourses)."<sup>68</sup> In fact, the first physician employed at the hospital, Moudon Faulchier, was taken on after having been "seeing" the sick poor two or three times a day free of charge. Such services may well be used before appealing to the hospital, or possibly calling on the hospital may be a means of obtaining the payment of drugs or treatment counselled during a charitable consultation.<sup>69</sup>

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62 AEG, P. C. 7169: Réponses personnelles de Michel Clément de St-Etienne en Provence, du 17 mai 1724.

63 AEG, P. C. 11723, Declaration de la veuve de feu Sieur Louis Benjamin Macaire, le 23 mai 1768; AEG, P. C. 7169: Déclaration d'Isabelle Sauvan, née Noblet du 19 mai 1724.

64 Jütte, 1996, pp. 96–99.

65 AEG, R. Consist., 72, le 3 juin 1706.

66 The most spectacular in the area is count Cagliostro: GERVASO, 1974.

67 Joseph Frédéric Hilmer, for instance, an oculist practicing in Geneva during the Summer of 1749, treats the poor free of charge. This is common practice. Rieder, 2004 (sous presse); Brockliss / Jones, 1997.

68 Text from the 1658 edicts, in substance, comparable to that of the 1569 edicts. Published in Gautier, 2001, art. 8, p. 627.

69 Drugs are rarely given free of charge.

## Conclusion

Research results clearly indicate that medical practices and practitioners are legitimised by the expectations of patients and do not depend solely on the guaranties of official training. Although Geneva's ecclesiastical authorities strive to stamp-out superstitious practices, revealing how many popular healers are available in the neighbourhood, health policies are organised on the grounds of lay expectations and convictions. Like the patients, the town authorities regard all practitioners with suspicion. Poor relief includes medical commodities: the sick poor are consistently assisted and treated. Healers, officially trained or not, are paid by public funds for that purpose, both within and without Geneva's institutions. The picture remains sketchy as sources are inconsistent, and informative private documents relatively scarce, namely for the 16th and 17th centuries. The data under scrutiny here tends to suggest two ways of dealing with health: the poor way and the affluent way. This may be misleading: sources relating to each group of patients or would be patients are distinct, but in their content, they suggest, as does the quality of drugs given to the poor, that treatment finally given is often similar.

Thinking of medical practices in terms of self-help is a complex undertaking. There are, as yet, no clear models on which to base assumptions in order to explain long term trends. Beyond the question as to whether these practices were effective or not, the point of view expressed in this paper suggests that a variety of medical services were available to both the poor and the rich in Early Modern Geneva. Self-help and patient perspectives are generally seen as marginal in respect to orthodox medical practice based on traditional medical documents. Confronting this data with that found in other sources tends to suggest a different picture: an ever present lay medical culture and beyond all, the patient's control on important decisions. In a sense, the prevalence of a variety of practitioners tends to minimise the role of orthodox medical practices. Moreover, although richer patients probably consume greater quantities of medical commodities and services, one wonders if they are really different in kind. Are not, for instance, the numerous paupers cared for free by Cagliostro in Bienne in 1787,<sup>70</sup> treated any differently than Isabelle de Charrière, rich and famous, who travels specifically to Strasbourg to consult the same healer in 1783?<sup>71</sup>

*Philip Rieder* is research assistant at the Institut d'histoire de la médecine of Geneva (Medical school) and teaches regional history at the History department of the University of Geneva.

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70 Frêne, 1993–1994, pp. 2083–2084, le 28 juillet 1787.

71 Details on this expedition are spread-out in later letters, see Rieder, 2002.

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# Old Age Coping Strategies of the Ionian and Maltese Poor, 1800–1865

John Chircop

## Introduction

A growing corpus of historical work is increasingly showing the complexity and diversity of old age, while proving that it was common for the elderly to remain active and continue working up till they became incapable, in different European societies and periods.<sup>1</sup> Elaborating on this accumulating historical knowledge, the present study seeks to examine the survival strategies adopted by the aging poor in response to unanticipated changes in their life circumstances, due to disability, illness or financial mishaps, and to mitigate the more predictable vulnerabilities associated with advanced old age. This means focusing attention on the daily practices and tactics employed by old men and women to acquire provisions, social assistance and medical treatment from the intersecting social nets of the household, neighbourhood and the parish, from communal and formal state charity establishments.

Most historical studies on old age point to the fundamental role, which the household and the neighbourhood played as a mainstay of social support and human care for the elderly during long-term illness.<sup>2</sup> At the same time, on the whole, this literature corroborates Pieter Spierenburg's conception that "a golden age" of unequivocal respect for the elderly in which children, relatives and the

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1 Margaret Pelling and Richard M. Smith, eds., *Life, Death and the Elderly. Historical Perspectives* (London-N. York, 1991), 'Introduction', p. 23; Pat Thane, *Old Age in English History: Past Experiences, Present Issues* (Oxford, 2000), p. 459; Paul Johnson, 'Historical readings of Old Age and Ageing', in P. Johnson and P. Thane, eds., *Old Age from Antiquity to Post-modernity* (London, 1998), p. 1.

2 P. Laslett and R. Wall, *Household and Family in Past time* (Cambridge, 1972); Jack Resch, 'Poverty, Patriarchy and Old Age: The Households of American Revolutionary War Veterans 1820–1830', in R. Ottoway, L.A. Botelho and K. Kittredge, eds., *Power and Poverty. Old Age in the Pre-Industrial Past* (Connecticut-London, 2000), pp. 21–47; Susannah R. Ottoway, 'Introduction', in *ibid*, p. 5.

community in general took care of their elderly ‘as a matter of course’ never existed”.<sup>3</sup> The present study substantiates this pragmatic outlook, while further concentrating on the roles played by the household and community as fundamental welfare nets for the aged. This is done from a perspective which attempts to be as inclusive as possible of old age differentiations existing due to social status and health condition, gender, household composition, and cultural practice.

In order to facilitate analysis through such an inclusive approach, we take on Paul Johnson’s proposal to concentrate on aged people in localised social-spaces,<sup>4</sup> from a wider comparative perspective. In this way, the elderly poor and the coping strategies they adopted are examined within the immediate social settings, in specific rural and urban landscapes, and as embedded within the broader political economies of the Ionian Protectorate and Malta. During the period under discussion, these sets of islands formed part of the British imperial maritime network in the Mediterranean,<sup>5</sup> through which they experienced uneven economic, social and demographic developments due to their respective strategic imperial value. Accordingly, from the 1840s, Malta’s central harbour district developed as the most intensively urbanised colonial zone in this imperial network, in response to this island being stepped up as the key British strategic naval-military base and trade entrepot in the Mediterranean. Corfu Town, the capital of the next most important British-controlled island in the region passed through a similar, but less intensive process of colonisation and urbanisation. This, while the remaining areas in these principal domains, and more remarkably still the remoter southern Ionian islands, remained prevalently rural and generally unaffected by the British imperial presence.

One difficulty encountered throughout this research work was the scarcity of primary sources dealing with the daily life of the elderly poor. With their vast majority unlettered, they left no written record of their ordinary activities for posterity. The problem is particularly acute for most of the period covered in this study, as official documentation and published statistics on old age issues are scarce and, when available, very fragmented. To be sure, the first inclusive census published in these British Mediterranean domains was that of Malta in 1851, and this provides important figures and indicators on the use of hospitals and formal relief by the elderly, even if for the last part of the period under review.

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3 Pieter Spierenburg, *The Broken Spell. Cultural and Anthropological History of Preindustrial Europe* (New Brunswick, 1991), p. 285.

4 P. Johnson, “Historical Readings of Old Age and Ageing”, p. 7.

5 These archipelagos were under British imperial control throughout the period framing this study: the Ionian islands were held as a Protectorate from 1815 up till 1864, and Malta, having been occupied in 1800, was made a Crown Colony in 1813. The latter came under direct colonial administration, with a governor on the spot, while the Ionian Islands were nominally an ‘Independent State’, though in reality they were governed on strict colonial lines by a Lord High Commissioner from Corfu.

Nonetheless, this shortage of officially published evidence and of statistical data is, to an extent, compensated by information contained in a handful of specific – mostly unpublished – reports and in the voluminous administrative correspondence deposited in separate archives, but also by a large body of literature written by officials, medics, travellers and Protestant missionaries, most of whom were British colonial men stationed on these islands. Paying particular attention to the colonialist preconceptions pervading most of these narratives – especially when it comes to their interpretation of the social manners, roles and lifestyles of the Ionian and Maltese “native elderly”, as much as of the other poor of their ‘subject’ populations – their colonial ethnographic accounts provide revealing details, if principally on the use of charities and relief institutions by the aged.

By locating disadvantaged old men and women at the centre of analysis, this research article seeks to gain a better insight into the complex of routine practices – formal, semi-formal or illegal – which these people engaged in, in order to mitigate their high exposure to under-nourishment and disease. This elderly-centred approach also helps to delineate the extent to which self-help activities were actually sufficient for these elderly to survive on a daily basis and particularly during long-term crises. Then, of course, as the main arguments of this study unfold, a series of correlated questions will emerge: What situational tactics were employed by the elderly poor to procure specific resources from communal welfare providers, state institutions and relief agencies? Did the different types of resources offered by separate voluntary organisations and state relief institutions complement or supplement each other? Therefore, does the thesis adhered to by various scholars, and clearly presented by Angela Groppi, that “cyclical oscillations in which the state, families, and charitable institutions redistribute the tasks of caring” for the elderly,<sup>6</sup> hold for the elderly in these island environments during the period under study? Answers to these inquiries can be found in the intricate relationships, and bargaining abilities, which the elderly poor developed with their household, neighbourhood, community social bodies and with the various formal institutions for a wider range of resources on offer. For this reason, the notion of social negotiation, drawn from a critical tradition in the social sciences,<sup>7</sup> is employed here to assist the analysis of the habitual bargaining, give-and-take relations, going on between the aging poor and the just mentioned informal, intermediate and formal social nets and institutions operating in the Ionian islands and Malta, in times of normality, and more remarkably still during collective calamities.

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6 Angela Groppi, ‘Old People and the Flow of Resources Between Generations in Papal Rome, Sixteenth to Nineteenth Centuries’, in Ottoway, Botelho and Kittredge, eds., *Power and Poverty*, p. 89.

7 Peter Burke, *History and Social Theory* (N. York, 1996), pp. 86–87; Joseph V Femia, *Gramsci’s Political Thought* (Oxford, 1981), p. 42.

## Self-Help, Reciprocal Assistance and the Pooling of Resources

In contrast to the wealthy, whose possessions, capital and power allowed them to be in a better position to secure a better-off old age,<sup>8</sup> the aging poor strove to procure their daily sustenance and care themselves whilst capable of doing so. It was habitual for them to remain active participants in their household's affairs and to draw on a common pool of resources. As functional members of the household they were actively engaged in a shared subsistence economy which involved the common use of utensils, tools and provisions, and usually included a particular division of labour. This involved the common use of utensils, tools and provisions and usually included the keeping of "rabbits and fowls" at home, both for consumption and to "bring up for sale, and pay rent with the produce".<sup>9</sup> On a more particular level, the elderly also made use of their own belongings, to put their minds at rest regarding the availability of basic necessities and care in the household sphere during long-term illness and frail old age.

Within the peasant households, one principal asset which grounded the old folks' authority and their claim to respect was the men's hold over property, the house and the parcels of terrain which they cultivated, and the aging women's influence on domestic affairs in extended family networks. Similarly within both the Maltese and the Ionian peasantry, it was usual for newly married couples to take up home with one or other of their old folk: a custom which often resulted in "the paternal mansion [being] subdivided into a number of separate dwellings".<sup>10</sup> Alternatively, newly-weds found a place in very close proximity. This spatial propinquity grounded the extended family network and the associated pooling of resources and reciprocal assistance. In this kind of domestic setting, women played a pivotal role. Their marriages arranged by heads of families, daughters were provided with dowries which included house furniture and utensils, dress and body ornaments.<sup>11</sup> Consequently, daughters and daughters-in-law were expected to care for their husband's elderly parents, as much as for their own elderly, within the domestic space of the

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8 Pelling and Smith, p. 12.

9 'Report of the Committee on the Relief of Distress – 13 December 1824', in Hastings to Bathurst, 3 March 1825, Colonial Office [hereafter CO.] 158/41, Public Record Office, London [hereafter PRO.L.].

10 William A. Goodison, *Topographical and Historical Essay upon the Islands of Corfu, Leucadia, and Zante* (London, 1822), pp. 223–224; Cf. also Tetius T.C. Kendrick, *The Ionian Islands. Manners and Customs* (London, 1822), p. 224.

11 Kendrick, p. 15; Viscount Kirkwall, *Four Years on the Ionian Islands, their Political and Social Conditions with a History of the British Protectorate* (London, 1864), vol.ii, pp. 143–144.

home.<sup>12</sup> Thus, familial reciprocal relations and the reputation of the household were both sustained at high level, the latter being greatly dependent on the visible caring of the old.

Certainly, the centrality of the elderly in this system of domestic solidarity based on reciprocal assistance of the family members,<sup>13</sup> and the accompanying respect they expected, helped to secure for them the needed care particularly when they were unable to help themselves and during the last stages of their life. Even British colonial officials and Protestant missionaries who were frequently severe critics of their Ionian and Maltese 'subjects', would observe that in these islands the elderly who were ailing and unable to work were usually "not abandoned by their children and grand children [even when] these can do nothing for their relief."<sup>14</sup>

Although domestic solidarity towards the old was an ordinary affair in the Ionian and Maltese households, some variations can certainly be observed in the attitudes towards social and health care practices between rural and urban households. But in order to understand this difference it is necessary to provide a brief explanation of the different rural-urban landscapes which structured these household's material conditions of poverty. During the British Protectorate, the Ionian islands' economy remained fundamentally agrarian and characterised by the cultivation and export of currants and olives. This trade was directly dependent on the shifts in demand from external, markedly British, markets.<sup>15</sup> The sharecropping system, and the conditions upon which field tenancy was held on these islands – the *colono* arrangement in which the peasant paid a pre-agreed portion of the produce to the *signori* – kept most of the rural households directly subjugated to their landowners.<sup>16</sup> Identically to their Maltese counterparts, most of the Ionian peasantry held tenancy over small parcels of land on which all the family members worked, including those elderly who were "less worn out".<sup>17</sup> When it came to aging women, besides their contribution as farm hands, they also took care of the goat and sheep herds. Together with the younger females they also occupied themselves in other manual activities, thus

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12 See John Davy, *Notes and Observations on the Ionian Islands and Malta with some remarks on Constantinople* (London, 1822), vol. ii, pp. 141–142; Goodison, p. 186; Kendrick, p. 14.

13 For the domestic organisation of the household in Greek society during the nineteenth century see Paul Sant Cassia and Constantina Bada, *The Making of the Modern Greek Family: Marriage and Exchange in nineteenth century Athens* (Cambridge, 1992), pp. 1–45.

14 W. Bullock Webster, *English Governors and Foreign Grumblers in Malta in 1864* (London-Malta, 1864), p. 58; *Reports of the Commissioners Appointed to Inquire into the Affairs of the Island of Malta and of Correspondence Thereupon* (London, 1838), p. 9.

15 David Hannell, 'The Ionian Islands under the British Protectorate. Social and Economic Problems', *Journal of Modern Greek Studies*, 7 (1989), pp. 105–132.

16 Adam (Corfu) to Bathurst, 13 July 1824, CO.136/22, PRO.L; Michael Pratt, *Britain's Greek Empire. Reflections on the History of the Ionian Islands from the fall of Byzantium* (London, 1978), p. 115.

17 *Reports of the Commissioners*, pp. xvii, 8–12, 140.

supplementing the family's income.<sup>18</sup> Indeed, colonial officials and travellers observed that, for instance on Corfu, "nearly all, young and old [women], carried the never-ceasing distaff and spindle, with which they are forever at work [while] tending their goats and sheep".<sup>19</sup> Peasant women were also seen knitting and embroidering,<sup>20</sup> carrying "wood and water ...at the olive mill and perform, in fact, every laborious office", while looking after their grandchildren.<sup>21</sup>

Living precariously on economies of subsistence, these insular rural communities were characterised by a continuous migration movement. During the sowing and harvest periods Southern Ionians, mostly males, crossed the sea to work as labourers in the Morea, the Albanian littoral and other islands in the vicinity. For their work they were usually paid in kind.<sup>22</sup> Apart from these seasonal flows, other thousands of Ionians and Maltese gravitated towards the Levantine and North African territories to work as labourers, artisans or petty traders and thus supported their family, and aging parents, by regularly sending back remittances.<sup>23</sup> Emigration was by and large left to the younger male members of the household:<sup>24</sup> those feeling "too old" to travel were left at home with the responsibility to help and protect the family and to manage domestic affairs. They kept the farm going and, when need arose, secured better terms of tenancy and negotiated new deals and alliances with land-owners and other family clans through deep-rooted networks in which loyalty and respect played a pivotal part.<sup>25</sup>

This kind of multifaceted and active involvement of the aged in household matters, accompanied by their share of daily labour, was essential to the creation of a receptive and caring atmosphere that would ensure that the necessary support would be forthcoming during illness and infirmity. For this purpose, within the intimate domestic space, the elderly would consolidate affective relations with specific individual members through generous gifts, mainly of personal effects which

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18 D. T. Anstead, *The Ionian Islands in the Year 1863* (London, 1863), p. 318; Davy, p. 45; *Reports of the Commissioners*, p. 9.

19 Dr. Corrigan, *Ten Days in Athens with Notes by the Way* (London, 1862), p. 23.

20 Davy, pp. 141–142.

21 Anstead, p. 37; Goodison, p. 210; John Hennen, *Sketches of the Medical Topography of the Mediterranean. Comprising an Account of Gibraltar, the Ionian Islands and Malta* (London, 1830), p. 145; Kirkwall, pp. 142–143, 288; On child caring as a daily occupation for the elderly in the villages see Fatima Mansur, *Bodrum. A Town in the Aegean* (London, 1972), p. 147.

22 H. Holland, *Travels in the Ionian Isles, Albania, Thessaly, Macedonia &c. during the years 1812 and 1813* (London, 1815), p. 22; Kendrick, p. 65; W. M. Leake, *Travels in Northern Greece* (London, 1835), vol. iv, p. 72.

23 Bullock Webster, p. 58; Pratt, p. 144.

24 *Ionian Islands Blue Books* [hereafter *IIBB.*], 1863.

25 Cf. George Bowen, *Ithaca in 1850* (London, 1851), p. 17; C. P. De Bosset, *Parga and the Ionian Islands: Comprehending a refutation of the various Mis-Statements on the Subjects* (London, 1822), p. 31; C. Willis Dixon, *The Colonial Administration of Sir Thomas Maitland* (London, 1968), pp. 204–405.



included body ornaments<sup>26</sup> (worn both for aesthetic reasons and as security for pawning purposes), gained during their lifetime, as dowry or as inheritance. Besides the parcels of land, which the family cultivated were a most important asset in the hands of the elderly, mainly the males, and were deployed to ensure the provision of caring and treatment within the household. With the prevailing system of inheritance, dictated by the tradition of the “male line of descent”, land holdings were divided among the males of the family. Due to the internal family arrangements which it sustained, this customary mode of property transmission remained nearly intact on all of these islands, in spite of the fact that the British authorities on Corfu sought to abolish it.<sup>27</sup>

Although the British maritime domains under discussion remained predominantly rural, the colonising presence was nevertheless felt, in different degrees, in the core harbour areas of the main islands of Malta and Corfu and to a much lesser extent in Argostoli (Cephalonia) and Zante Town.<sup>28</sup> Narrowing down our analysis to the urban districts of the two principal islands, it still remains evident that the households of the urban poor played an important role in the care of their aged. Having said this, the elderly living in these urban districts were characterised by their inclination to make use of the more immediately available relief institutions and services, particularly the asylums, as key elements in their daily survival strategies. This could be observed more remarkably with the passing of time, within the social parameters of the Valletta-Cottonera Harbour district in Malta, followed by Corfu Town. As from 1841, especially from the time of the Crimean War (1854–56) onwards, Malta was built up as the key strategic naval-military and coal-bunkering station on the British maritime route to the Levant and to India. It was this enhanced geo-strategic position that transformed this island’s central harbour district into a strategic imperial base which, in turn, attracted an increasing number of people to work in its naval and trade establishments. Inside this densely populated urban district, working class households came, at least formally, to depend on the wage earned by a male breadwinner during his most productive years. In this way, working class households became ever more strongly characterised by a strict division of labour based on gender and age.<sup>29</sup> The age factor meant that as the end of their productive years approached, male workers who were still in employment became liable to summary dismissal from one day to the next. A small number of

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26 Cf. Hennen, p. 178; Martin R. Montgomery, *History of the British Possessions in the Mediterranean* (London, 1837), p. 342.

27 Napier (Cephalonia) to Rusdell, 24 June 1828, CO.136/1309–647, PRO.L.; Davy, pp. 318–320.

28 Douglas to Normanby, 25 Apr. 1839, in enclosure Douglas to Glenelg, 21 June 1838, CO.136/93, PRO.L.; Kirkwall, p. 42.

29 John Chircop, ‘The British Imperial Network in the Mediterranean 1800–1870. A Study of Regional Fragmentation and Imperial Integration’, Unpublished Ph.D. thesis, University of Essex, 1997, p. 90.

those who claimed a long period of permanent service with such establishments as the British Commissariat were granted a very modest annual sum on retirement. This could happen at any point after sixty years, on being declared old and infirm or “unhealthy” – usually suffering from rheumatism, apoplexy, dropsy or a “disordered intellect”.<sup>30</sup> Unavoidably then, most of the wage-dependent aging men had to resort to a combination of self-help occupations of every sort, complemented by an extensive use of the state institutions and poor relief services available in their vicinity, when out of work.

For aging males who were unemployed in the urban districts, and who did not suffer from disabilities, there was only a restricted choice of other paid occupations available. In Malta, one option was recruitment into the poorly-paid police force which, until the mid-1830s, was reportedly made up mainly of “aged men”.<sup>31</sup> Others who were progressively over forty years of age, “still going strong”, and who had already served in the army, could also enlist in the Veterans’ Battalion. At first constituted as a three hundred men corps, recruited “from amongst the oldest and most steady for this purpose”, the Veterans were employed to assist the civil government and the police in the keeping of social order and public sanitation.<sup>32</sup> Enlistment provided a monetary income, essential provisions (food and clothing) through the “army’s bounty”, and an option to reside in the barracks, besides a degree of formal respectability which came with the wearing of a uniform. Each veteran who was engaged in a three or five year contract was provided with 12 dollars, out of which the following provisions were supplied: “1 knapsack; 1 pair trousers; 2 shirts; 1 pair of shoes; pair gaiters; brushes, forage cap, great coat cap strap, comb, sponge etc.: clothing and appointments as ascribed by H.M.’s regulations”.<sup>33</sup>

Army supplies, medical treatment and the possibility of shelter, made the Veterans very popular with the elderly poor and their families. It was for this reason that the battalion was retained even after the restructuring of the military establishments. Then, by 1850, veterans were enlisted in the Royal Fencibles Pensioners on a seven year contract open to those over forty years old and who had already served in the army.<sup>34</sup> This recruitment was primarily intended to encourage “young natives” from 15 to 25 years (for the Royal Fencibles Artillery) or from 18–35 years (for the Royal Malta Regiment), and who had the required 5 feet 3/4 inches in height, to involve themselves in the Army: “where they would hope for such an

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30 ‘Estimates of Amount required for Retired Pay, Compensation etc 1845–1846’, in *British Parliamentary Papers* [hereafter *BPP.*], 1845, vol. XXIX, 104; ‘Compensation and Superannuation Allowances for the Commissariat – 1850’, in *BPP.*, vol. XXIV, 119.

31 *Reports of the Commissioners*, p. 42.

32 A. Chesney, *Historical Record of the Maltese Corps of the British Army* (London, 1897), pp. 35, 37.

33 *Ibid.*, pp. 48, 95.

34 More O’Ferrall (Malta) to Earl Grey, 5 Dec. 1850, disp. no. 133 in “Report Accompanying the Blue Book for 1849”, in *BPP.*, 1852–1853, vol. LXII.

asylum in their old age”.<sup>35</sup> The Pensioners performed duties related to policing and state ceremonials,<sup>36</sup> being called out for military drills one day each month on payment, up till 1861 when upon expiration of their contract, this corps was dismantled. The public protests and the petitions presented to the authorities, when the disbandment of this force became known, attest to the part played by these army corps in the all-round survival strategies of the poor: “the proposed disbandment, besides casting many families into distress, is sensibly felt by all the population [...as the corps] provided food for practically 3,000 souls”.<sup>37</sup> This occurred in Malta, with no similar arrangement for veterans being found on the Ionian islands. Here, even the Island Militia, organised during the first decade of the British protectorate, which included all males “from 16 to 60, capable of bearing arms”, had been discontinued,<sup>38</sup> leading High Commissioner Sir Henry Ward to voice concern that for the locals there was “no army or navy to go into”.<sup>39</sup>

Besides those fit and wanting to join the army in Malta, cases recorded from the main urban districts in all of the islands under discussion show the elderly poor active in makeshift occupations. Old men frequenting wine taverns and coffee shops, or in public squares, were observed lending a hand to passers by and offering their services to travellers as guides, as porters, or as carriage drivers upon payment of money or in kind.<sup>40</sup> Aged women were witnessed as domestics, but also offering rooms in their homes for lodging to foreigners, and frequently met as hawkers, petty-brokers, healers and midwives.<sup>41</sup> Suchlike activities were usually blended with an array of semi-formal or illegal activities including practicing of witchcraft, pawning and purchasing food on credit from shopkeepers, begging and all sorts of thievery.<sup>42</sup> Most of these informal practices were observed in the central towns of the main islands, as in Corfu Town and Argostoli, or the area known as Nix Mangiari in Valletta where crowds of elderly and children gathered to beg.<sup>43</sup> Yet it is only from the earliest published official census of Malta in 1851, that one can get the first rare glimpse of the sex distribution of the officially “known elderly mendi-

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35 Chesney, *Historical Records*, pp. 47, 129.

36 A.Chesney, ‘The Maltese Corps of the British Army’, in A. MacMillan, ed., *Malta and Gibraltar Illustrated* (London, 1915), pp. 289–291.

37 Ibid, pp. 103–104.

38 Martin R. Montgomery, *History of the British Empire, Comprising the areas, agriculture, commerce of each colony: Possessions in Europe*, (London, 1843), vol.iv, pp. 398–399; Henry Jervis-White Jervis, *History of Corfu and of the Republic of the Ionian Islands* (London, 1852), pp. 320–321.

39 Quoted in Hannell, p.109.

40 Anstead, p. 318; Hennen, pp. 188–189, 408; W. Kimber, *Edward Lear in Greece. Journals of a Landscape Painter in Greece and Albania* (London, 1965), p. 75.

41 Davy, pp. 141–142; Goodison, p. 193.

42 ‘Report of the Committee – 13 Dec. 1824’, in Hastings to Bathurst, 3 March 1825, CO.158/41, PRO.L.

43 Davy, pp. 120–121; Hennen, pp. 188–189; *Reports of the Commissioners*, p. 9.

cants”, in the 66+ age bracket, active in this harbour urban district. It transpires that old males, in this age range, formed the largest proportion of this officially counted localised sample of beggars: with 125 males against 70 females.<sup>44</sup> Aging women are shown to be less inclined to go out begging or, in any case, to declare this to official enumerators.

## Resourceful Elderly and the Care of the Body and the Mind

Prolonged economic crises and cyclical unemployment, which distinguished the economies of these British-held island territories<sup>45</sup> hit hardest in the colonial port urban centres of Malta and Corfu, where, for many of the elderly, poverty was transformed into outright destitution. Together with the rest of the unemployed, the aged crowded the streets, “some in a state of absolute nudity, with all the others in rags [...] old men scarcely able to work; women the picture of famine”,<sup>46</sup> struggling to maintain themselves by “gather[ing] herbs and dung off the roads which they sell”.<sup>47</sup> Besides queuing at charity soup kitchens, scavenging and pilfering from public and private property, old males and females made the most of communal resources found in the towns, such as water fountains and wells, and used open spaces at the margins for snaring and trapping. Common land, stretches of public wasteland, accessible woods, and mountain forests as in Cephalonia, or the seashore common to all islands, were primarily exploited to increase nutritional intake, but also for medical purposes, from the natural resources – spring water, wild vegetation, plants, herbs, wild game, seafood, weeds and fish – found therein.<sup>48</sup>

On these occasions, the local village elderly were usually fetched for advice on the customary rights and obligations regulating the utilisation of the commons, which were normally left for grazing. Knowledgeable of the specific locations, and of the most sensible times and ways of foraging and collecting wild plants and raw materials, the local elderly were indispensable to help the urban poor locate, properly extract and utilise such natural resources as food, medicine and, when it came to dry wood and thistle, for practical survival purposes. When it came to consumption, the indiscriminate foraging and haphazard ingestion of wild vegetation, herbs and roots, including those which were “indigestible [and] fit only for cattle” were

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<sup>44</sup> *Census of the Islands of Malta, 1861*, p. 146. This gender disparity in the recorded ‘beggar population’ continued, at least, to the last decade of the nineteenth century (Cf. *Census of the Islands of Malta, 1891*, Table XXIX).

<sup>45</sup> *Reports of the Commissioners*, p. 9; Chircop, pp. 161–162.

<sup>46</sup> A. Malcolm, *Letters of an Invalid from Italy and Malta* (London, 1897), p. 275.

<sup>47</sup> *Reports of the Commissioners*, pp. 8–9.

<sup>48</sup> Charles J. Napier, *Memoir on the Roads of Cephalonia* (London, 1825), p. 9; Kirkwall, p. 142.

known to cause inexperienced town people a variety of illnesses.<sup>49</sup> Consonant with their roles as depositors of indigenous wisdom, and as upholders of customary law, several village elders, both men and women, were regularly fetched for their curing practices and for advice on bodily care and herbal medication.<sup>50</sup>

Knowledge on the potential for nourishment and healing contained in natural resources constituted only a portion of the indigenous knowledge which the elderly transmitted verbally, and through habitual practice, within the family and the neighbourhood. Old men and women also passed on to their children and grandchildren fundamental notions, values and skills which were believed to be indispensable for survival in a poverty ridden environment. This they did through story telling, lamentations, anecdotes and songs, in which wise old persons like themselves were central protagonists and heroes.<sup>51</sup> It was through these verbal arts that values of communal solidarity and mutual assistance, and related notions of prudence, hoarding ('saving for a rainy day') and recycling were transmitted to the young. Individual cleverness and shrewdness, which were highlighted as negative Orientalist features of the Greek Ionians, and also of the Maltese, by many British colonial officials and travellers<sup>52</sup> (and lately explored by modern anthropologists such as Michael Herszfeld as elements in a strategy to defend the Greek household's reputation),<sup>53</sup> were actually indispensable attributes that enabled the poor to manipulate, and effectively bargain, relief for themselves and their household. Being such, these were positively reinforced by the elderly within the family sphere.

Embodying indigenous wisdom, traditional values and shared memories of the community, several elderly were looked upon as organic representatives of the general interests. This should not be taken to mean that all the elderly were looked upon with unwavering respect by all, as contemporary recorded cases of usurpation and public disrespect by the young confirm.<sup>54</sup> Talented older persons did hold important positions in local social bodies and mainly in confraternities. Deeply entrenched in the villages and towns, these semi-religious associations played an

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49 *Reports of the Commissioners*, pp. 9–11.

50 On indigenous medicine and healing practices in the Ionian Islands and the Maltese archipelago see. Agius de Soldanis, *Ghaudex bil-Grajjja tieghu* (Malta, 1836), pp. 45–47, 144–145; Hennen, pp. xxxiii, 166, 193–197, 278, 293–297, 329–330; Montgomery, *History of the Colonies*, pp. 341, 344.

51 G. F. Angas, *A Ramble in Malta and Sicily in the Autumn of 1841* (London, 1842), p. 34; G.F. Badger, *Description of Malta and Gozo* (Malta, 1838), p. 97; Charles J. Napier, *The Colonies; treating of their values generally and of the Ionian Islands in particular* (London, 1833), p. 264; A. A. Pallis, *Greek Miscellany. A Collection on Medieval and Modern Greece* (Athens, 1964), p. 168.

52 Anstead, p. 450; Hennen, p. 371.

53 Michael Herzfeld, *The Poetics of Manhood: Contest and Identity in a Cretan Mountain Village* (Princeton, 1985), p. 198.

54 Goodison, p. 224; Kendrick, p. 13.

important role in helping to organise social assistance and to help individuals mitigate misfortune, especially during fragile old age. Although these social bodies aided the general community of the poor through alms, food and clothes, normally on specific days of the liturgical calendar, their primary concern lay with the welfare of their own members: the majority of *confratelli* and the small number of female *consorelle*. When members faced protracted illness or infirmity, the confraternity provided the services of a doctor, nursing care, medicine and foodstuffs, but also a measure of emotional support. To be sure, for such a benefit system to be economically sustainable, membership had to start early in life, with the annual payment increasing according to the age of the individual. As a rule, one could not become a member in old age and this meant that each associate would normally provide long-term contributions, both in financial terms and as service to the collective body, before one's own time to receive assistance arrived.<sup>55</sup> Certainly, this makes evident the fact that in their majority, confraternity members were labouring poor and artisans and did not come from destitute households.

With paid membership in a confraternity, an individual did not only secure a certain measure of assistance during eventual illness, but also guaranteed spiritual support, solace on the death bed and interment of their corpse in a consecrated grave.<sup>56</sup> A paid-up *confratello* would expect post-mortem prayers and the celebration of mass for suffrage of his own soul, when "in Purgatory", after death. He also expected his widowed wife to be helped out, at least for a short period of time, with money, cereals and clothes. Meanwhile being one of the confreres, he was expected to accompany the priest carrying the *viaticum* (the last communion) and to be present when extreme unction was performed to a dying 'brother'. Afterwards all brothers were likely to help in the preparations for the funeral ritual and for burial in the confraternity's chapel<sup>57</sup> as was done in Corfu, or in the assigned grave within the village church crypt<sup>58</sup> as in Malta. Reassurance of a decent funeral and entombment in an identifiable grave was considered by most of the common people as of utmost importance, as this was associated with a person's respectful social and moral status.<sup>59</sup> The paramount significance given to the burial issue by the parishioners was demonstrated when the British authorities prohibited the custom of interment

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55 Joseph Galea, *Il-Konfraternita' tal-Bumbardiera fil-Knisja ta' Santa Barbara* (Malta, 1988), pp. 45–48.

56 Cf. Christopher F. Black, *Italian Confraternities in the Sixteenth Century* (Cambridge, 1989), p. 231; L.B. Lenoci, 'Il Culto del SS. Sacramento in due statuti confraternali meridionali', in *Archivio Storico Pugliese*, 39 (1986), pp. 161–183.

57 Nondas Stamatopoulos, *Old Corfu – History and Culture* (Corfu, 1993), pp. 39, 40, 213, 223.

58 Hennen, pp. 85, 188, 466; Montgomery, *History of the British Possessions*, pp. 183, 101.

59 Elena Brambilla, 'The Definitions of Citizenship and the Sacramental System of Churches' in A. Cimdina, ed., *Religion and Political Change in Europe: Past and Present* (Pisa, 2000), pp. 77–78.

of bodies within the boundaries of Greek Orthodox and Catholic churches by orders issued, for sanitary reasons, in all their Mediterranean possessions.<sup>60</sup> According to these sanitary regulations, interment of corpses was to be carried out only in government approved extra-mural cemeteries and this provoked lingering dissent and varying forms of opposition throughout these islands.<sup>61</sup>

In the Greek Orthodox and Catholic cultures which were dominant in Ionian and Maltese social terrains respectively, the process of dying was in itself an important household and community affair. As Dr John Hennen, a contemporary medic and author stationed on these islands, observed: “A Santa Mauriot [an inhabitant of the island of Santa Maura] always dies amid companions and visitors, however neglected he might be during life, or little thought of after death”.<sup>62</sup> And so did the poor inhabitants of all the other islands under discussion. Being accompanied by confraternity brothers or not, dying was a social affair, encompassing the family, neighbours and friends – all of whom were expected to help out in the funeral ceremony and the burial of the corpse.<sup>63</sup> Thus, the fear of dying alone constituted one other reason for the elderly sick to dread the civil hospital and the asylum, as will be discussed below, and must have also further motivated those who could afford it to seek membership in a confraternity.

### Negotiating Formal Relief and Expecting a Place in an Asylum ‘by Right’

The extensive system of state public outdoor relief and charitable institutions, sanctioned by the local Churches and the confraternities, constituted a mainstay of British colonial power in the Ionian Protectorate and Malta. Certainly, maintaining a network of charitable establishments and relief services for the elderly poor formed part of a wider low-cost strategy to extend social control and to foster consent for the colonial state and the social order.<sup>64</sup> This was made evident by the Crown Advocate of Malta who, in 1861, declared that the colonial administration had an intimate interest in assisting, through alms, relief and medical care “all of those afflicted with old age and disease”.<sup>65</sup> In this way it was anticipated that the

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60 Hennen, p. 187; Montgomery, *History of the British Possessions*, pp. 183, 101.

61 W. E. Gilpen (Corfu), 6 Oct. 1836, ‘Circular to the Respective Residents’[‘on the subject of forming a cemetery for individuals of the dominant religion instead of continuing the injurious practice of interning bodies in the Churches’], CO.136/1137, PRO.L.; Galea, p. 49.

62 Hennen, p. 375.

63 Cf. Goodison, p. 225.

64 Adams (Corfu) to Douglas, 18 Jan. 1824, CO.136/22, PRO.L.; *Letter to H. E. Duke of Newcastle by Four Elected Members of the Council of Government* (Malta, 1864), pp. 22–23.

65 Library Mss., 16 Jan 1861, Rabat National Archives of Malta [hereafter RNA.M].

state could prevent the aging poor and their families from resorting to undesirable activities, such as vagabonding, trespassing, begging and theft, which were all classified as crimes.<sup>66</sup> And this power strategy was articulated by a colonial rhetoric which coupled the “native elderly” poor with orphan children and the foundlings as being in constant need of the government’s paternal benevolence, caring and nurturing.<sup>67</sup> Indeed, although attempting, now and again, to reform – with some doses of Benthamite Utilitarianism – these old charitable systems inherited from the previous regimes of the Venetians and the Order of the Knights of St. John, that had ruled Corfu and Malta respectively, the British authorities, aware of the social and political implications any such alterations might have for the colonial state of things, continued to implement a paternalist policy towards the poor throughout the period under discussion.

What needs to be stressed at this juncture is that the cost of maintaining such an extensive government charitable system for the poor, and the old in particular, was mainly defrayed from local revenue, though this was supplemented by constantly inadequate private subscriptions and bequests. In the Ionian islands and Malta the annual government expenditure on the upkeep of the charity establishments, including the asylums for the aged poor, were funded from taxation, principally from a tax on grain which weighed heavily on the poorer classes.<sup>68</sup> This confirms the soundness of the recirculatory theory of state charity, which suggests that the poor were ultimately paying for their own relief through their life-long tax contributions. When considered in conjunction with the paternalist mentality of the people as moulded by its experience of the ancient regime, the actual experience of contributing directly for their own relief through taxation helps to explain the claims, and expectations, of the poor for state charitable relief “as by right”.<sup>69</sup> It is in this context that one starts appreciating this extensive public charity sphere, maintained by British colonial governance, as a major cultural-hegemonic terrain in which the common people were constantly able to negotiate outdoor relief and social assistance.<sup>70</sup> In their face-to-face modes of bargaining, or through official petitioning, the elderly with the other groups of the poor, employed, or rather manipulated, the same official discourse used by the state. They pleaded to their administrators’ “paternal hand of authority and benevolence” when applying for

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66 ‘Bandi della Corte di Malta’ (24 Aug.1812), RNA.M; Davy, pp. 118, 303; Montgomery, *History of the Colonies*, pp. 220–223.

67 Adam to Douglas, 18 Jan. 1824, CO.136/12, PRO.L.; Anstead, p. 15; Kirkwall, p. 37.

68 *IIBB.*,1847; Maitland to Bathurst, 24 Oct. 1814, CO.159/39, PRO.L.; Mrs. C. Lushington, *Narrative of a Journey from Calcutta to Europe in the Years 1827 and 1829* (London, 1829), p. 205.

69 Paul Cassar, *Medical History of Malta* (Malta, 1964), pp. 102–126; Hankey to Horton, 24 July 1825, CO.158/42, PRO.L.

70 Hennen, pp. 485; Cf. also P.P. Castagna, *Lis-Storia ta Malta bil Gzejer Tabha* (Malta, 1888), vol. i, p. 441; *Malta Government Gazette* [hereafter *MGG.*], 16 April 1817.



relief and, more specifically, when requesting admittance in the *Ospizio*. The language of distress employed in their petitions tacitly cautioned that without poor relief most of them would resort to “begging and other disorderly occupations”, thus making the authorities “fear that idle if not vicious habits will quietly become generated amongst them”,<sup>71</sup> possibly provoking social disturbances.

In the urban centres, the elderly were at the foreground of the numerous poor who used formal charitable institutions and outdoor relief as an essential part of their strategy for survival. A large portion of the poor faced harsh destitution when getting old. These people included those who had depended all their life on precarious work activities, and most of whom were normally paid in kind, and thus could not, “however frugally and industrially they may pass their youth, put by any provision for old age”.<sup>72</sup> Most of these attempted to use all relief services available in their immediate surroundings. Besides the parish-based services of the proto-medico, or doctor of the poor, and the public dispensaries in the main towns,<sup>73</sup> the aging poor employed the state institutions of the *Ospizio* and the *Monte di Pietà*. Having a long established history, starting as from the seventeenth century on Corfu, Zante, Cephalonia, Ithaca and Malta,<sup>74</sup> the *Monti* were state-owned pawn-brokers consolidated as principal social safety valves to afford “pecuniary relief to the distressed [...] thereby preventing them from having recourse to usurious contacts” by the British authorities.<sup>75</sup> Subsequently, private pawning was officially prohibited on those islands of the Protectorate where a *Monte di Pietà* was operating.<sup>76</sup> By pawning their commodities and personal belongings (including clothes, silk/linen, woollen articles and body ornaments) in the *Monti di Pietà*, the elderly could sustain themselves, and their households, at least temporarily, during times of adversity. Records show that most of them generally retrieved their objects when

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71 ‘Report of the Committee – 13 Dec. 1824’, in Hastings to Earl of Bathurst, 3 Mar. 1825, CO.158/41, PRO.L.; *An appeal on behalf of the Widows, Orphans among the Corfiotes now suffering*, (Corfu, 1836); *Rapporto della Societa` Caritatevole di Cefalonia* (Corfu, 1843).

72 *Reports of the Commissioners*, p. 9.

73 Hennen, p.328; Montgomery, *History of the British Possessions*, p. 247.

74 F. Lunzi, *Dalla Conditione politica delle Isole Ionie sotto il Dominio Veneto* (Venezia, 1858: fasc. repr. 1969), pp. 243–248; R. Micallef, *Origins and Progress of the Government Charitable Institutions in Malta and Gozo* (Malta, 1901), p.19; ‘Inventario del Santo Monte di Pietà in Corfu de Gennaio 1842 a tutto Dicembre 1846’, 11/43, State Archives Corfu, Greece [hereafter SAC.G.].

75 Hennen, p.189; Kirkwall, p. 37.

76 *Seconda Sessione Del Primo Parlamento degli Stati Uniti delle Isole Jonie tenuta in virtù della Costituzione del 1817. No. XI. Atto del Parlamento che proibisce ai particolari in tutte le Isole degli Stati Uniti delle Isole Jonie, ove esistessero Monti di Pietà, di dar o ricever denari con pegno* (Corfu, 1819).

able to do so,<sup>77</sup> and reutilised them, time and again, for the same or for other survival purposes.

The combined use of these various charities formed part of a strategy employed by the elderly in which the *Ospizio* or Asylums for the Aged and the Infirm, played a central role. These institutions were located within the capital towns of the main islands, and even though leaving much to be desired by the official standards of the time,<sup>78</sup> were nonetheless sought by the old in need, at least for periodical stays: “or till that can be done, to be allowed a monthly stipend, as out door partakes of the funds of that establishment”.<sup>79</sup> During hard times, the transfer of an elderly person, and usually the male, to the asylum, formed part of a shared strategy practiced by old couples, and their families, in order to “free the confined habitation of a large family [and provide] more room for working something profitable”,<sup>80</sup> giving them a temporary respite.

One other trait can also be discerned in the use of the asylum by the aged poor. Many moved in and out of these institutions as part of a flexible strategy to secure daily dietary requirements, shelter and medical assistance according to the season, their household subsistence situation and the general economic circumstances prevailing at specific times. Evidently, during economically stable periods, and during summer, many of the elderly could do without the resources found in this institution to the point of finding it opportune to bargain their place of stay. This is most evidently seen in the case of the central Floriana asylum in Malta. Confronted with the problem of limited space and the associated high-risk of epidemic outbreaks, the authorities of this asylum introduced the practice of discharging as many inmates as possible during the summer months. Those elderly inmates who were willing to return to their households, relatives or friends, were given an allowance of three pence each day in lieu of rations.<sup>81</sup> In the subsequent years, as the warm months approached, the inmates would start making it evermore difficult to leave the asylum, pressing the respective authorities to pay more. Money continued to be disbursed, even though the authorities knew well enough that this did not prevent the elderly from begging and that the payment was going “in the pockets” of their relatives.<sup>82</sup> In contrast, this asylum was usually packed throughout the winter, dur-

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77 Cassiere del Monte` di Pieta` (Corfu) to Collona, 9 April 1846; “Inventario del Santo Monte di Pieta` di Corfu. Da Gennaio 1842 a tutto Dicembre 1846”, 11/43, SAC.G; *MGG.*, 4 Oct. 1846.

78 *Regulations of the Charitable Institutions in Malta and Gozo* (Malta, 1858), pp. 45–46; Davy, p. 109.

79 ‘Report of the Committee – 13 Dec. 1824’, in Hastings to Earl of Bathurst, 3 Mar. 1825, CO.158/41, PRO.L.

80 *Reports of the Commissioners*, pp. 8–9; Hastings (Malta) to Earl Bathurst, 20 April 1825, CO.158/41, PRO.L.

81 Cassar, p. 379.

82 *Ibid.*, pp. 378–379.

ing general crises and massive unemployment. During the cold months, it was usually more secure to stay in the *Ospizio*, with less risk of contracting summer-related diseases, where basic necessities and medical care were immediately available. Effectively, one meal a day for each of the aged in the Floriana asylum included: “bread (20 oz.), paste for soup (4 oz.), meat or salt fish, cheese (2 oz.), 2 eggs, olives, 1 piece of fruit, wine (½ pint for men and ¼ pint for women), vegetables for soup [...]. broth and other extras allowed to those sick inmates.”<sup>83</sup> On entry, each old person was also provided with: “1 palliase; 1 bolster, 1 blanket, 1 coverlet, 1 set of boards and trestles. 2 sheets and pillow cases [were] allowed to the bedridden and infirm, 1 locker or bedside table and all other necessary utensils. For men – 3 shirts; 3 jackets; 3 pairs of trousers; 2 caps; 1 straw hat. For women – 3 shifts; 3 jackets; 3 petticoats; 2 kerchiefs”.<sup>84</sup> Both the asylums and the civil hospitals provided an ordinary burial for the destitute elderly who died within their confines.

Even if periodical stays in the asylum was a key element in the combined strategy of survival of the aged, permanent confinement in these same institutions was dreaded by most of the poor not least because of their separation from family and friends. Before the reorganisation of the public charity establishments in Malta and the Ionian islands, which started from the mid-1840s, asylums enclosed paupers, “deranged” and disabled persons, poor spinsters, prostitutes and women prisoners with the aged under one roof.<sup>85</sup> This state of affairs, added to the restriction of space and overall shabby conditions, helped to spread the perception of the *Ospizio* as a bleak place and therefore, permanent transfer to these places was usually resisted by the infirm elderly, especially by those coming from the countryside and from the smaller isles.<sup>86</sup> Evidently, for the aging poor, moving permanently to one of these institutions was associated with the last stage of life, with disability, mental decay, powerlessness and with dying in an impersonal environment. The higher rate of death “incurred among aged paupers” in these charity institutions, and their association with the outbreak of epidemics such as cholera, as much as the believe that the corpses of dead inmates were used for post-mortem examinations, deepened popular fear of dying in these asylums.<sup>87</sup>

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83 *Storia della Societa' Medica d'Incoraggiamento* (Malta, 1845), p. 156; Bullock Webster, p. 26.

84 Montgomery, *History of the British Possessions*, pp. 246–248.

85 Hennen, pp. 196, 483. See also notes on the use of the *Ospizio* in Corfu, ‘da recuperare gli indigenti colorosi’ in 1850: ‘Commissione Municipale del’igiene Pubblica, Corfu, il 12 Settembre 1850 – copia del processo verbale tenuto alla Commissione Municipale all’ Igiene Pubblica, per ogni successivo effetto di legge’ (Corfu, 7 Settembre 1850), 11/6, SAC.G.

86 Cassar, pp. 192–193; A. Cremona, *L'Ospizzju tal-Furjana u l-Erwieh ta' Wied Ghammieg* (Malta, 1959), *passim*.

87 Cassar, pp. 193–194; Davy, pp. 109, 265; Henry Jervis-White Jervis, p. 236; Micallef, p. 20.

As part of the above-mentioned state reorganisation of the hospital sector in Malta and Corfu and in the adjoining islands,<sup>88</sup> the elderly were placed in separate buildings from other sick patients, the mentally ill and from female prisoners. But the policy of separation according to sex within the same institution led to the splitting of aged couples in different sections of the same asylum.<sup>89</sup> This procedure must have further shaped the elderly couples' decision for only one of them, usually the male, to find a temporary place in this institution. This itself helps to explain why elderly males formed the bulk of those within the 65–90+ years bracket occupying a bed in the central state asylums of Malta and Gozo in 1851–1861, even though females constituted the larger share of the total age range as of the general population. To be sure, males formed the majority of those elderly, within the above age range, counted in all the other civil hospitals all over the islands. In contrast, elderly women in the same age group were, in their large majority, to be found at home. At this point, it is significant to note that the 1851–1861 statistics indicate that those 'aged and infirm' being domestically cared for lived longer than those found in the asylums, and not infrequently living up to the ripe age of 95 and 100 years.<sup>90</sup>

## Conclusion

The general picture which emerges out of this study shows the elderly poor, in both rural and urban contexts, actively engaged in obtaining daily requirements for themselves and, more frequently than previously thought, for their families, for as long as they were physically capable of doing so. While self-help practices, both within and out of the households, consumed most of the daily energy and time of aging men and women, it also becomes evident that these activities were usually not sufficient to secure the provisions, medication and social care they needed during times of unforeseen adversity caused by illness, disability and economic ruin. In response to these distressful conditions of poverty, the aged employed their life-experience, customary knowledge, social skills and multivarious practical competences, to bargain for relief and medical care from a combination of household, community and the more formal state charity agents and institutions.

From the specific inquiry over the use of the state charitable institutions and relief by the elderly, two remarkable traits have surfaced. Firstly, that a circular movement, in and out, patterned the use of the asylum by the elderly, and this according to season, individual and household situational requirements, and general

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88 Leiton (Corfu) to Earl Grey, 18 April 1846, no. 45, CO.136/124/1846, PRO.L.; W. Reid (Malta) to Duke of Newcastle, 13 April 1853, no. 27, in *BPP*, 1852–53, vol. LXII.

89 Davy, p. 109.

90 *Census of the Islands of Malta 1861*, pp. 144–145.

economic circumstances prevalent at a particular time. Secondly, that when it came to avail themselves of the formal outdoor relief and charitable institutions, elderly couples within their households practiced what is here termed a shared coping strategy, by which one of them, usually the male, occupied a place in the asylum, at least temporarily, and thus providing some respite for the rest of the household. Both these traits illustrate the flexible and adaptive nature of the coping strategies employed by the aging poor, particularly in the urban districts under discussion. Moreover, this goes a step further to explain why, at least according to the more reliable statistics available as from 1851, males formed the largest proportion of inmates in the public asylums, of those petitioning for relief and of those recorded as public 'professional' beggars.

Another contribution made by this study is to prove that on these British-controlled islands, the elderly poor, most particularly those living in the urban districts, showed themselves capable of negotiating with state relief agencies and institutions, especially when it came to procure indispensable provisions, medical treatment and shelter. Besides their individual face-to-face culture of bargaining with these providers, it has also been shown that the old people's claims for relief were expressed in a common language of distress which articulated the collective mentality of the Ionian and Maltese poor of expecting relief from the state "as by right". It has been argued here that this did not only form part of a cultural tradition inculcated in the people by centuries of state paternalism, but was grounded in and reproduced by immediate material factors: primarily the lifelong tax contributions on consumables paid by the poor themselves and which, forming the greater part of state revenue, compensated for all the charitable support they would get throughout their life cycle, especially during old age.

One final, underlying, conclusion of this paper is that elderly poor, in their rural and urban social landscapes, adopted coping strategies to mitigate under-nourishment, destitution and distress, by employing a combination of resources and assistance from the household, community bodies and public charitable institutions, in a complementary way. Thus they were able to reduce the risk incumbent in reliance on one sole provider. It was through such flexible survival strategies that the aging poor endeavoured to respond to their daily requirements and also to unforeseen changes in their life circumstances, and at the same time assure themselves that their basic needs during advanced old age would be met. This represented an attempt to hold on, as much as possible, to a measure of control over their lives, within the limitations imposed by health and poverty.

*John Chircop* is senior lecturer at the Department of History, the University of Malta.

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# Professional Responsibility and the Welfare System in Spain at the Turn of the 19th Century

Pilar León Sanz

## Introduction

This presentation forms part of a wider study on attitudes of physicians prior to the establishment of a social welfare system in Spain. The research is based on professional sources from the decade immediately prior to, and that immediately following, 1900. More specifically, the sources consist mainly of medical publications of the recently founded Medical Professional Associations, written by ‘experts’ who considered themselves spokespersons for the medical class.<sup>1</sup>

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1 We are referring to Andrés del Busto y López (1832–1899): professor and chair of various subjects in Madrid, member of the Royal Academy of Medicine (1877); physician in the court of Queen Isabel II. In charge of the professional matters section of the first board of the Colegio de Madrid in 1894. (José Alvarez-Sierra, *Diccionario de autoridades médicas* (Madrid, 1963), p. 90; Agustín Albarracín Teulón, *Historia del Colegio de Médicos de Madrid* (Madrid, 2000), p. 19). Eloy Bejarano y Sánchez (1855–1917), first Inspector General of Interior Health of Spain (1904–1910). Academic occupied various political positions (Director of Public Health in 1903) and played an active in association policy. (José Alvarez-Sierra, *Diccionario de autoridades médicas* (Madrid, 1963), pp. 68–69; Agustín Albarracín Teulón, *Historia del Colegio de Médicos de Madrid* (Madrid, 2000), pp. 44, 66; Pilar León Sanz, “El poder de los médicos. Un análisis de *El ejercicio profesional de la medicina en nuestros días* (Madrid, 1906)”, *Estudios do Século XX*, 5 (2005), 223–241). Antonio Piga y Pascual (1879–1952): forensic scientist, professor in the School of Legal Medicine and department head of the center. Academic (1941) and president of the College of Physicians of Madrid (José Alvarez-Sierra, *Diccionario de autoridades médicas* (Madrid, 1963), p. 110; Agustín Albarracín Teulón, *Historia del Colegio de Médicos de Madrid* (Madrid, 2000), p. 648). Eduardo Toledo y Toledo, known for his book *Sociología médica. Breve estudio de Moral profesional*. Madrid 1897, advertised in *El Siglo Médico*. Angel Pulido Fernández (1852–1932) (Delfín García Guerra, Víctor Álvarez Antuña, “Salud Pública y regeneracionismo en la tarea de Ángel Pulido al frente de la Dirección General de Sanidad”, *Dynamis* 14 (1994), 23–41; José Alvarez-Sierra, *Diccionario de autoridades médicas* (Madrid, 1963), p. 113; Agustín Albarracín Teulón, *Historia del Colegio de Médicos de Madrid* (Madrid, 2000), p. 630). First International

Before moving forward, it has to be said that the crisis through which the medical profession was passing during this period had a significant impact on the physicians' response to the newly created social welfare systems. Although the need to improve healthcare for the least favoured social classes was considered by physicians as a medical necessity, this did not mean that physicians were willing to give up their right to protect their own interests and prevent other social classes from taking advantage of the new situation. Physicians were responding to a change in the professional model that implied labour dependence with respect to a third party (corporations, private health insurance companies, etc.). They tried to conserve the liberal model of practice and to defend the freedom to establish fees. To this, one needs to add the influence of events taking place in other European countries on Spanish physicians.

## Systems of Collectivised Assistance during the Transition from the 19th to the 20th Century

From the 1880s, the reform and hygiene movements, legislation and socio-economic conditions ignited the desire for change in the social welfare system in Spain.<sup>2</sup> The systems that evolved were linked to worker collectivism and with movements related to the social doctrine of the Catholic Church, promoted by Pope Leo XIII.<sup>3</sup> Recognition of the importance of the Catholic movements and of the structures that evolved under the auspices of the Church is unanimous: its

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Conference of Professional Medicine and Medical Deontology 1900. And others like Alfredo Fischer Santamaría, José Codina Caltellví, physician of the Academic Hospital and part-time professor, etc. We also reviewed articles which appeared in the professional press such as *El Boletín de medicina, cirugía y farmacia. Sociedad Médica Oficial de Socorros Mutuos* (1834–1853). And that which resulted from the merger with the medical gazette: *El Siglo Médico* (1854–1936). It is also necessary to examine the writings of authors such as Severino Aznar Embid (1870–1959), sociologist, politician and journalist Mercedes López Coira, *El pensamiento social de Severino Aznar: 1870–1959* (Madrid, 1986); Salustiano del Campo, *Historia de la sociología española* (Barcelona, 2001). Or Alvaro López Núñez, José Maluquer y Salvador, etc. for their respective role in the creation of the National Welfare Institute.

2 Feliciano Montero García, *Los seguros sociales en la España del siglo XX: orígenes y antecedentes de la previsión social* (Madrid, 1988); Santiago Castillo, ed., *Solidaridad desde abajo: trabajadores y socorros mutuos en la España Contemporánea* (Madrid, 1994); Esteban Rodríguez Ocaña, “Los servicios de salud pública en la España contemporánea”, *Trabajo social y salud* 43 (2002), 91–116; Esteban Rodríguez Ocaña, “La asistencia médica colectiva en España, hasta 1936”, in J. Álvarez Junco et al., *Historia de la acción social pública en España: Beneficiencia y previsión* (Madrid, 1990), pp. 321–361; Rafael Huertas García-Alejo, “Salud Pública en la España contemporánea”, *Dynamis* 14 (1994), 17–21, and the bibliography included therein.

3 José Andrés-Gallego, *Pensamiento y acción social de la Iglesia en España* (Madrid, 1984), pp. 12–52. Also Feliciano Montero García, *El primer catolicismo social y la "Rerum Novarum" en España* (Madrid, 1983); Louis Garriguet, *La Asociación obrera* (Madrid, 1900).

actions contributed to the maintenance and support of initiatives intended to improve the precarious situation in which a large segment of society found itself.<sup>4</sup>

In the final decade of the 19th century there were, on the one hand, the traditional charitable institutions (general hospitals, homes for the elderly, asylums, orphanages) and others organised at the municipal level.<sup>5</sup> On the other hand there were *sociedades de socorros mutuos* (associations of mutual assistance), a system of private, non-profit-making, social welfare institutions, operating in a number of European countries.<sup>6</sup> The so-called mutualist movement grew uninterruptedly during the second half of the 19th century, with significant growth in the period from 1890 to 1910. In absolute numbers, subscribers and companies reached maximum levels between 1896–1906.<sup>7</sup>

In Spain at this time, there was ongoing socio-political debate about whether the State should intervene in the social welfare systems and about whether social security should be obligatory. In the last decade of the 19th century, the *Comisión de Reformas Sociales* (Commission on Social Reform) proposed the creation of a *Caja Nacional de Previsión* (National Welfare Fund).<sup>8</sup> It was not until 1900, however, that public social welfare actually came into being. That was the year the labour accident law was passed.<sup>9</sup> And in 1908, with the approval of all the political parties after heated debate, the *Instituto Nacional de Previsión* (National Welfare Institute) was founded. It was severely under-funded, however, and so its functions were limited to other areas:

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4 José Andrés-Gallego, *Pensamiento y acción social de la Iglesia en España* (Madrid, 1984), p. 39; Javier María Pejenaute Goñi, “Las Sociedades de Socorros Mutuos en Navarra (finales del siglo XIX)”, in *II Congreso Mundial Vasco* (San Sebastián, 1987), VI, 273–285; Ángel García-Sanz Marcotegui, *Navarra. Conflictividad social a comienzos del s. XX y noticia del anarcosindicalista Gregorio Suberviola Baigorri 1896–1924* (Pamplona, 1984), p. 45, etc.

5 In the 19th century, the charity was regulated by the municipal laws of 1823 and 1836, Decree 1854; Health Law of 1855 and its Regulations of 1868; Municipal Law of 1870; Royal Decree of 1891. Carried forward in the General Health Training Act of 1904.

6 Severino Aznar Embid, *El riesgo-enfermedad y las Sociedades de Socorros Mutuos* (Madrid, 1914); Alvaro López Núñez, *Ideario de previsión social* (Madrid, 1943), p. 79; Feliciano Montero García, *Los seguros sociales en la España del siglo XX: orígenes y antecedentes de la previsión social* (Madrid, 1988), p. 97.

7 José Andrés-Gallego, *Pensamiento y acción social de la Iglesia en España* (Madrid, 1984), pp. 146–150, 408.

8 Feliciano Montero García, *Los seguros sociales en la España del siglo XX: orígenes y antecedentes de la previsión social* (Madrid, 1988), p. 15.

9 It was followed by others laws: in 1900 the labor of women and children was regulated and in 1904, the law for the protection of minors was approved. Regarding the approval of the Law on Accidents, Feliciano Montero García, *Los seguros sociales en la España del siglo XX: orígenes y antecedentes de la previsión social* (Madrid, 1988), pp. 121–125.

Actions relating to the strengthening of the economic, pedagogic and social activities, of both individual and collective nature; vigilance and a higher compensation of risks through reinsurance.

The notion of a subsidiary role for the State prevailed at this time. Private health insurance companies also began offering medical-pharmaceutical services in urban centres.<sup>10</sup>

## A Delayed Reaction

Professional sources, books and magazines, did not examine the relationship between physicians and the associations of mutual assistance until the end of the 19<sup>th</sup> century, although we have found references to what is happening in other European countries. In 1856, *El Siglo médico* endorsed the idea that the *Sociedades de Socorros Mutuos* were frequently "copies of foreign associations"<sup>11</sup>. Two years later, in 1858, it writes about the charity congress held in Frankfurt, where, according to this professional journal, there was discussion about whether charity should be public or private; if it should be organised by town councils or by the state; if it could be secular or lay, religious or organised by individuals.<sup>12</sup>

However, the issue was not debated by professional theorists, such as Bofill,<sup>13</sup> nor was it included in written works produced by clinicians, such as Letamendi, although he commented extensively on medical fees, the relationship between professionals, responsibility before the law, and the relationship between law and society. References in the medical press were also rare.<sup>14</sup>

It is difficult to explain this apparent lack of interest in the issue, given the large number of publications – we have identified around fifty – on professional topics which appear between 1840 (the year after approval of legislation associated with the associations of mutual assistance) and 1889. There are a number of possible explanations for such an omission: it was not a topic of interest to influential foreign authors who were quoted by Spanish physicians in the first half of the 19<sup>th</sup> century. It did not appear in the works of Forget<sup>15</sup>, Simon<sup>16</sup>, or Hufeland<sup>17</sup>, one

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10 Feliciano Montero García, *Los seguros sociales en la España del siglo XX: orígenes y antecedentes de la previsión social* (Madrid, 1988), p. 165; Severino Aznar Embid, *El riesgo-enfermedad y las Sociedades de Socorros Mutuos* (Madrid, 1914), p. 20.

11 *El Siglo Médico* (1856), 398.

12 *El Siglo Médico* (1858), 31.

13 Simón Bofill y Nonell, *Deberes que el médico tiene contraídos con la humanidad* (Madrid, 1861).

14 José de Letamendi, *Curso de Clínica general ó Canon perpétuo de la practica médica* (Madrid, 1894); cf. *El Siglo Médico* (1897), 373–8; (1898), 22–23 and 54–55; etc.

15 Charles-Polydore Forget, *Deberes del médico* (Madrid, 1849).

could also suppose a peaceful and natural collaboration between the physicians and institutions which continued to provide traditional forms of assistance, such as the trades and the guilds. We must keep in mind that those same physicians had their own associations of mutual assistance.<sup>18</sup> Also, it may be that the numerous and serious problems that the medical profession was experiencing at this time<sup>19</sup> may have been distracting, perhaps causing it to underestimate the significance of the new institutions being proposed. Moreover, we have already commented *supra* on the high rise both in the number of bodies and members from the early 1890s. Together with the traditional Societies and Mutual Protection Societies, new bodies such as mixed (employees and employers) and trade unions appeared.

It should be noted that during the final years of the 19<sup>th</sup> century meetings were held both inside and outside Spain to discuss social welfare. As a result of these meetings, an ample bibliography was compiled outside Spain. In Spain, a subtle optimism was apparent in the solutions to the urgent professional problems proposed by the consolidation of the professional Councils which facilitated debate and the taking of corporate stances in the medical press.<sup>20</sup> Most notably, the physicians themselves were those who participated in the establishment of the new welfare systems. This is reflected in the publications and in the events at the end of the 19<sup>th</sup> and beginning of the 20<sup>th</sup> century. An excellent example was the organisation in 1900 of the First International Conference of Professional Medicine and Medical Deontology which dedicated the first portion of its agenda to the relationship between the physician and the collectivises, among which were included the mutual insurance companies.<sup>21</sup> The issue was also included in speeches and papers presented in the newly created medical associations and even in medical school textbooks. The Moureau and Lavrand text of 1901, translated by Sarmiento, in the section on “professional honor”, discussed the “involvement of the physician in associations that earn profit” and among the “specific cases”, specifically mentioned

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16 Maximilien Isidore Amand Simon, *Deontología médica. Treinta lecciones sobre los deberes de los médicos en el estado actual de la civilización con un breve resumen de sus derechos* (Madrid, 1852) (First edition: *Déontologie médicale ou des devoirs et des droits des médecins dans l'état actuel de la civilisation* (Paris, 1845).

17 Cristoph Wilhelm Hufeland, *Enchiridion medicum: or the practice of medicine* (New York, 1849).

18 In *El Siglo Médico* are gathered the statutes and regulations of some of the medical-pharmaceutical associations published during this period: (1892), 377, 489, 796; (1898), 217. Also, Severino Aznar Embid, *El seguro de enfermedad y los médicos* (Madrid, 1934).

19 See *infra* subtitle: *A Corporativist Reaction*.

20 Agustín Albarracín Teulón, “La profesión médica ante la sociedad española del siglo XIX”, *Asclepio* 25 (1973), 303–316.

21 The first section of the First International Conference of Professional Medicine and Medical Deontology (1900) was denominated: relationship of the physician with the collectivites.

“life insurance” and the “associations of mutual assistance” and the “medical reports of the ill”.<sup>22</sup>

In 1902 a Labour Accident Congress was held in Bilbao,

which was attended by prestigious national and foreign representatives, [and] gave the public ideas that until then were only held by a limited number of specialists<sup>23</sup>.

Angel Pulido himself, in his speech to the *Colegio de Médicos de Madrid* in 1903, confirmed the backwardness of Spain and gave details of the systems set up in USA, France, Belgium, Germany and England<sup>24</sup>. And Bejarano admitted “because of the currents of social solidarity which have done miracles in Belgium and in France”, organisation was going ahead of “mutual aid associations and trade unions in our country, especially in the large towns”<sup>25</sup>.

In Spain, as in the other European countries, the German experience was seen as the background to the argument on the introduction of Social Health policies<sup>26</sup>. However, we must remember that the French model was also of great importance. *El Siglo médico* simultaneously describes the references from Berlin and Paris. Thus, for example, in 1902, it published the fees of physicians in these two capitals, and news from professional congresses that were held in Germany and France in 1900<sup>27</sup>. And in the same year it published: “The New French Health Law and the need for a similar one in Spain”<sup>28</sup>.

López Piñero pointed out that for many years Spanish 19<sup>th</sup> century work habitually used the analogical application of foreign studies and statistics, which situation, of which authors were very aware, continued during the first few decades of the 20<sup>th</sup> century<sup>29</sup>. For example, Severino Aznar complains “the European States are a great distance ahead of us”. In fact, he knows and quotes the different statistics for European countries, when the Spanish ones are unknown<sup>30</sup>.

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22 Hippolyte Moureau, Hubert Lavrand, *El Médico cristiano. Lecciones prácticas de moral médica* (Bellín, 1901), pp. 46–50, 120, 123, 124 and 138.

23 Alvaro López Núñez, *Ideario de previsión social* (Madrid, 1943), pp. 96 and 101. (Conference of 1920).

24 Ángel Pulido Fernández, *Relación de las clases médicas (con las asociaciones cooperativas e industriales benéfico-sanitarias)* (Madrid, 1903), pp. 14–16.

25 Eloy Bejarano y Sánchez, *Discursos leídos ante la Real Academia de Medicina*. (Madrid, 1906), p. 72.

26 Feliciano Montero García, *Los seguros sociales en la España del siglo XX: orígenes y antecedentes de la previsión social* (Madrid, 1988), p. 43.

27 *El Siglo médico* (1902), 402–408.

28 *El Siglo médico* (1902), 758–759.

29 Jose María López Piñero, Luis García Ballester, Pilar Faus Sevilla, *Medicina y sociedad en la España del siglo XIX* (Madrid, 1964); Esteban Rodríguez Ocaña, *La constitución de la medicina social como disciplina en España (1882–1923)* (Madrid, 1988), p. 17.

30 Severino Aznar Embid, *El riesgo-enfermedad y las Sociedades de Socorros Mutuos* (Madrid, 1914), p. 31.



## A Corporativist Reaction

The unease felt in the medical community due to its low standing in society, a reflection of the troubled period through which the profession passed in the 19<sup>th</sup> century, continued unabated.<sup>31</sup> This was somewhat difficult to explain, given the scientific advances of that time. At the heart of the situation were various professional factors. There continued to persist the question of the various types of professionals: physicians, surgeons, physician-surgeons, of the first, second or third class.<sup>32</sup> The similarity between the qualifications resulted in an increase in the number of physicians, to which was added the increase in medical school enrollment.<sup>33</sup> And with it

the inexorable law of supply and demand that also governs the financial destiny of our profession (...) fuelled scorn for the profession and brought severe disorder to the economic state of the physicians.<sup>34</sup>

Bejarano accurately noted: “The medical crisis demonstrates three distinct facets: the scientific, the social and the economic.”<sup>35</sup>

From the corporate perspective, the call to collectivise was constant. Only in this manner would a solution be found to such a critical situation.<sup>36</sup> The physicians’ mistake was in not joining together to defend their mutual interests. “Our error was in not knowing how to counteract the effects produced by the few effective measures taken against us.”<sup>37</sup> This perception strengthened the tendency towards professional associations which had begun to take hold:

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31 Agustín Albarracín Teulón, “La profesión médica ante la sociedad española del siglo XIX”, *Asclepio* 25 (1973), 303–316 (308); Anne Digby, *The evolution of British general practice 1850–1948* (Oxford, 1999), pp. 23–25, 111; Jacques Léonard, *La vie quotidienne du médecin de province au XIXe siècle* (Paris, 1977); José Valenzuela Candelario, “El espejismo del ejercicio libre. La ordenación de la asistencia médica en la España decimonónica”, *Dynamis*, 114 (1994), 269–304; Francisco Villacorta Baños, *Profesionales y burócratas: Estado y poder corporativo en la España del siglo XX 1890–1923* (Madrid, 1989).

32 Agustín Albarracín Teulón, “La asistencia médica rural en la España del siglo XIX”, *Asclepio* 25 (1969), 35–42; Agustín Albarracín Teulón, “La titulación médica rural en la España del siglo XIX”, *Asclepio* 21 (1969), 27–34.

33 Agustín Albarracín Teulón, “La titulación médica en España durante el siglo XIX”, *Cuadernos de Historia de la Medicina Española* XII (1973), 15–80.

34 Eloy Bejarano y Sánchez, *Discursos leídos ante la Real Academia de Medicina*. (Madrid, 1906), p. 64.

35 Eloy Bejarano y Sánchez, *Discursos leídos ante la Real Academia de Medicina*. (Madrid, 1906), p. 15.

36 Eloy Bejarano y Sánchez, *Discursos leídos ante la Real Academia de Medicina*. (Madrid, 1906), p. 15.

37 Eduardo Toledo y Toledo, *Sociología médica. Breve estudio de Moral profesional* (Madrid, 1897), p. 99; also the same idea in Ángel Pulido Fernández, *Discurso exponiendo el*

We physicians have much to learn, in this sense, from any workers' collective: the stonecutters and the carpenters join together in a union to dignify their art and to counter attempts to denigrate their labor at any cost.<sup>38</sup>

This resulted in a period of development of professional self-regulation, of corporate protest in support of the recently achieved medical autonomy. There were few alternatives proposed in response to the new collectivised social welfare systems. Only Ángel Pulido, pointed out, in both 1902 and 1907, the harmful effects that such systems had had in other countries, such as Belgium and France, such as the lack of respect for the individual, for which he enunciated the slogan “united, but not by force”. He attempted to assimilate the dissident voices, complaining about the limitation imposed on the freedom of practice by part of the profession.<sup>39</sup>

## Attitude of the Physicians to the Different Welfare Systems

Criticism of insurance companies was unanimous. The negative image was due to the corporation's focus on profit and these corporations were often compared with businesses that buy and sell, leaving families, the ill and medical professionals vulnerable. This was the view of Eduardo Toledo y Toledo<sup>40</sup>, Antonio Piga<sup>41</sup>, Eloy Bejarano<sup>42</sup> and Ángel Pulido.<sup>43</sup> They called for the medical community to unite and to resist the development and implantation of the corporate model. This will be further discussed later.

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*programa económico y profesional del Colegio en la Junta celebrada el día 27 de octubre de 1907* (Madrid, 1907), p. 20.

38 Eloy Bejarano y Sánchez, *Discursos leídos ante la Real Academia de Medicina*. (Madrid, 1906), p. 73.

39 In *El Siglo Médico* (1902), 379; Ángel Pulido Fernández, *Relación de las clases médicas (con las asociaciones cooperativas e industriales benéfico-sanitarias)* (Madrid, 1903); Ángel Pulido Fernández, *Discurso exponiendo el programa económico y profesional del Colegio en la Junta celebrada el día 27 de octubre de 1907* (Madrid, 1907). Cf. Agustín Albarracín Teulón, “Asociaciones médicas del siglo XIX”, *Cuadernos de Historia de la Medicina Española* X (1971), 119–186 (180–183).

40 Eduardo Toledo y Toledo, *Sociología médica. Breve estudio de Moral profesional* (Madrid, 1897), p. 19.

41 Antonio Piga y Pascual, *La Moral Médica y la “Fundación Sta. Cándida”* (Madrid, 1907), p. 5.

42 Eloy Bejarano y Sánchez, *Discursos leídos ante la Real Academia de Medicina*. (Madrid, 1906), p. 35.

43 Ángel Pulido Fernández, *Discurso exponiendo el programa económico y profesional del Colegio en la Junta celebrada el día 27 de octubre de 1907* (Madrid, 1907), p. 20.

As to mutual societies and the associations of mutual assistance, there was a variety of opinions. While Eloy Bejarano criticised them,<sup>44</sup> Ángel Pulido applauded them as long as they were not for profit.<sup>45</sup> Above all, the three general principles defended by the latter in 1903 were the following:

1. the principle of the right of the patient to medical assistance; 2. the right of the physician to practice; 3. the mediation between corporations.<sup>46</sup>

The resonance of these ideas in later documents – even those of today – was because they were based on a concept of rights and duties and participation of the physicians in the coordination of the systems. However, the context and significance was quite different since the right to practice referred not only to the physician's duty to society and its institutions but also to his relationship with other professionals.<sup>47</sup>

Yet, in practice, collaboration existed between the physicians and the associations of mutual assistance. Take, for example, the participation of physicians in the *Sociedad de Socorros Mutuos Centro Escolar y Dominical de Obreros de Pamplona* which, beginning in 1881, became involved in welfare, education, and prevention activities.<sup>48</sup> This was in response to the concern of the physicians for society and the environment: the issues of hygiene and sanitation were very important at the time.<sup>49</sup>

## Professional Responsibility

The professional arguments used against the associations, mutuals and insurance companies were formulated around, in addition to the professional instability of the times, the changes in civil and criminal responsibility of the physician as a result of

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44 Eloy Bejarano y Sánchez, *Discursos leídos ante la Real Academia de Medicina*. (Madrid, 1906), p. 72.

45 Ángel Pulido Fernández, *Discurso exponiendo el programa económico y profesional del Colegio en la Junta celebrada el día 27 de octubre de 1907* (Madrid, 1907), p. 30.

46 Ángel Pulido Fernández, *Relación de las clases médicas (con las asociaciones cooperativas e industriales benéfico-sanitarias)* (Madrid, 1903), p. 10.

47 Mercedes Samaniego Boneu, *Los seguros sociales en la España del siglo XX: la unificación de los seguros sociales a debate: la Segunda República* (Madrid, 1988). Y Esteban Rodríguez Ocaña, "La asistencia médica colectiva en España, hasta 1936"; in J. Alvarez Junco et al., *Historia de la acción social pública en España: Beneficiencia y previsión* (Madrid, 1990), pp. 346–7.

48 Sagrario Anaut Bravo, *Luces y sombras de una ciudad: los límites del reformismo social y del higienismo en Pamplona* (Pamplona, 2001), p. 248.

49 Henri Hatzfeld, *Du Paupérisme à la Sécurité Sociale: essai sur les origines de la sécurité sociale en France, 1850–1940* (Paris, 1971).

new legal regulations.<sup>50</sup> The physicians were sensitive to, and anxious about, maintaining their independence and autonomy which they felt were being threatened.

### *a) An Intermediary in the Doctor-Patient Relationship*

The physicians cautioned that the intervention of a company, corporation or mutual association in clinical practice would have a negative impact on the doctor-patient relationship due to the involvement of interests alien to the administration of medical assistance:

The physician, as individual and professional under such conditions, could not treat patients as individuals but rather would be obliged to treat the ill of institutions and vast collectives, disciplined and powerful, prepared to defend their interests and objectives.<sup>51</sup>

The physician would have to justify his work to third parties and obligatorily confer that which before he previously offered out of virtue; thereby exercising restrictions on the delivery and generosity of patient care which had until now been proverbial.<sup>52</sup> The result would be, as Pulido stated in 1903, a distancing of doctor and patient.<sup>53</sup> It should be noted that the author seemed to allude more to the status and professional independence of the physician than to the needs of the infirm in so far as any threat to confidence as a result of changes to the doctor-patient relationship was concerned.<sup>54</sup>

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50 Changes came about in a good number of European countries. In Spain in 1822 appeared the Penal Code (revised in 1848, 1870 and 1928), in 1829 the Commercial Code (modified in 1885), in 1859 the Civil Code (revised in 1889). There were numerous commentaries in this area in the medical journals during the second half of the 19th century. Cf. Juan José Llovet, "Problemática e ideologías de la responsabilidad médica en España (1850–1949)", *Asclepio* 44 (1992), 71–94.

51 Ángel Pulido Fernández, *Discurso exponiendo el programa económico y profesional del Colegio en la Junta celebrada el día 27 de octubre de 1907* (Madrid, 1907), p. 9.

52 Ángel Pulido Fernández, *Relación de las clases médicas (con las asociaciones cooperativas e industriales benéfico-sanitarias)* (Madrid, 1903), p. 10; Ángel Pulido Fernández, *Discurso exponiendo el programa económico y profesional del Colegio en la Junta celebrada el día 27 de octubre de 1907* (Madrid, 1907), p. 30.

53 Ángel Pulido Fernández, *Relación de las clases médicas (con las asociaciones cooperativas e industriales benéfico-sanitarias)* (Madrid, 1903), p. 10.

54 Ángel Pulido Fernández, *Discurso exponiendo el programa económico y profesional del Colegio en la Junta celebrada el día 27 de octubre de 1907* (Madrid, 1907), p. 22.

## *b) Freedom to Practice*

The freedom to practice medicine was a constant demand. Toledo called for it in 1897,<sup>55</sup> Bejarano in 1906,<sup>56</sup> and Pulido in 1907,<sup>57</sup> among many others. All were opposed to physician activities being overseen by persons outside the profession, although they recognised the duty to continue medical attention once initiated:

The free physician has the perfect right to deny certain assistance if he or she so decides, but once accepted, such assistance should continue until no longer necessary.<sup>58</sup>

They reinforced the argument by stating that the right of election similarly existed for the patient:

Is it proper to assign a particular physician to a patient, when to a physician the patient must submit his life, secrets, powers, all that which he holds dear? Is it proper to impose on him a physician who is not to his liking?<sup>59</sup>

The Union of Physicians of Girona focused on this issue:

In the ideal situation, the patient's freedom should be respected, allowing him to choose from among those physicians in the community willing to provide that service.<sup>60</sup>

It is interesting to note that by calling for a patient's liberty to choose a physician, the physicians are displacing, at least partially, the responsibility for the medical act towards the patients and their families.<sup>61</sup>

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55 Eduardo Toledo y Toledo, *Sociología médica. Breve estudio de Moral profesional* (Madrid, 1897), p. 54.

56 Eloy Bejarano y Sánchez, *Discursos leídos ante la Real Academia de Medicina*. (Madrid, 1906), p. 72.

57 Ángel Pulido Fernández, *Discurso exponiendo el programa económico y profesional del Colegio en la Junta celebrada el día 27 de octubre de 1907* (Madrid, 1907), p. 25.

58 Eduardo Toledo y Toledo, *Sociología médica. Breve estudio de Moral profesional* (Madrid, 1897), p. 223.

59 Ángel Pulido Fernández, *Discurso exponiendo el programa económico y profesional del Colegio en la Junta celebrada el día 27 de octubre de 1907* (Madrid, 1907), p. 27.

60 Association des Médecins de La Gironde, *Consejos profesionales y principios de Deontología médica* (Girona, 1898), p. 30. This recommendations were assumed by the Medical Union of the province of Girona.

61 Ángel Pulido Fernández, *Discurso exponiendo el programa económico y profesional del Colegio en la Junta celebrada el día 27 de octubre de 1907* (Madrid, 1907), p. 28.

### *c) Professional Secrecy and Truthfulness, and the Insurance Companies*

The sanctity of the doctor-patient relationship was often a burning issue during this period<sup>62</sup> and it appeared once again threatened by the interference of the mutuals and insurance companies. The medical profession's reaction was predictable: the Physician's Union of Girona imposed on its members the obligation to maintain professional secrecy with warnings similar to those existing today.<sup>63</sup> Dr. Bejarano was also strict in this respect.<sup>64</sup> Nevertheless, the relationship between the physicians and the companies also had to be a loyal and truthful one. Protection of the insured patient would not justify acts against insurance company interests:

Whoever accepts the position as insurance company doctor becomes an extension of same and is obliged to provide the truth whenever demanded.<sup>65</sup>

The lines of conflict were drawn since doctors could not respect the requirements of the associations or corporations and those of the insured patients simultaneously.<sup>66</sup>

The medical reports caused many complications. They required constant, in-depth training in wider areas but the worst thing was that some physicians would have to supervise and demand compliance from other physicians, since their function was to "watch over the treatment in the hospitals, infirmaries or in the private home."<sup>67</sup> This was, in the opinion of Bejarano, yet another example of interference by the State into areas which were exclusively medical in nature, prompted by "the currents of social solidarity and charity".<sup>68</sup>

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62 In Spain – as well as in other European countries – doubts arose about the new laws and civil codes which obligated professionals to testify as experts before companies and judges. In Spain, this was the professional issue most often addressed in doctoral theses and speeches in the second half of the 19th century.

63 Association des Médecins de La Gironde, *Consejos profesionales y principios de Deontología médica* (Girona, 1898), p. 31.

64 Eloy Bejarano y Sánchez, *Discursos leídos ante la Real Academia de Medicina*. (Madrid, 1906), pp. 35 and 42.

65 Association des Médecins de La Gironde, *Consejos profesionales y principios de Deontología médica* (Girona, 1898), p. 31.

66 Antonio Martín y Menéndez, *Apuntes médico-legales referentes al secreto profesional en España* (Madrid, 1900), pp. 14–16.

67 Eloy Bejarano y Sánchez, *Discursos leídos ante la Real Academia de Medicina*. (Madrid, 1906), p. 75.

68 Eloy Bejarano y Sánchez, *Discursos leídos ante la Real Academia de Medicina*. (Madrid, 1906), p. 74.

## Conclusion: In Favor of a Good and Necessary Social Welfare System?

We found physicians in favour of establishing a welfare system that was not exclusively public which, in addition to benefiting the needy, would benefit the interests of the profession as well. To that end, they proposed reinforcing systems which offered assistance to the greatest number of needy, which in turn would most benefit them.

Properly understood, mutualism represents nothing more than the effort by the lowest social classes to be integrated into society. That is, these social classes try to free themselves from State charity, so if all those classes remove themselves from State charity, they can again form part of the doctors' clientele.<sup>69</sup>

We can conclude by stating that during the last decade of the 19<sup>th</sup> century and the first of the 20<sup>th</sup>, there began a debate regarding the systems of collectivized health care in Spain. It may have been triggered by the State's initiative toward greater intervention and its moving ahead with legislative measures, in addition to the proliferation of private insurance companies. The issue discussed by the physicians had to do with their professional identity – the fear of changing from free professionals into professionals contracted or paid by third parties. The professional association and its obligatory nature justified the promising tone of the debate, based on the strength provided by the cohesiveness of the physicians. We discovered intransigent and theoretical postures regarding the limitation of the freedom to practice that, over time, would become further radicalised,<sup>70</sup> balanced against a pragmatic collaborationism, extremely conventional in its attention to those most in need.

The awareness of change is perceived in this attitude, a change toward a greater role of the State and towards the obligatory nature of the welfare systems which the physicians could easily observe in other countries.<sup>71</sup>

*Pilar León Sanz* is Professor of History of Medicine at the Department of Biomedical Humanities, School of Medicine, University of Navarra. Pamplona 31008 Spain.

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69 Ángel Pulido Fernández, *Discurso exponiendo el programa económico y profesional del Colegio en la Junta celebrada el día 27 de octubre de 1907* (Madrid, 1907), p. 25.

70 Esteban Rodríguez Ocaña, "La asistencia médica colectiva en España, hasta 1936"; in J. Álvarez Junco et al., *Historia de la acción social pública en España: Beneficiencia y previsión* (Madrid, 1990), pp. 353–355.

71. Ángel Pulido Fernández, *Discurso exponiendo el programa económico y profesional del Colegio en la Junta celebrada el día 27 de octubre de 1907* (Madrid, 1907), p. 27.

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# The Invention of a Medical Institution?

## A Discussion of Hospitals Around 1800

Fritz Dross

Discussing health care between self-help, intermediary organisations and formal poor relief in terms of choices between the informal and the formal it seems quite clear on which side research of hospitals in the late 18<sup>th</sup> century is placed. Based on the formula of the “Birth of the Clinic” and relying on sociological research of hospitals of the late 1960s and 1970s wide parts of the German-speaking social history of medicine dedicated to the 19<sup>th</sup> and early 20<sup>th</sup> century development of the modern hospital claimed their historical subject to be “one of the most complex institutions of man.”<sup>1</sup> This research abandoned the suggestion of a long-term transition from the medieval hospital to the late 20<sup>th</sup> century high-tech-clinic in which religion has been slowly disappearing from hospitals while clinical observation and permanently growing knowledge of nature of disease and finally scientific medicine captured the charitable home of benevolence.<sup>2</sup> This research had to suggest a systematic rupture around 1800.<sup>3</sup> Two reasons were named for that. Firstly, in a systematic sense, the main objective of medieval and early modern hospitals was not the physical cure of sick patients (i.e. the restoration of their ability to work). Being a charitable foundation it was dedicated to the salvation of its founder’s soul. Secondly, as a historical argument, it is obviously striking that the modern hospital fits extremely well in the discourse of medical police in the late 18<sup>th</sup> century.<sup>4</sup> An example reference for these discussions is the German book published in 1790: “On the advantages of (modern) hospitals for the state.”<sup>5</sup>

Both arguments have been criticised in recent historical research. On the one hand, one could ask if there were any institutions that were not dedicated to the salvation of the Christians’ souls in medieval Europe. At least in this very shortened form, the systematic argument is not really convincing. Furthermore, there was of

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1 Labisch/Spree, 1996; Labisch / Spree, 2001; Stollberg/Tamm, 2001; Rohde, 1974. The citation of Edward D. Churchill is from Faxon, 1949, p. 1.

2 Jetter, 1969, p. 121–138; Jetter, 1977; Murken, 1988.

3 Labisch: Stadt, 1996, p. 287.

4 Dinges, 2000; Wahrig / Sohn, 2003.

5 “Von den Vortheilen der Krankenhäuser für den Staat”. Markus, 1790.

course curing in early modern hospitals, at least since the 16<sup>th</sup> century.<sup>6</sup> To give a prominent example, one could name the hospitals dedicated to the so called “French disease” (Syphilis) which were houses where academically trained medical doctors treated their patients in order to cure them within several weeks. On the other hand, late 18<sup>th</sup> century discourse had not only popular proponents of modern hospital care but also strong arguments for domiciliary care.<sup>7</sup>

In the following I will try to develop some arguments for a hypothesis which I would like to call “the invention of a medical institution”. Like Micheline Louis-Courvoisier, who asked the very convincing question: “Why attend a hospital if one is ill in the late 18<sup>th</sup> century”,<sup>8</sup> I want to ask “Why does a society discuss hospital care, while there is obviously no medicine, which could cure better there than in the homes of the sick”? While the epistemological change of medicine led to the “Birth of the Clinic” (Michel Foucault), I want to take a look at historical circumstances, which generated demand for and acceptance of new forms of public welfare. Deciding whether to go to a hospital or not is obviously dependent on the offer to have a hospital to go to.

Social institutions are not invented in enlightened moments of a sole genius. The formula of an “invention of an institution” is understood as a result of a debate which reflects and which at the same time is strongly depending on its own social conditions and necessities in its culturally and historically given language. Maybe there will be a chance to understand the hospital as “one of the most complex institutions of man” if we take a look at a very early stage of discussion, when there still were several options to achieve the institutional aim. In a historical perspective one has to draw special attention to failed hospital foundation and to choose a starting point, when the contemporary debate still knew serious arguments against hospital cure.

I am not going to present a concise theory of institutions or institutionalisation in history for several reasons. In a wider, sociological sense, the term institution means an organised group of interacting individuals in order to satisfy basic and persistent needs with common values and shared norms, which define interaction in the group as well as the communication of the institution with outside individuals, other institutions and the outside world.<sup>9</sup> Sociologists use the term to describe phenomena like economy and consumption or family and kinship, for example. If in this case, for example, family is one of the oldest and strongest institutions maybe of mankind in general, it will hardly be possible to draw a line between self-

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6 Knefelkamp, 1989; Stein, 2003; Jütte, 1996, p. 34f.

7 Dross, 2004, p. 84–112.

8 “Pourquoi aller à l’Hôpital quand on est malade au XVIII<sup>ème</sup> siècle?” Louis-Courvoisier, 2000.

9 Rohde, 1974, p. 91–125; Robertson, 1987, p. 93; Lenski / Nolan, 1991, p. 43; Maconis/Plummer, 1997, p. 407–604; Eder 1997.

help and institutional help, which should be one of the major aims of this volume. At the same time theories about institutional externalisation and organisational professionalisation of institutions are already well-known. To give some more historical pieces of circumstantial evidence does not contribute all-too-much to our purpose. In this sense, my method is theoretically low-leveled as I suppose that there was something like a hospital, which could be the subject of a debate. Given merely linguistic and situational evidence in this first step, I want to understand what the debate about hospitals historically was about and thus have to avoid assuming exclusive criteria of what hospitals should have been in a frameset of a strong theory of modernisation. This way I hope to get a trace for historically understanding a process of institutional and, in the end, social change.

The analysis is divided into two major parts. Firstly I am going to present some examples of the non-foundation of hospitals. Based on archival material and cases given in the literature, I intend to reflect on the administrative problems coming along with the foundation of hospitals in late absolutist and early 19<sup>th</sup> century Germany. As hospitals tend to be expensive organisations one will firstly be confronted with the overall lack of funds. Furthermore, the frictional resistance of the historical administrative organisational frame can be observed. Both are not specifically connected with deliberating the foundation of a hospital, of course.

Obviously the main promoters of hospital foundations have been doctors, sometimes invisible behind their princes, who formally gave the instructions to begin the deliberations among the governmental bodies. Thus, doctors should have been prepared with conclusive arguments in favour of hospitals. This would be the point where medical expertise should have been translated into political and administrative discourse.

Beyond that transition in argumentation from medical into political debate, one has to look at the discussion between the doctors themselves to completely comprehend the transition. The second part of this paper aims to introduce that discussion. Late absolutist Germany has been depicted as the era of “medical police” accompanied by a wave of hospital foundations throughout the bigger and the smaller territories.<sup>10</sup>

The position claiming “the advantages of hospitals for the state” is very much better known<sup>11</sup> whilst the contra-position is so underestimated that a real discussion is scarcely visible so far. Based on an analysis of late 18<sup>th</sup> and early 19<sup>th</sup> century (mostly medical) periodicals, a brief overview of the debate concerning hospitals will be given. The two main positions in the debate on hospitals around 1800 (i.e. pro and contra hospital care) will be regarded with respect to their ability to create convincing arguments on the background of historical discourse. This reasoning

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10 See the list in Murken, 1988, p. 268; Paul, 1996.

11 Paul, 1996.

allows for a close look at the contemporary thinking of what hospitals are, of what healing is, and, of course, of what medicine is about. Finally, in conclusion I want to reconsider the position of the late 18<sup>th</sup>/early 19<sup>th</sup> century hospital and its historically given alternatives in terms of institutional care and the formal versus the informal in health care and poor relief.

Below, two efforts to establish a hospital will be considered for emphasising the arguments suggesting their foundation or non-foundation respectively. These cases have been analysed in a case study on the German town Düsseldorf (approximately 20,000 inhabitants around the year 1800), which was the capital of the territory of Jülich-Berg in north-western Germany.<sup>12</sup>

Johann Peter Brinckmann, the director of the Medical Authority of Jülich-Berg was the first to suggest the foundation of a modern hospital in Düsseldorf in 1776. Once he found 14 people in one house who had fallen ill with “rotten fever”.<sup>13</sup> He proposed a hospital which could break the vicious circle of poverty caused by the inability to work and the hardly avoidable infection of the other members of the household, the house and – at the worst – the whole quarter. As a member of government, Brinckmann reported his suggestion to the prince, the elector of the palatinate Karl Theodor, who instructed his privy council to deliberate the matter. They conferred quite elaborately, but 20 years later there was still no hospital founded.<sup>14</sup>

Noteworthy is the fact that Brinckmann did not only address his prince but also the well-known statesman and historian Justus Möser in Osnabrück. The debate on hospitals was obviously not exclusively a debate among physicians and doctors. Möser knew that hospitals were expensive and that proposing their foundation needed good arguments. According to Möser these were: the cure of the poor sick and the education of physicians as well as the scientific development of medicine itself. Since Düsseldorf was not big and had no University, Möser dissuaded Brinckmann from the foundation of a hospital in this town. Despite this advice Brinckmann continued his initiative to establish a hospital in Düsseldorf.

The second attempt to found a “modern” hospital in Düsseldorf in the year 1786 did not rely on the governmental authorities.<sup>15</sup> Johann Andreas Varnhagen propagated his concern to the public via press. Within a few weeks he gained almost 30 members for his philanthropic society which was to support a hospital for the sick poor. Being a physician, as his predecessor, Varnhagen focused on those who earned their living in good times without earning enough to save some money or just food to have enough in times of rising prices or unemployment. Even the least dangerous diseases had a lot of victims among the undernourished poor living in

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12 Dross, 2004.

13 “Faulfieber” or “faules Fieber”. Brinckmann, 1997, p. 19–21.

14 Dross, 2004, p. 174–182.

15 Ibid, p. 182–199.

the most unclean and impure homes which Varnhagen knew but the government forbade his advertisements and in 1791 he left Düsseldorf for Strasbourg as he was an adherent of the early revolutionary movement in France.

In 1792, the governmental commission which was still deliberating the older proposal of Johann Peter Brinckmann conceived a hospital comprising three parts: one for the old and weakened, another for people with infectious diseases and a third one for servants in order to protect the homes of their masters. But there was still no hospital founded. Thus, there was no hospital in Düsseldorf in the 1790s. At the same time, the idea of a hospital for the sick poor was already well-known among the governmental personnel and the newspaper-reading intelligence and merchants.

In the Westphalian city of Münster, the first attempt to found a new hospital in the 18<sup>th</sup> century goes back to the bishop Clemens August who established a mission of the Hospitaller Brothers of St. John of God in Münster in the early 1720s. But to build up a new hospital took several attempts before 1754, when the patients were moved to the new hospital building, which contained 16 beds only for men.<sup>16</sup> One could expect that this should have changed after Christoph Ludwig Hoffmann in 1764 came to Münster. Hoffmann was one of the most famous protagonists of medical reform in terms of “medical police”. He was in close contact with the above mentioned Justus Möser and Hoffmann’s reorganisation of the Medical Authority of the bishopric Münster was copied in several other territories as well as it was the archetype of Brinckmanns’ respective reform in Jülich-Berg.<sup>17</sup>

The governmental deliberations to found a new hospital in Münster started in 1784 – exactly the year of the completion of the famous General Hospital in Vienna containing about 2,000 beds. In the course of the governmental deliberations several examples of medical care were discussed. On the one hand the big hospital projects in Vienna and Würzburg had been under consideration. On the other hand, already in 1785 a goldsmith from Cologne reported his experiences concerning domiciliary care driven by beguines. Already in an early stage of debate, the planning of a big new hospital was abandoned in favour of a smaller one which, in addition to the St. Clemens hospital for men, should have been founded as a hospital only for women conducted by a female catholic order.<sup>18</sup> In the end, no hospital was founded. In 1810 the St. Clemens hospital was incorporated into the municipal poor relief organisation and after the brothers had left in 1818, their former rooms were devoted to the medical care of women.<sup>19</sup>

In 1786/87 Hoffmann left Münster when he was called to conduct a principal reorganisation of the medical authority by his patient Friedrich Karl Joseph von

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16 Jungnitz, 1981, p. 25–40.

17 Terhalle, 1987, p. 101–124; Brinckmann, 1997, p. 3; Labisch, 1997, p. 38–40.

18 Jungnitz, 1981, p. 70–73.

19 Ibid, p. 74.

Erthal, the elector and archbishop of Mainz. In Mainz again he was engaged with the question of hospital care. The new academic hospital had just opened when Hoffmann in 1788 published a small brochure claiming the necessity to provide not only a bed but a single room for each patient and thus affronting his colleague and medical professor in Mainz, Carl Strack, who conducted the project of the new academic hospital in Mainz.<sup>20</sup>

Obviously, there were two strong complexes of argumentation. On the one hand the clinical complex comprising the suggestion that (academic) hospitals would provide a better education of physicians which could be linked to the Leyden school of academic medical teaching.<sup>21</sup> Furthermore, the suggestion that medical knowledge as a whole could be improved by systematic awareness of medical observation which could be linked to the empiricist movement of late 18<sup>th</sup> century science in general. On the other hand we have the complex of argumentation that curing the poor in hospitals would be quite useful – if not necessary – for the common best.<sup>22</sup> The most successful hospital foundations like those in Vienna and Würzburg came along with both major revisions in the medical teaching system as well as in the organisation of poor relief.<sup>23</sup> In Göttingen poor relief reform conducted by the magistrate and reforms in academic medical training driven by the University could not agree. In consequence, the “Birth of the Clinic” in Göttingen (as well as for example in Halle and Jena) preferred a policlinical model avoiding the foundation of a big and expensive hospital.<sup>24</sup> Würzburg, Bamberg and of course Vienna seemed to have been the exceptions proving the rule.

At the same time, one can detect two main points of criticism. Obviously, the cost of a hospital foundation, especially of building a hospital, could be avoided if domiciliary care would have been strengthened. Thus, without convincing arguments referring to the better chances of healing the patients and educating medical students hospital projects could hardly be debated seriously. The question how to plan and realise a hospital with respect to the location of the building and the design of the rooms even between physicians in favour of hospital care was still not unanimously decided as for example the Mainz case shows.

The problems got even worse when, in the beginning of the 19<sup>th</sup> century, doctors translated the argumentation of separating the curable and the incurable into the field of psychiatric ailments. Consequently, they had to persuade the state authorities to convert prisons and old-type hospitals into hospitals for the curable mentally ill. At the same time the prison itself changed its goal from just punishing criminals into their betterment. As well, early general hospitals usually rejected mentally ill

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20 Hoffmann, 1788a; Strack, 1788; Hoffmann, 1788b.

21 Buelzingsloewen, 1997; Karenberg, 1997.

22 Cunningham / Grell / Jütte, 2002.

23 Brinkschulte, 1996; Karenberg, 1997.

24 Buelzingsloewen 1997, p. 42f.; Karenberg, 1997, p. 33.



people in order to prove their ability to heal their patients. Around 1800 justice and medicine developed the analog model of an organisation aiming to better the bourgeois society by isolating their clientele. But these were referring to three at least theoretically clearly separable groups as their clientele: criminals (penitentiary/prison), the mentally ill (lunatic asylum/psychiatric hospital) and the poor sick (general hospital). This is the “discovery” of Michel Foucault, of course. But as all of these institutions of betterment had been (and still are) quite expensive organisations, at the moment of their “invention” they had to compete for the devotedness of the state for their goals.<sup>25</sup>

This has been studied for the case of Pforzheim/Heidelberg/Illeben in southwestern Germany and Munich.<sup>26</sup> Even more complicatedly undulated the debate on the foundation of a lunatic asylum in Hesse which began in 1806 and did not end before 1876 with an academic hospital in Marburg.<sup>27</sup> The first project suggested a lunatic asylum on the outskirts of Kassel and was proposed by the municipal physician but opposed by the burgomaster who preferred the Kassel Charité to leave some rooms for the mentally ill. Whilst the (general) hospital in Kassel (and elsewhere in Germany) tried to get rid of the lunatics in favour of curing the physically sick, the early 19<sup>th</sup> century discourse on hospitals for curable mentally ill people preferred locations in the countryside but rejected incurable and raving lunatics from hospital care. Since 1831, the medical authority as well as the parliament of Hesse discussed a clinical association of a lunatic asylum with the university of Marburg, which contradicted the concept of an idyllic location on the countryside as well as the idea that ease and order should be the main factors in curing the mentally ill.

A remarkable summary of the older debate on hospitals can be found in a memorandum which the state physician of the Düsseldorf Department Franz Joseph Servaes unsolicitedly sent to the ministry of the interior in 1810 (“Considerations of a sanitary police on charitable establishments and the related care for the poor and sick”).<sup>28</sup> Having arrived in Düsseldorf just some months before, he obviously wanted to demonstrate his ambitions to the government. The first thing to learn from that is the point that Servaes obviously assumed the governmental personnel, if not the minister of the interior himself, were willing to read his essay on domiciliary versus hospital care because he suggested medical advice in matters of poor relief. The doctor addressed the government of a very new state, the Great Duchy of Berg, which was founded by Napoleon I. not before 1806. Beneath

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25 Dross, 2006.

26 Chmielewski, 2003; Chmielewski, 2006; Lederer, 2003.

27 Vanja, 2001.

28 „Sanitäts Polizeyliche Betrachtung über die Wohlthätigkeits-Anstalten in Hinsicht der damit verbundenen Armen und Krankenverpflegung“ Hauptstaatsarchiv Düsseldorf, Großherzogtum Berg 5513. Dross, 2004, p. 199–208.

juridical reform, centred around the introduction of the Code Napoleon, and far reaching reforms in governmental administration the new state was indeed occupied with matters of a modern system of poor relief under unitary responsibility of the state but performed by local authorities.<sup>29</sup>

The Servaes' memoir comprises 45 paragraphs on 83 recto verso handwritten pages. In general, it cannot be taken as being especially witty in substance. However it shows that the discourse on medical police was well-known below the level of the all-time cited authorities in the early 19<sup>th</sup> century. Servaes very clearly provides a concise summary of the standard topics treated in the discourse on medical police.

My attention to that manuscript was first attracted by the fact that his author stated a very concrete position pro-hospital care. Further in-depth reading revealed that Servaes in his memoir cited two famous authors, both physicians: August Friedrich Hecker and Christoph Wilhelm Hufeland. Of course, Servaes did not mention them. Those, let me say “mid-level” physicians like Servaes, did not only know the general topics of the discourse, but they had also read the original texts and they were able to compose new texts out of their precise knowledge. Servaes combined the original texts in a very special way: following the structure of Hufeland's essay, which was not published before 1809, he puts the arguments of Hecker taken from an essay published in 1793. The result can not be called trivial because both essays took the completely opposite view in the mentioned debate on domiciliary versus hospital care. That way, Servaes provided his government with a commented survey of the medical debate on hospitals.

The medical debate on hospitals and domiciliary care (“Besuchsanstalten”) after the 1780s reflected on the role of medicine in fighting beggary and poverty by means of health care provision in poor relief and in providing the state with a healthy population in terms of “medical police”.<sup>30</sup> It began in Hamburg<sup>31</sup> in 1785 after some physicians had been infected with the so-called “rotten fever” and gained wide publicity when in 1785 the historian and publicist Georg August Schlözer published the articles of Hamburgian physicians Philipp Gabriel Hensler and Daniel Nootnagel in his “Stats-Anzeigen”.<sup>32</sup> The German debate also looked for international discussion on the topic. In 1791 Johann Christian Friedrich Scherf published his translation of a French publication in his famous “Beyträge zum Archiv der medizinischen Polizei und der Volksarzneikunde”.<sup>33</sup>

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29 Dross, 2004, p. 247–252. The development in the “german” Départements – on the left bank of the Rhine – of the Napoleonic empire has been studied by Hudemann-Simon, 1995; Hudemann-Simon 1997.

30 Brinkschulte, 1996, p. 191f.; Buelzingsloewen, 1997, p. 87–100.

31 Lindemann, 2002; Jütte, 1997.

32 Nootnagel, 1785; Hensler, 1785.

33 d'Apples Gaulis, 1786.

In the first instance the Hamburg debate discussed the risk for physicians to be infected by their patients, stating “it would not be the same if a sanguine young doctor or a journeyman would die from the pox.”<sup>34</sup> But the question, whether the risk of infection was greater in the malodorous hovels of the poor or in a synthetical environment accommodating all kinds of diseases in a highly concentrated manner could not be answered by and with scientifically convincing arguments. Beneath the risk of infection Hensler and Nootnagel paid special attention to the character and role of the interaction between a doctor and his patients. Hensler claimed the hospital as the perfect environment for the observation of the course of disease, diet, medication, heating etcetera whilst Nootnagel worried about the doctor getting confused among all the ill people whose names he would hardly be able to remember. When visiting patients in their homes the young doctors especially could concentrate on one sick person taking notice even of hardly visible symptoms as well as the concrete circumstances of living. In reaction to the superior social position of the doctor, patients would feel honoured and behave much more mercifully and servilely if visited at their homes.

In 1793, August Friedrich Hecker published his essay on “Which are the most convenient and cheapest means of providing the poor sick with the required (medical) help?”<sup>35</sup> This essay can be regarded as the almost classical argumentation in favour of hospitals and was the base of Servaes memoir. His argumentation begins distinguishing different groups of poor. He specifically defines who should generally not be entitled to hospital care: idle beggars and vagrants are not to be helped by the public. This is the very consequence of the discourse on poverty elaborated since the 15<sup>th</sup> century. Furthermore, hospitals do not have to incorporate patients with incurable diseases – this is one of the general parts of a definition of a modern hospital. The hospital is defined as an institution for curing people, who in better days are earning just enough to survive by their daily work or work by the day.

Following Hecker, there are at least four major advantages of hospitals compared to domiciliary care: 1) A doctor could medicate considerably more patients if they were in one place. 2) In the hospital, the nursing personnel are trained and monitored by doctors. In the homes of the poor the relatives do not care for their sick fathers, mothers, brothers and sisters as the bourgeois prejudice might assume. 3) In a hospital, besides diet, fresh and clean air, ventilation, illumination and heating are controlled by doctors in favour of the cure of the patients. Hecker suspects that a nursing family sold the food and the medication instead of giving it to the ill family member. 4) As a consequence of the better hospital environment, the risk of infec-

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34 „Es ist doch nicht eins, ob ein unbeerbter Kurfürst, oder sein Trompeter, in den Pocken verhudelt wird. Und es ist auch nicht völlig einerley, ob ein hoffnungsvoller junger Arzt, oder ein Handwerks-Bursch, dahin stirbt.“ Hensler, 1785.

35 „Welches sind die bequemsten und wohlfeilsten Mittel, kranken Armen in den Städten die nöthige Hülfe zu verschaffen?“ Hecker, 1793.

tions in a hospital is very low. The question whether patients in hospital deprave of morality is in Hecker's view simply ridiculous and not to be taken into consideration.

The most striking in Hecker's essay is his enormous self-awareness in presenting quite unassertive arguments. On the background of the contemporary debate one has to bear in mind that "rot" or "infection" are metaphorical terms differing considerably in meaning from what is meant by "infection" in nowadays post-bacteriological medicine. There were neither "bacteria" nor "viruses" in late 18<sup>th</sup> / early 19<sup>th</sup> century discourse.<sup>36</sup> In an essay on beggars in the countryside and in small towns, published in 1787, this context becomes clearer:

The beggars have to be seen as numb and rotten members of society. One has to be aware that rot in a political as well as in a moral or a physical sense always proliferates, and by and by infects and depraves the healthy.<sup>37</sup>

Strictly opposed to Hecker's view was the one of Christoph Wilhelm Hufeland. The statement in his essay on the care for the sick poor in Berlin, published in 1809, summarises his position: Following Hufeland, the sick person "meets in hospitals the most lewd people, familiarised to idleness, and after staying in hospital for two or three months he will return from hospital with an ameliorated body but a deteriorated soul."<sup>38</sup>

Thus, hospitals do not suit the means of poor relief at all, which after all has an educational and a moral intention. Beyond that, neither medical education nor scientific observation or classification should take place in hospitals. Like Daniel Nootnagel in the Hamburg debate on hospitals in 1785, Hufeland also claimed the necessity for the doctor to be especially aware of the environment of his patients. In hospital, the doctor only sees what should be – only in the homes of the poor he can observe the real conditions. Therefore, Hufeland claims domiciliary care to be the perfect "clinical" institution:

In hospital young doctors are trained to be just artists. Solely in the homes of the poor, doctors learn to become men, sanctifying their art and the sense of philan-

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36 Schott, 1998, p. 150–160.

37 „Diese [die Bettler, FD] sind nun ein für allemal schon als abgestorbene und in Fäulniß geratene Glieder der Gesellschaft anzusehen. Aber man bedenke, daß die Fäulniß im Politischen und Moralischen so gut wie im Physischen immer weiter um sich greift, und nach und nach auch die gesunden Glieder ansteckt und verderbt.“ *Berlinische Monatsschrift* 1787, 1, p. 9.

38 Hufeland, 1809. "Er wird dort [im KH, FD] mit Menschen aller Gattung, grösstentheils unsittlichen, liederlichen, an Müssiggang gewöhnten, in Verbindung gebracht, und er wird, nach einem Aufenthalt von 2 bis 3 Monaten, gebessert am Leib, aber verschlechtert an der Seele, aus dem Hospitale zurückkehren"

thropy. In the homes of the poor, humanity which is dying off in hospitals is nourished and intimately interwoven with the art.<sup>39</sup>

It was as early as in the middle of the 16<sup>th</sup> century that a Janus-faced debate on the modern state and the role of the individual began. The argument was settled around the possibility and necessity, if not the imperative, for the state to raise taxes.<sup>40</sup> Thus, the labouring individual paying her or his taxes could no longer be regarded as plain and simply selfish. Consequently, a wealthy state could be seen as a state ruling the largest possible number of subjects being able to earn their living and pay their taxes, which became the undoubted common-sense position in the political economy of the 18<sup>th</sup> century. Political and economic theory as well as confessional theology began to explore a new balance between the common best and private profit already before Adam Smith. Furthermore, medicine could serve political science and economics by providing an account of the demographic behaviour and the conditions of an increasing population. Finally, medicine began to develop the concept of a wealthy state managing the conditions of theoretically everyone's health by means of medical police. Within that frameset, developed over some 300 years, the arguments that poverty causes diseases and that a sick person runs the risk of pauperising as she or he is unable to earn her or his living due to sickness made health care a central mean of poor relief. Nevertheless, the debate on hospital versus domiciliary care in the early 19<sup>th</sup> century shows that neither medicine nor public opinion or governmental authorities preferred centralised hospital care for the sick poor.

With respect to the discussion on choices between the informal and the formal which should be the focus here I would like to abandon the formula of the "hospital as the most complex institution of man", as individuals always choose to rely on complex institutions. The more closely regarded, the more complex they get, regardless of whether morality or religion, family/kinship or neighbourhood constitute the analysed institution. Social institutions always aim at simplifying complexity in order to attain the bare possibility to make a decision.

Going back to a lower level, the hospital as well as domiciliary care could be analysed as an organisation which in general could be understood as negotiated order.<sup>41</sup> That way there may be a chance to open up a perspective which could be helpful in analysing the influence of changing institutions on more concrete organisations. Thus, we would lose a strict and clear line of demarcation between the

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39 „Im Hospital sehen sie, wie es seyn sollte, hier, wie es ist, dort werden sie blos zu Künstlern gebildet, hier auch zu fühlenden, und dadurch erst ihre Kunst heiligenden Menschen, und der Sinn der Menschenliebe und Humanität, der dort so leicht erstirbt, wird genährt, und innigst mit der Kunst verwebt.“

40 Schulze, 1986; Dross, 2004, p. 64–67; Schneider-Ludorff, 2004.

41 Watson, 2001.

formal and the informal. Strengthening the aspect of agency and choice systematically seems to weaken the differences between formally or informally organised collective models of curing as well as an unquestionable barrier between magic/religious/medical attitudes and practices in healing. Like the pro-hospital position could declare with Hecker that “collecting for a hospital in favour of the suffering mankind is for surely no worse divine service than building a church”, the contra-position stated the following Hufeland: “The whole affair has to be dealt with as a divine service and should be practised gratuitously and driven by inner incentive.”<sup>42</sup>

In fact, we are facing blurred borders as mentioned by Susanne Hoffmann in her contribution to this volume. Maybe self-help could be analysed more precisely if understood as the active choice to rely on different organisational models providing (medical) help. But at the same time by blurring the borders we could gain a wider perspective of choosing: The historical choices made in a discourse inventing a new organisational model of curing as well as the choices of the patients whether to confide in hospital care or not and, not least, the choice of historians to stress the formal conditions of the informal – or vice versa.

*Fritz Dross* is assistant professor at the Institute for History of Medicine and Medical Ethics, Friedrich-Alexander-Universität Erlangen-Nürnberg, Germany.

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<sup>42</sup> Hecker, 1793, 62 (literally cited by Servaes, Hauptstaatsarchiv Düsseldorf, Großherzogtum Berg 5513, Bl. 82. Hufeland, 1809, 7.

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