CULTURES OF HEALING

Medieval and After

Peregrine Horden

VARIORUM COLLECTED STUDIES

ROUTLEDGE

CULTURES OF HEALING

This volume brings together for the first time an updated collection of articles exploring poverty, poor relief, illness, and health care as they intersected in Western Europe, the Mediterranean and the Middle East, during a 'long' Middle Ages. It offers a thorough and wide-ranging investigation into the institution of the hospital and the development of medicine and charity, with focuses on the history of music therapy and the history of ideas and perceptions fundamental to psychoanalysis.

The collection is both sequel and complement to Horden's earlier volume of collected studies, *Hospitals and Healing from Antiquity to the Later Middle Ages* (2008). It will be welcomed by all those interested in the premodern history of healing and welfare for its breadth of scope and scholarly depth.

Peregrine Horden is Professor of Medieval History at Royal Holloway, University of London. He is co-author, with Nicholas Purcell, of *The Corrupting Sea* (2000) and of both its forthcoming successor and a collection of supplementary studies entitled *The Boundless Sea*. He is also writing a global history of hospitals.

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PREFACE

The studies collected here explore the domains of poverty and poor relief, and illness and health care, as they overlap or intersect in western Europe, the Mediterranean and the Middle East, during a 'long' Middle Ages. A more descriptive, if scarcely commercial, title might be: 'Healing and care of the sick and needy in the context of political, social, cultural and religious history, from Late Antiquity, through the Middle Ages, and into more recent centuries where there are topics illuminated by a medieval perspective'.

'Cultures of Healing': the 'healing' in the actual title thus has to be taken in a very broad sense. It embraces the attempted 'social healing' of charity, Jewish, Christian, and Islamic (Chapters 1–5, 8, 9, 13); the healing of body, mind, and soul variously practised by priests, doctors, and others; the auto-therapy of ordinary people with no special credentials or experience (2–7, 12, 13). The 'cultures' in the actual title stands for all the relevant contexts (political, social, and so on) in which the kinds of healing studied were embedded and in terms of which they must be understood. It is meant to evoke an open, anthropological conception of culture, not one confined to cultivated elites (e.g. 4 and 19). In many ways what I do is standard social history of charity and medicine. I have always resisted the reduction of everything to discourse or social construction, and do not think Foucault had all the answers. A recent 'turn' in the study of health and disease away from the constructivist towards the 'hard data' of ancient DNA and the like suggests that a synthesis of several different types of evidence and approach, textual and archaeological, in the history of healing remains desirable, and may even be moving from the rear- to the vanguard. That is what I have tried to practise. I am drawn to the histories of charity and medicine because both require transects through society, potentially involving every social group, every kind of subject, every type of data.

'Medieval and After': the study of both charity and medicine also can benefit from a view over the long term, whether the focus is Hippocratic medicine, the paradigm of which was not finally dissolved until well into the nineteenth century, or religious charity with its roots in the Bible or

the Qur'an. Questions of continuity or discontinuity, novelty or tradition, are important and can be tackled only by trampling down chronological boundaries. That is why it is often useful for a medievalist to move later. As a historian of medicine who loves music, I ventured into the history of music therapy, which I first came across in medieval Islamic hospitals before turning to study several of its more recent forms. Doing that took me from antiquity and the Middle Ages to the sixteenth to late twentieth centuries (14–16).[1] I am emphatically not tracing some grand transition from medieval to modern, partly because I do not know what 'modernity' is, and partly because of its inherent teleology. So much theorizing of modernity implies that history is a one-way street, and a comparativist historian who looks across several centuries or periods needs to move in more than a single direction. I once strayed into the history of Freud and psychoanalysis (18), treating it as a part of the intellectual history of the last century, a culture of healing if ever there was one. But reading in that area not only joined up with topics in the history of psychotherapy that I had come to under the music therapy heading (16); it helped me approach questions prompted by evidence of early medieval monasticism (17). More generally, though I do not argue the case in what follows, I have found in psychoanalysis – with its dynamic system of invisible entities, technical rhetoric, immunity to critique and counter-example, assumed explanatory power, and crucial complicity between therapist and patient – a very helpful analogy for the successes of medieval Galenic medicine.

This collection complements and overlaps with my earlier *Hospitals and Healing from Antiquity to the Later Middle Ages* (2008). The hospital, an institution in which healing, charity, and politics meet, remains a preoccupation here, viewed both over the long term and in close-up, as I worry away at its origins and early diffusion, at the medicine that has been dispensed within it, and at its effects on the poor and sick and on society as a whole (2–5, 8, 9, 11). Other forms and sources of charity are adduced for comparison and in one case, as a contribution to the history of the medieval parish, they are given a study of their own (13). A variety of healers appear: not only learned doctors but also nurses, saints in their shrines, alchemists prolonging life, magicians (e.g. 4, 6, 12). Likewise, a variety of sources and explanations of illness or perceived abnormality, including sexual and mental abnormality: humours, demons, families, sinfulness (and the Freudian id) (4–6, 18). There is also a range of medicines, from the usual sort of drugs to soothing music and vulture's giblets (14–16, 7). The geographical focus is western Eurasia, but there are brief excursions to America (1, 16). And I plan, elsewhere, to pursue the history of 'the first hospitals', in a monograph of that title, on a global scale.[2]

I have arranged the chapters as far as possible by period covered, rather than by theme, putting fourth-century hospitals first, after an opening panorama, and ending with the recent ethnography of demons.

The old-style Variorum offered photographic reprints, the listing of addenda and corrigenda being the only means of updating. The new style of text derives from the author's computer, and that presents both temptation and challenge. The challenge is that the original computer file, assuming one can find it, never exactly matches what was eventually published. The temptation, since corrections can now be made anywhere in the text, is to start extensive rewriting – to which there might be no end. I have resisted temptation (this one at least) and not rewritten on that scale. The principle has been to respect the integrity of the original form and argument of each paper. Thus, two previously unpublished papers from a few years ago have been checked and the references have been updated, but they have not been recast (6 and 17). Three contributions, as indicated in their opening notes, have been carved out of larger originals but not otherwise fundamentally changed (1, 15, 16). Overlaps between papers, as I tackle the same problem at different times and from different angles, have not been removed: I wanted each paper to be self-sufficient. I have, however, allowed myself very minor alterations, correction of local errors, and omission of a few topical references that date a piece, and I have inserted proper notes in place of brief in-text cross-references to other parts of the volumes in which some chapters first appeared. I have not updated existing endnotes systematically (especially with such a fast-developing profession as contemporary music therapy), but I have added a few more recent references in square brackets. Where fuller discussion of the newer literature of the subject seemed called for, I have written a separate Postscript (7, 13, 15, 18). Much of the labour has focused on getting the computer file to match what is in print. But occasionally I have reversed the well-intentioned ministrations of editors and copy-editors and restored a slightly longer, slightly different original – the director's cut.

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August 2018

Peregrine Horden

Notes

1 See now also P. Horden, 'Ottomans, Neo-Ottomans and Invented Tradition in Hospital Music Therapy', in L. Clark and E. Danbury (eds), *'A Verray Parfit Praktisour': Essays presented to Carole Rawcliffe* (Woodbridge: Boydell, 2017), pp. 175–183.

2 For an analogous attempt at a global, comparative history (and anthropology) of humours, see Peregrine Horden and Elisabeth Hsu (eds), *The Body in Balance: Humoral Medicines in Practice* (New York: Berghahn, 2013).

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1

THE WORLD OF THE HOSPITAL

Comparisons and continuities

I A cross-roads of hospital history?

Vienna around the year 1780.[1] Anyone with a time machine and a desire to gain some vantage point on the long-term history of hospitals, but allowed just one period and place to visit, could make a far worse choice of venue. In this city with a population of over a quarter of a million people, some 1,000 hospital beds were available for the care of the sick and needy. They were distributed across a range of institutions that varied greatly in size and services. But most exemplified a tradition of Catholic charity that would have been instantly recognisable back in the Middle Ages. Under the Church's aegis, though subsidised – inadequately – by the government, they offered shelter and nursing to poor immigrants, the homeless, the elderly, and the needy sick. There was the Bürgerspital, the oldest in the city, with 200 beds, founded in the thirteenth century. There was the Bäckenhäusel, which had been established as a lazaretto or plague house in 1656, a year in which the Viennese suffered very badly from plague. And there was the Great Poorhouse, dating from 1693. Reports of high institutional mortality, in these and a few other lesser establishments, did nothing to diminish their reputations as gateways to death. By the 1780s one-third of hospital patients were reckoned to have contracted the *morbus Viennensis*, the 'Viennese disease' of pulmonary tuberculosis.

At the more salubrious end of the spectrum, a few private institutions such as the seventy-bed Spanish hospital could attract paying middle-class patients, and a monastic hospital in the city even set aside rooms for the nobility. Nor was learned medicine lacking. Formal clinical medical instruction was already several decades old in Vienna in 1780. It had been formally instituted in 1753 by Gerard van Swieten, the Empress Maria Theresa's personal physician and a disciple of Hermann Boerhaave, whose ward round was observed by his students in Leyden's municipal hospital from the gallery of a special ward.[2] This ward was the *collegium medico-practicum*, in which lay six male and six female patients each selected for some exemplary pathological condition. In Vienna another Boerhaave student, Anton

de Haen, carried out what has been famed (mistakenly) as the first such bedside teaching.[3] It took place in two rooms of six beds each in the Bürgerspital, by the eighteenth century metamorphosed into a retirement home for the elderly. This contribution to university teaching was financed by the emperor, and was part of a sweeping curricular reform designed to produce a corps of well-trained professionals who would oversee, police-like, the public health and medical needs of the Austrian masses. Though a follower of Hippocrates, and thus guided by two thousand years of tradition in his clinical observations, de Haen also developed an interest in thermometry, and many of his colleagues were engaged in research that would, within decades, contribute to the dissolution of the Hippocratic paradigm.

In 1784, not only the teaching but the whole configuration of Vienna's hospital regime changed. Having seen the fire-ravaged and decrepit Hôtel-Dieu in Paris while visiting his sister Marie Antoinette in 1777, Joseph II decided to centralise hospital care and to confine it to the sick, emulating (as he hoped) the best and avoiding the worst of the French model.[4] Poor relief was clumsily devolved to parishes and fraternities. Foreign beggars were expelled. The assets of twelve existing Viennese hospitals were 'nationalised'. The massive old alms house was turned into the two thousand-bed Allgemeines Krankenhaus or General Hospital, although it still sheltered the poor as well as providing medicine for the sick.

In accordance with Enlightenment rationalism, the general hospital was neatly divided into four medical and two surgical sections, one venereal section, and one for contagious diseases. There was a lying-in facility, a tower for the insane, and an establishment for foundlings. Some space in private rooms was reserved for patients with means. The emphasis lay on using secular medicine to help the sick recover. The hospital had a staff of some fifteen university-educated physicians, an equal number of surgeons, and 140 lay attendants. Yet even though no altars were to be seen, two resident Catholic priests toured the wards daily, administering the sacraments. By 1800, after some vicissitudes, the hospital had added its own medical library. Stables were converted into isolation wards. A surgical amphitheatre was constructed so that operations would no longer be performed on the wards; and there was a new mortuary in which physicians and senior students dissected their own deceased patients. Since 1785, there had also been a subordinate military hospital, the *Josephinum*.

Some of these reforms and developments were attributable to Johann Peter Frank, author of the *System of a Complete Medical Police*.[5] His totalitarian ambitions for the health of the masses appealed to Joseph II's 'enlightened despotism'. The emperor's successor but one, Francis II, appointed Frank director of the General Hospital in 1795, his mission being in part to combat the enormous risk of cross-infection run by patients in such a large establishment.

What first strikes the time traveller about the hospitals of late Enlightenment Vienna is their sheer variety and the range of functions that they

performed, even when rationalised by despotic emperors and medical 'policemen'. The poor – whether indigenous or immigrant – the aged, the pregnant, the insane, the syphilitic are all embraced by them, alongside the acutely and chronically sick. The environment in which some attempt is made to meet their needs is an 'over-determined' one (the Freudian analogy surely permissible in this of all cities). That is, it is subject to pressures from every conceivable direction – demographic, financial, governmental, and ideological as well as medical. It has to be interpreted within the widest context of Viennese history.

Aspects of this hospital scene apparently point to the future. In the general hospital there is a clear shift from almshouse to house of the sick: the new purpose is to promote recovery rather than to offer palliative care. This hospital is no longer primarily an agent of poor relief. University-trained physicians are present, if not in proportionally very large numbers. There is a degree of secularisation: in the absence of altars, the liturgical round becomes far less prominent than the ward round.

'Fast forward' only a few decades and it is in the maternity wards of the same general hospital that, in 1848, Ignaz Semmelweiss will make the observations and deductions that herald modern – biologically effective – antisepsis. Such antisepsis is one of the essential preconditions of the hospital as we have known it in the later twentieth and early twenty-first centuries: the hospital that is accepted, and indeed preferred, as the place of treatment for serious conditions by all socio-economic groups, not only the poor. In Enlightenment Vienna, there were already better-off patients paying for privacy and superior medical attention, and their history is a good deal older than that. Frank was combating the cross-infections that would keep many away from hospital wards.

Also pointing to what we take to be modernity is the use of the wards and the autopsy room by physicians or surgeons for medical education and enquiry. We are at an early chapter – though by no means the first, as Boerhaave shows, without even looking back to the real beginnings in the Renaissance – in a story that will lead to the conception of the hospital as situated at the 'cutting edge' of medical technology and research.[6] In such a hospital, so its critics have contended, patients almost cease to be persons and become more like specimens. Removed from their normal surroundings, they can be treated in ways that ignore those surroundings precisely because the physician is now focusing on disease entities, undistracted by the 'whole person'. That reductionism, which only in relatively recent times has shown any sign of being reversed in favour of paying attention to patient 'narratives', originates in clinical education and its conceptual or physical alignment of cases that are medically, rather than socially, similar.

Such education was centuries old in Joseph II's Vienna, and is one respect in which the example of the city's hospital seems to point us back in time as well as forwards. Another respect is the emperor's desire for centralisation

under governmental control. This is really a phenomenon that historians label 'early modern' or even 'Renaissance' rather than 'Enlightenment'.[7] In many ways it was old-fashioned in France when Joseph visited his sister and inspected the massive and not very salubrious Hôtel-Dieu. Large hospitals had long been seen by reformers to generate at least as much disease as they cured. In France, where the general hospitals were most numerous and prominent, their mission to house and discipline the disorderly poor actually had the effect of enhancing the medical, curative function of other smaller hospitals, to whom they passed suitable cases.

The old hospitals still functioning in Joseph II's time not surprisingly take us deepest into the past of hospital history. Here was exemplified a tradition of Catholic charity that, if a millennium younger than the Hippocratic medicine with which it could be associated, was still of considerable antiquity. The earliest of Vienna's surviving hospitals had been a part of a great wave of foundations that spread right across western Europe in the 'high' Middle Ages of the twelfth to thirteenth centuries. The lack of 'true' medical attention, the low discharge rate, and the corresponding patient mortality were always likely to be exaggerated by later 'reformers' of the sixteenth to eighteenth centuries, blackening the objects of their reform to an extent that later historians can easily accept too uncritically. The least we can say, by way of counter-argument, is that there were notable havens in which the best and most expensive of contemporary medicine was available free to patients. And it was not only in Protestant northern Europe that an emphasis on ensuring the patient a safe passage to the other world was counterbalanced by a this-worldly concern to get a sick or injured labourer quickly back to work. That aim had for example been demonstrated much earlier in some of the hospitals of Italian Renaissance cities. Still, surveying European hospitals over several centuries preceding the reign of Joseph II makes three conclusions unavoidable. First, hospitals were essentially institutions of charity in which the primary criteria of admission were as likely to be economic and social as they were to be medical. Second, secular medicine was almost always subordinate to the therapy of the sacraments in Catholic countries, or to the ethical imperatives of a godly community in Protestant ones. Finally, those who could afford to stay at home for treatment or poor relief nearly always did so. It was only when hospitals, under financial pressure, took in better-off pensioners offering lifetime security in return for benefactions that the choice between hospital and home became more evenly balanced.

II A view of the long term in hospital history

Taking Vienna *c.*1780 as a 'moment' in hospital history alerts us to many components in the generally accepted outlines of the subject.[8] I shall now retrace those outlines, adding some minor modifications without, I hope, distorting the received view, and giving proportionate space to the medieval

and early modern period instead of cantering briskly through them as a mere warm-up to 'modernity'. More substantial reservations and additions will be set out in the next section.

Hospitals were originally Christian charitable foundations for the overnight care of transients or immigrants, the local poor also lacking in the support networks that transients would have left behind, and the sick who could not pay for treatment.[9] They had, as we shall see later, a few forerunners in pagan antiquity, but they were essentially an architectural expression of the Christian charitable imperative. They began to be founded by rulers, leading churchmen, and wealthy pious individuals after the 'establishment' of the Christian Church by Constantine in the early fourth century. These *xenodocheia* (houses for strangers, as they were originally called) spread rapidly across the Byzantine empire and, more slowly, around the Mediterranean, to France, Italy, and Spain. Some, especially in major pilgrimage centres, were quite large. Some, again in the largest cities, were highly 'medicalised' in that they had wards for specific diseases or conditions, and physicians and surgeons on their staff. Others specialised in the care of the poor, the elderly, the blind, and so on.

In general, early medieval hospitals increase in size and complexity, and probably also in numbers, as one traverses Eurasia in an easterly direction. Thus western European hospitals were, on the whole, more hospice-like, offering the ultimate therapy of the sacraments, less intent on returning patients to the community than in easing chronic need and the effects of aging – or of leprosy. The biggest Byzantine hospitals displayed a more obvious emphasis on secular medicine. When the 'hospital idea' was exported from Byzantium to Islam, primarily through the intermediary of Christian communities in Islamic lands, in the ninth and tenth centuries, hospitals attained what it is tempting to conceive as a new stage in their development. Islamic hospitals were not so overwhelmingly charitable, catering more prominently for well-to-do patients. They offered medical treatment by court physicians. They were, indeed, centres of medical learning and teaching. And many of them introduced a relatively novel element: they housed the insane – treating them perhaps harshly, but in a medical manner, as sick rather than possessed.

The hospital spread eastwards, across Asia, principally with Islam (as did Islamic medicine) rather than with Christian missionaries. Thus one major chapter in hospital history is the story of Islamic foundations, a story that stretches with few interruptions from tenth-century Baghdad to parts of India and Sri Lanka in the present day. But the next major phase of European hospital history begins in the twelfth century.[10] In Byzantine Constantinople, medicalisation seemingly reached its apogee in the Pantocrator hospital (attached to a monastery) in which there were almost more physicians and support staff than patients. In the Crusader states the Knights Hospitaller's hospital of St John in Jerusalem stands out as, by western standards, a

medically intensive establishment, and as one which showed its charitable ethos in a pronounced and individual way, by proclaiming the 'Lordship of the Poor' – whom the Knights of St John were to serve as if the poor underlings were really their 'feudal' superiors.[11] More generally, across the Crusaders' home territories in western Europe, hospitals were founded for the poor and, among the sick, especially for the leprous. Yet this was not because paupers and lepers were becoming proportionately more numerous, but because the prayers of such unfortunates were increasingly recognised as a sure means of helping donors' souls through purgatorial fire. The Catholic doctrine of purgatory may not have solidified until the thirteenth century, but its ingredients were already clearly recognised long before.

In parts of northern Europe, the wave of foundations that began in the twelfth century had lost impetus by the time of the Black Death. Fewer hospitals were founded. In England, for example, the almshouse, with its distinct if conjoined dwellings for the respectable elderly, became the favoured type of foundation. Many existing hospitals also mutated into retirement homes, into chantries (offering liturgy rather than charity), or into colleges of priests.

Naturally there were exceptions to this general picture, mostly to be found in the larger cities. Paris, with its Hôtel-Dieu, is one of them. No medieval English hospital could measure up to its size or the number of its medical personnel. The main contrast to the northern pattern is, however, to be found in southern Europe, to some extent in Spain,[12] but especially in the Italian city-states of the later Middle Ages and Renaissance. The hospitals of Renaissance Florence in the fifteenth and sixteenth centuries were, for example, widely admired and often the objects of emulation, as in the case of Santa Maria Nuova, which became the model for the Savoy Hospital in London. In their combination of a continuing religious ethos – altars in view of the patients, the literal centrality of the sacraments to daily life – with lay, sometimes civic, control, they show how difficult it is to carve hospital history up into periods. For they straddle the end of the Middle Ages and the beginnings of the early modern period. And, right back in the fourteenth century, they already anticipate what are usually taken to be early modern features of hospitals in major cities: lay control, centralisation, learned physicians in attendance, pharmacies attached, rapid turnover of patients (no gateways to death here, although women patients did stay for longer than men). It is in Italy too that we encounter the first specialised hospitals in Europe to have been founded in any numbers since the *leprosaria* of the twelfth and thirteenth centuries: large foundling hospitals like the famous Innocenti in Florence and, later, hospitals for victims of the era's two greatest scourges, plague and the Great Pox.[13]

A degree of continuity across the supposed medieval/early modern divide is evident not only in Catholic Europe but even in England. The dissolution of almost all hospitals at the Henrician Reformation, as well as monasteries,

obviously marked a break in hospital history. But many hospitals were quite rapidly refounded and new ones added – not just in London (as is commonly observed), but in provincial cities such as Norwich.[14] These hospitals of the later sixteenth century broke with English traditions only in one respect, which aligns them more with their continental coevals. They, or the bigger ones at least, had attendant physicians; they were attuned to ideas about the potential of hospitals that had been aired in Italy over two centuries previously.

As we move closer in time to the Viennese example with which we began, we return to developments already sketched. The French model has usually been taken as defining the next distinct phase. In this, a division arose. On the one hand, there were the general hospitals that provided some medical care, but served primarily as catch-all establishments for the supposed work-shy, vagrants, gypsies, religious dissidents, prostitutes, beggars, the disabled, and the insane. On the other hand, there were the older *hôtels-Dieu* that, with the aforementioned social groups interned elsewhere, could concentrate more on acute and curable sickness.[15] But it should be remembered that the *hôpital général* was not peculiar to France. It was in some respects an elaboration of that English sixteenth-century invention and export, the workhouse. Further, the apparently clear distinction between it and the *hôtel-Dieu* is muddied by all the other kinds of hospital that continued to develop alongside them, in France and elsewhere in Europe. These included lying-in hospitals, hostels for vagabonds, houses for the reform of prostitutes, 'conservatories' for the moral education of orphans, and, not least, the military hospital, 'a kind of laboratory for experimentation in medical services within a hospital setting'.[16]

At the opposite extreme from the governmental schemes manifested in large general hospitals, we find the 'voluntary hospitals'. These establishments began to appear in England in the 1720s, and are often treated as another distinct chapter in hospital history. They are projected against a background from which hospitals had mostly disappeared, which makes them seem a novel departure. And they are presented as peculiarly English when in fact they had continental counterparts or imitations, in Germany, Switzerland, and elsewhere. Seen in the *longue durée* of hospital history their peculiarity is less in the fact that they were, at least to begin with, controlled by their leading (financially most beneficent) 'voluntary' subscribers than in the particular way in which this control was exercised. Hospital benefactors had been determining the nature of institutions to which they lent their support since the earliest Christian foundations of the fourth century. They had set the criteria of admission in generic terms, and doubtless exercised influence over the selection of individual patients on occasion. What was new in the eighteenth century was the regularising of this connection between patron and patient, such that the purchase of a subscription at a particular level brought corresponding privileges in the nomination of inmates.[17]

Power to the patrons is one strident theme in hospital history of the eighteenth century – and many preceding centuries. The equivalent for the nineteenth century and since is conventionally: power to the physicians, and to the surgeons; and then power to the professional administrators. The centuries do not divide neatly, of course; and developments since the late eighteenth century are so many and various that they defeat all brief generalisation. The two largest and clearest phenomena of the nineteenth and early twentieth centuries are surely these. First, the enormous expansion of patient demand for hospital services (crudely estimated as a tenfold increase across the nineteenth century in Britain)[18] and the concomitant increase in the number of hospital beds (over fourfold in England and Wales between 1861 and 1938).[19] Second, the growing status of hospital medicine and surgery, such that by about 1920 they had achieved the dominance that we take to be the defining feature of the modern hospital. General hospitals consumed more resources and offered a greater range of services than any other type of health care provider. So it was *c.*1800–*c.*1920, so it has been ever since.[20]

To elaborate only on the second phenomenon: from the later eighteenth century, doctors on the whole supplanted governors in the determination of hospital admissions, staff appointments, and overall policy. For the first time in history, hospital medicine was different in kind from non-hospital medicine, and not just a simplified, cheaper, version of a medical 'vernacular'. New techniques and instruments – the electro-cardiograph in the nineteenth century, the iron lung and dialysis machine in the twentieth – were either developed in hospitals or were used in them as nowhere else. The medicine with which they were involved was based conceptually in pathological anatomy – as revealed in the post mortem and refined in the hospital laboratory. With effective antisepsis and anaesthesia, the hospital became by the early twentieth century the almost exclusive locus of surgery too. The criteria for admission were now chiefly medical rather than socio-economic. In England, as the Poor Law hospitals of the later nineteenth century removed pauper patients from the voluntary hospitals, so the latter became far more acceptable to paying patients than they had ever been before – either middle-class fee-payers or the working poor who contributed to some insurance scheme. Design was changing too – the pavilion style advocated by Florence Nightingale being adopted in response to concerns about the hospital environment and the need for fresh air and cleanliness. (Such concerns were hardly new and clearly affected hospital architecture in, for instance, Renaissance Florence, but on the basis of a very different – humoral – medical theory.) Reference to Nightingale is a reminder, if any were needed, to add to the overall picture the changing image of the hospital nurse between 1830 and *c.*1918 – from *relatively* unskilled carer to respectable educated professional – even though the image does a serious injustice to the

longer-term background of women in nursing orders who provided hospital food and basic medication and surgery in eighteenth-century France,[21] not to mention earlier generations of women who had been dispensing remedies in hospitals since the Middle Ages.[22]

Enhanced specialisation is the final major feature of nineteenth to twentieth century hospitals to be noted: hospitals for teaching; eye, skin, and fever hospitals; and above all that characteristically nineteenth-century phenomenon, the lunatic asylum. The insane had a long if patchy history of being admitted to general hospitals in Europe since the later Middle Ages (earlier in some places, especially in Islamic lands, but even in the late antique Mediterranean world).[23] Small private asylums proliferated in the second half of the eighteenth century, but the large, dedicated asylum and the whole social and legal culture of 'asylumdom' is a nineteenth-century development lasting until the decarceration movement of the 1960s. By the mid-nineteenth century, in parallel to the centrality of the hospital to general medicine, 'the asylum was endorsed as the sole, officially approved response to the problems posed by mental illness'.[24]

Perhaps the most recent phase to date in hospital history should be assigned a beginning in the 1960s. What distinguishes the twentieth century may prove to be less the formation of the British National Health Service or the elaboration of national or individual insurance schemes in other countries, but the sharply rising costs of the capital- and technology-intensive hospital medicine, of which such schemes are only particular expressions. The critique of hospitals that emerged in the 1960s and that has continued to be voiced in the twenty-first century seemingly marks the end of a relatively brief, quite positive, phase in hospital history. There had been 'anti-hospital' movements before, in later medieval England perhaps, as patrons favoured other types of foundation, and at the close of the late eighteenth century for example;[25] and the hospital had often (although not nearly as often as modern historians used to maintain) been stigmatised as a locus of pauperism, infection, and death. Yet it has experienced no downturn in its general reputation quite as dramatic as that registered by the biomedical 'high-tech' hospital in the later twentieth century. After many decades of growing popularity, hospitals are now a focus of those anxieties about bureaucratic, corporate modern medicine, its costs and allegedly skewed priorities, and the nosocomial infections that it passes to those whom it should be curing – anxieties that enhance the attraction of alternative therapies. Hospitals are likely victims of further cost-reducing decentralisation: the devolving of services to outpatient clinics and primary health care providers. It is not hard to foresee a time when the power and cheapness of computer-run medical technology could nullify the economies of scale and concentration that have been the rationale for hospitals' existence since the time of Joseph II, if not

from the very beginning. As the late Roy Porter wrote in one of his last books:

> Whether, for its part, the general medicine of the future needs, or can afford, the ever-expanding hospital complex remains unclear. Today's huge general hospitals may soon seem medicine's dinosaurs. Will they go the way of the lunatic asylums?[26]

III Minding the gaps

Such is one possible view of the long term in hospital history, from the fourth century to the twenty-first. It adds a few local twists and comments of its own, but essentially is meant to convey a broadly uncontroversial narrative. It is, of course, nevertheless seriously deficient, and not just in the ways that inevitably attend summaries of over 1,500 years of history in a few paragraphs.

Some of the deficiencies are glaring. First, the story has been mainly European. I have not so far mentioned hospitals in North America.[27] The earliest such hospital is the Pennsylvania Hospital (1751), followed by the New York Hospital (1791) and then, after a pause, the Massachusetts General (1821). These were modelled on the English voluntary hospitals, and, in simplified outline, the story of American hospitals is that of European hospitals – telescoped in the initial stages, varied in subsequent ones, but still overall clearly recognisable. The wealthy physicians who specialised in diseases of the rich nonetheless used poor patients to burnish their expertise, and these patients lay in the hospitals philanthropically financed by the physicians' rich patients.

The multiplication of institutions that in Europe began in the twelfth century came late to North America even when allowance is made for its having started only in 1751. A survey of 1873 revealed no more than 120 general hospitals in the entire country. The Civil War, with its one million hospital cases in the North alone, seemingly produced no major lasting changes to hospital provision. At the end of the war the military hospitals were closed and most of the soldiers still needing treatment were packed off to their families. It required the unprecedented immigration, urbanisation, and industrialisation of the century's closing decades to produce a significant expansion of hospital establishment. By 1909 there were over 4,300 hospitals with 420,000 beds, but it had been only relatively recently (after *c.*1880) that middle-class patients could be enticed to occupy any of them.

There is obviously much more to American hospital history – and not only since 1900. In keeping with the Eurocentricity of most hospital history written in English, America is so far only North America, and only since 1751. Yet there is wider history, both earlier and contemporary, that remains to be written in detail: colonial hospitals, exported from Old Spain to New Spain, for instance, as instruments of attempted control, conversion,

acculturation, the containment of epidemics – and even medical experimentation.[28] There was a hospital on the Spanish Caribbean island of Santo Domingo from the very early sixteenth century, and one opened in what would become Mexico City soon after the subjugation of the Aztecs. It was followed in the 1530s by the first establishment exclusively for indigenous people. By the beginning of the seventeenth century there were some 128 hospitals in New Spain. Later that century, in New France, supposedly even the rich settlers availed themselves of hospital services.

This colonial hospital history of course extends to Asia and, later, Africa.[29] In Asia it again begins in the early sixteenth century. The Portuguese founded a hospital in Goa – for their own soldiers and seamen – soon after the creation of the colony in 1510. In the comparatively brief period during which Japan was open to foreigners, 1549–1639, the Portuguese were responsible for the first western-style hospital at the other end of Asia.[30] Such a history is but one aspect of the 'globalisation' of the hospital, the earlier phases of which were outlined above. Filling out the picture in this way does not go far enough, however. The narrative presented in section II above was not only European. It was also Christian. It takes the beginnings of Christian hospitals in the fourth century CE as the beginnings of hospital history *tout court*. That does some injustice to the various settings in which historians of the ancient world have, mostly without convincing result, tried to detect the pagan equivalent of the Christian hospital: in the courtyards of healing shrines in which the sick camped out for days at a time hoping for a therapeutic dream; in doctors' private clinics; and, above all, in the *valetudinaria* (literally, recovery homes; seldom medicalised; and few in number) in which some sick or injured soldiers and slaves were for a short time, during the 'high' Roman Empire, nursed back to health.[31]

Beginning – as we did – with Christianity may do another, and perhaps greater, injustice to the Jewish contribution. Jewish hospitals are first clearly attested in the sixth century CE. But both their medical development and the extent to which they inspired or imitated Christian hospitals remains unclear. It may be that, within synagogue complexes, a room or rooms had been set aside, hospital-like, for lodging transients a long time before the sixth century. And there was at least one first-century CE hospital-cum-guesthouse to cope with the great influx to the Jerusalem Temple. The history of the Jewish hospital deserves to be rescued from the margins and set alongside that of, on the one hand, the Christian hospital and, on the other, the mutation of the clearly Christian-inspired hospital idea characteristic of hospital founders in Islam.

Three religions of Abraham; three intertwined histories of hospital 'diasporas'. Even recognising that does not take us quite far enough. Hinduism, Buddhism, and Jainism each have their hospital histories – charitable in emphasis, and to that extent rather like the Judaeo-Christian type; but in the case of Jainism also producing the unusual feature (unusual in pre-modern times) of the hospital for sick animals.

This wider history of Asian hospitals brings out interesting, though presumably coincidental, similarities between East and West. It is not just that the groups to whom hospital charity is extended are similar – the sick poor, those unable to work, widows, orphans and so on. Chronological parallels are also detectable. In the early fifth century CE, for example, a Chinese Buddhist pilgrim touring India recorded:

> The cities and towns of this country are the greatest of all in the Middle Kingdom. The inhabitants are rich and prosperous, and vie with one another in the practice of benevolence and righteousness [...] The heads of the Vaiśya [merchant] families in them [all the kingdoms of north India] establish in the cities houses for dispensing charity and medicine. All the poor and destitute in the country, orphans, widowers, and childless men, maimed people and cripples, and all who are diseased, go to those houses, and are provided with every kind of help, and doctors examine their diseases. They get the food and medicines which their cases require, and are made to feel at ease; and when they are better, they go away of themselves.[32]

This has been called an account of a 'civic hospital system'.[33] It may not quite be that, but it prompts interesting comparisons with the hospitals contemporaneously being founded in the Byzantine empire.

The Middle Ages reveal other parallels. The medieval wave of European foundations beginning in the twelfth century is echoed in the government-sponsored poorhouses and hospitals being set up in northern Sung China.[34] A little later, at the time this western wave was cresting, around 1200 CE Jayarvarman VII of the Cambodian kingdom of Angkor was founding or restoring 102 hospitals across his kingdom. Some details of their intended organisation can be derived from inscriptions, for instance the stele of Say-feng, close to Vientiane in Laos, and among the northernmost points of the Angkorian kingdom. To quote an authoritative summary:

> The text of this inscription mentions the persons employed by the hospital: nursing staff and servants. The hospital is open to the four castes. Two doctors are to attend to each caste; they are assisted by a man and two women 'with a right to lodging'. The personnel also includes: 'two dispensers responsible for the distribution of remedies, receiving the measures of rice. Two cooks, with a right to fuel and water, who have to tend the flowers and the lawn, and to clean the temple [...] fourteen hospital warders, entrusted with the administration of the remedies [...] two women to grind the rice.' As the hospital is a religious foundation, 'two sacrificers and one astrologer, all three pious, are to be named by the Superior of the royal monastery. Every year each of them shall be provided

> with the following: three coats and three lengths of cloth, fifteen pairs of garments, three pewter vases.' In addition they were to receive paddy, wax and pepper. The sick are to be fed with 'the rice forming part of the oblation to the deities [fixed] at one bushel a day' and with the remains of the sacrifices. The text next gives a long list of the medicaments placed by the king at the disposition of the sick: honey, sesame, clarified butter, a mixture of pepper, cumin and rottleria tinctoria, musk, asafoetida, camphor, sugar, 'aquatic animals', turpentine, sandalwood, coriander, cardamum, ginger, kakola, origano, mustard seed, senna, curcuma aromatica of two kinds etc.[35]

To mention only one other, final, example: in nineteenth to twenty-first century India, hospitals dispensing either Ayurvedic medicine, or *Unani tibb* – the 'Greek medicine' brought to India by Islam – have been erected, if not alongside, then not far from those dispensing western biomedicine.[36] Of course, the different medical systems have not remained uncontaminated by one another; in particular, Ayurveda and *Unani tibb* have accommodated aspects of their therapeutics to biomedicine. But the globalising of biomedicine has hardly produced a uniformly modern medical landscape, whether in hospitals or in medicine generally.

IV Against grand narrative

Hospital history is large and complicated – far more so than conventional Christocentric, Eurocentric accounts suggest. Not surprisingly, historians who seek an Olympian view try to divide this history up into phases or stages; I have done the same in the opening sections.

Several classifications are currently on offer, all essentially similar. Back in 1936 Henry Sigerist sensibly divided hospital history into three broad stages.[37] The first saw the institutional care of the sick arising in the medical facilities incidentally offered by poor houses, guest houses and (implausible as it now seems) prisons. The second stage began in the thirteenth century, when hospitals emerged as medical institutions for the indigent and dependent. The third, and so far final, stage began in the mid-nineteenth century when the 'progress of medicine and surgery' induced the emergence of the modern hospital – the hospital that we, in the 2000s, know and (sometimes) love.

Much more recently than Sigerist, Guenter Risse, who in a very helpful monograph favours a series of case studies over a continuous narrative, nonetheless essays a summary typology.[38] Overall he sees hospitals as symbols of community, deliverers of social welfare, and mechanisms for coping with suffering, illness, and death. The hospital is first, originally, a 'house of mercy'; then in the later Middle Ages (also the start of Sigerist's phase two)

a 'house of segregation'; then in the Renaissance a 'house of rehabilitation'. In the eighteenth century the hospital becomes a 'house of care', as doctors come to dominate (in ways sketched above). From the 1880s it is a 'house of surgery', because of antisepsis, and for the first time it is used on a significant scale by the middle classes. For the last century or so, it has been a 'house of science'.

Risse's typology is elegant and memorable – and subtly qualified in all the appropriate ways. It may be preferable to proceeding by conventional historical periods (medieval, early modern, Enlightenment, and so on); as does Lindsay Granshaw, whose final division and longest section in her excellent survey article is, however, somewhat crudely, 'early modern and modern'.[39] But the problem with all these various ways of dividing up the hospital's past is not their artificiality or over-simplicity. All chronological schemes over-simplify, and are to be judged only by the heuristic value of the generalisations that result from them. The problem, rather, is in the way that the particular historiographical schemes that hospitals have attracted are all skewed towards a modernity defined by medicalisation. The background assumption is that true hospitals are medicalised – with medicalisation defined basically in terms of the presence of doctors and surgeons and, at a more sophisticated level, of the degree of authority that they wield, over the patients and over the institution as a whole. For Sigerist, that process began in the thirteenth century. For Risse, as for many others, it belongs above all to the nineteenth century and since. Whatever its particular inflection, the underlying idea is that there has been a great 'before' and 'after' in hospital history; some pivotal period in which charity gives way to medicine, care to cure, stigma to pride, the mortuary to the recovery room, the poor to the middle classes.

Why do we tend to think like this? Why do we look so persistently for the 'genesis of the modern', assessing over 1,500 years of hospital history on a yardstick calibrated for the last two centuries? The economic history of Europe since antiquity is not (or not usually) conceived solely as a search for the origins of industrial capitalism, nor the history of transport as a frustratingly long build-up to the railway and the steamship. Yet the historiography of hospitals is more often than not written with an eye on the present, or at least on the modern. Sometimes this is an effect of the rhetoric of hospital reformers over the past two centuries: reformers have tended to exaggerate the difference of 'before' from 'after', as if they are always engaged in dragging their particular hospitals from medieval darkness into modern light.

Historians have occasionally been seduced by this rhetoric from the past. But they have also generated theories of their own. The sociologist Nicholas Jewson strikingly identified the 'disappearance of the sick man' (and woman) in hospitals around the turn of the nineteenth century. A system of hospital medicine founded in a holistic view of the individual patient and his or her

environment gave way to a reductive clinical emphasis on diseased parts; the individual person was disregarded (an accusation normally reserved for, and perhaps unduly influenced by, later twentieth-century medicine).[40]

The most famous proponent of a 'big bang' theory of the origins of the modern hospital is of course Michel Foucault. His identification of the French Revolution as the brief but explosive period of 'the birth of the clinic' has proved so influential that historians have to continue rehearsing it even though few of them now accept it. Indeed, his account perhaps continues to enjoy currency precisely because it offers a clear theory to attack so that a more 'smoothed out' view of hospital medicine in the eighteenth and early nineteenth centuries can be substituted without having to arrive at some alternative conception of the period. This 'smoother' historiography finds medicalisation (when it happened at all) to have been a far more complex phenomenon than Foucauldians have alleged, yielding perhaps surprising agents of change:

> Probably the most medical process in [French] hospitals in the seventeenth century was the diffusing of nursing communities. Far from such women being – as is often simplistically alleged – the bearers of a religiously inspired anti-medicine, careful study of the contracts they passed with hospitals reveals nursing communities as a prime agent of hospital medicalization.[41]

Or again:

> to a considerable extent, we may see in military hospitals one of the prime sites in which the hospital patient qua patient was constructed over the eighteenth century, long in advance of the 'birth of the clinic' in the 1790s. Their overtly functional orientation made it more likely that their inmates were more truly sick than might be the case in civilian hospitals.[42]

The modern medicalisation of the hospital – however we define 'modernity' and 'medicalisation' – is undeniably important. But it does not have to skew the overall history of hospitals – an outline into which specialists insert their particular contributions – to quite the extent that it mostly has up to now. It may be that, for the first millennium of its history, indeed for longer than that, the modal hospital – the commonest form of hospital – was charitable, funded for the poor and offering the therapy of religion, a regulated environment, and a proper diet, rather than the attentions of secular physicians. That first millennium must be viewed in its own light, rather than that cast by the period since 1900.

Alongside the modal European hospital, we must also place others that make up the rest of the global population. The modal hospital of the early

Byzantine empire was grounded in the therapy of the sacraments, even though right from the documented beginning of Byzantine hospitals some foundations had doctors attached. The modal Islamic hospital of say the eleventh century, like the modal Cambodian hospital of the twelfth, was on the other hand highly medicalised, to judge simply by medical manpower. Considering Renaissance Florence, the highly medicalised, seemingly modern, though still essentially religious, Santa Maria Nuova may distort our overall picture. But the modal Florentine hospital of the fifteenth century remained what it had been in the twelfth – small, without medical staff, and providing overnight accommodation to pilgrims and poor travellers rather than treating large numbers of sick people.

As we move later in period so the mode becomes more elusive. We saw at the start, with the example of Josephine Vienna, and later when we returned to the Enlightenment in England and France, that towards 1800 the hospital population was still extremely diverse, old and novel elements kaleidoscopically interconnected. And the twentieth century? It might seem obvious that the modal hospital has been the one at the forefront of medical technology and intervention. But that may be true only on a circular definition – that all genuine hospitals are medicalised to that degree. If we add to the list of hospital types the hospices for palliative care of the terminally ill that have multiplied since the 1970s, and other similar institutions that would have been counted as hospitals in any period before *c*.1800, then the mode may not be so certain. Abandon the outright privileging of western biomedicine; add in the global 'population' of famine relief centres, Ayurvedic hospitals, private hospitals owned and run by individual physicians (as in twentieth-century Japan), small temporary clinics offering only basic medication, leper sanctuaries – and the most common form of hospital in the world since 1900 may not be the technological showcase we thought it was.

V Hospital historiography

Of the making of hospital histories there is no end. The modal study has been to a great extent local, institutional, somewhat introspective, perhaps celebratory – a story of physicians and local activists, of progress. Yet since the 1970s a 'new' hospital historiography has also developed. It is comparative (not looking at just one institution at a time) and in the broadest sense sociological or contextual. That is, it studies hospitals in their social, cultural, and religious as well as their medical setting, recognising that there is always much more to a hospital than its doctors.

An excellent sample of this more recent approach – now not so new, of course, but still not the numerically dominant form of historical writing on the subject – is the collection edited by Lindsay Granshaw and Roy Porter, *The Hospital in History* (1989).[43] Theirs is a volume of enormous chronological scope, ranging from about 1100 to 1980. And, although six of its ten

chapters deal with Britain, there are papers covering Italy, Germany, and the USA. The volume decisively breaks the traditional paradigm of hospital history written as if from the doctor's point of view. It offers a much more inclusive interpretation of the hospital in society based on an admirably broad variety of source material, not least visual evidence.[44] The functions of the hospital are shown to change over time, and an unprecedentedly wide range of institutions is considered, including children's hospitals. The volume also places a new emphasis on the vital relationship between hospitals, their founders and patrons, and the wider socio-political context, thus providing a valuable tool for reinterpreting the narrow, institutional vision of the hospital in history. The experience of patients before, during, and even after hospitalisation is brought into the picture. Another advance is to produce a more nuanced conception of the relationship between hospitals and their staff of administrators and nurses.

And yet, for all its sophistication, in the background of most of the contributions to Granshaw and Porter can be detected the Foucauldian master narrative of hospital history – a narrative predicated on the centrality to hospital history of the presence or absence of doctors and focused on the question of when they appeared on the scene so as to inaugurate modernity.[45] The overall trend of identifying some great transition from care to cure was, for the contributors to this volume, contradicted only by the history of cancer hospices. They were the exception proving the rule (even though some cancer hospices prescribe not only palliative treatment but also therapy based on pain relief).[46]

Since the publication of the Granshaw–Porter volume in 1989, there has, predictably, been a cascade of studies in hospital history. The catalogue of the Wellcome Library, to look no further, records a continuous and ample stream of publications in English alone. Many of these are substantial contributions, but they are still often chronologically restricted; others are local and introspective in scope and celebratory in tone;[47] others continue to chew over old debates.[48] Few collections in English have rivalled Granshaw and Porter in breadth.[49]

In what follows, rather than attempt to report comprehensively on this massive yet, on the whole, fragmented literature, I shall try to assess some broad trends in the historiography of the 2000s.[50]

VI The impact of hospitals

In contrast to the approach of Granshaw and Porter, there should be a deliberate decision to get away from medicalisation as the leitmotif. Instead we can expand their liberating multi-disciplinary perspective still further – to convey some of the most recent and innovative approaches in the wider field of the social history of medicine, not privileging any one aspect or period, so as to arrive at a rounded view of the hospital in society. Medicine and

doctors certainly will appear, but as only one facet of changing varieties of therapy rather than as the defining moment in the arrival of modernity. Indeed the hospital's health-promoting role is seen within a much wider context than that of doctors, whether in relation to physicians of the soul (priests) or singers of the liturgy or the nursing staff or, more broadly, to the built and natural environments as stimulants to recovery.[51] Eric Gruber von Arni's discussion of the two major military hospitals for sick and maimed soldiers in seventeenth-century London, the Savoy and Ely House, serves as a good example of what conventional accounts of medicalisation so often downplay.[52] Emphasis was placed on increasing patients' mobility, with (for example) special wooden limbs being made. Ely House had a 'hot house' for sweating 'pox' patients with mercury, and sufferers were also sent to Bath for spa-water treatment. Considerable attention was paid to the environment in each hospital so that wards were frequently fumigated with burning pitch, even though patients must have suffered from inadequate ventilation.

To avoid the teleology of looking for precocious signs of modernity, we must consider the hospital over the long term. But we must also range widely in space. Although I have in earlier sections of this introduction sketched a world-wide history of hospitals, the main focus has remained Mediterranean or European and is indeed envisaged as complementary to Mark Harrison's collection on 'the hospital beyond the west'. This adds the much-needed African and Asian dimensions to the subject.[53]

One of the themes to emerge from recent research is the range of institutions which called themselves 'hospital', whether for the sick poor or for other disadvantaged groups, from pilgrims to foundlings and sick children to abandoned women or the insane. (The last of these are not considered here but have their own mature historiography.)[54] Moreover, within the broad categories that recur, we find an enormous variety of function – from isolation to control, from treating the curable to comforting the incurable, from providing education[55] to returning patients to the community so that they could continue to make a useful contribution to society.

A related theme, already encountered in our opening historical sketch, is specialisation, as prominent during the Middle Ages and Renaissance as it is today. Thus Max Satchell has discussed rural *leprosaria* in medieval England and Flurin Condrau has looked at sanatoria for TB patients in Germany and Italy.[56] These papers are part of a wider recent trend to examine specialised institutions, not only *leprosaria* and military establishments but isolation hospitals (*lazzaretti* for plague victims, and the new hospitals which emerged in the sixteenth century in response to that other 'new' disease, the Great Pox).[57] Hospitals set up to cope with the epidemics of more recent times, such as polio and AIDS, also belong in this tradition. Indeed, each new epidemic underlines the broad institutional continuity of society's response, a main plank of which remains the isolation hospital, whether during the outbreak of plague in India in the mid-1990s or during the SARS epidemic in 2003.

Specialisation of function relates to another theme of recent historiography, the centralisation of resources and the development of 'systems' of care, whether (as we saw above) in Renaissance Italy or late eighteenth-century Vienna or in the move towards municipal medicine in Britain during the 1920s and 1930s and the foundation of the National Health Service after the Second World War.[58] The process whereby the political élite gradually took over the direction of hospitals was common to most European cities, but was even more pronounced in sixteenth-century Italy as an outcome of the gradual exclusion of the aristocracy from the governance of the state.[59] As for France, analysis of the social background of hospital rectors has shown that, in the minor centres, they were drawn from groups of leading citizens, while in major cities they were nobles.[60] It would, however, be a mistake to assume too monolithic a power structure. In his study of the *Hôtel-Dieu* in Beaune in the seventeenth century, Kevin Robbins shows how the administrative staff and nursing sisters mounted a spirited defence of the 'public honesty' of the hospital against the patronal family of the de Pernes, who had wanted to use their institution as a hotel.[61]

Centralisation had its limits at the 'macro' level too. Just as Foucault's 'birth of the clinic' is no longer identifiable in the way he suggested, so it is now generally accepted that his related thesis of the early modern state's power over charitable institutions, and in particular of its 'great confinement' of the poor in the seventeenth century, is to say the least exaggerated. The mechanisms through which charities and their inmates might be controlled were far more flexible.[62] Furthermore, the charitable and religious institutions of the Counter-Reformation were – as Brian Pullan has shown – separated from the world to help to convert the sick, the poor, prostitutes, and Jews to a life of salvation and virtue.[63] Indeed, it has been argued that 'spiritual salvation' was the main objective in the hospitalisation of such patients – a perspective to be set against Foucault's emphasis on the dangers of poverty and the insanitary conditions of the early modern city.[64]

Moral discipline was a more subtle form of the exercise of power over the bodies and souls of patients. It represented a means of enforcing religious conformity and a moral way of life that one finds equally in the hospitals of Elizabethan London, in Friuli, and in areas under the influence of the Ottoman empire.[65] This was the same kind of intrusive surveillance, as Nathan Wachtel has outlined, that penetrated into the cells of the prisons of the Inquisition, recording secretly and efficiently the glances, words, gestures, and the actions of the inmates.[66] From the political and moral standpoint, discipline was justified by reference to the campaign against licence, vice, disorder, and the desire for change that supposedly characterised the insolent masses. They were seen as contaminating, infecting, and offending the dignity and decorum of the city, since they did not observe rules and laws. They represented a danger to social stability and were therefore 'la plus dangereuse peste des Etats'.[67]

Government policy, then, as in other places and times, originated in a set of more or less noble motives, ranging from a desire to protect hospitals from impoverishment to exploitation of their resources to using them as a means to control the poor and sick when they were seen as threats to public order and health. And if institutional patrons in the shape of governments had mixed motivations, so did individual patrons seeking to establish and maintain hospitals. At the very centre of a number of the more recent studies dealing with earlier periods is the theology of almsgiving, which links the provision of charity with salvation. This was clearly the case in Byzantium, where the major 'monastic multiplex' in Constantinople was founded principally for the commemoration of the soul of the emperor. Indeed, so concerned with commemoration were medieval patrons that hospital statutes frequently gave more space to the details of masses than to the treatment of inmates. Carole Rawcliffe has argued that in late medieval England the larger hospitals were transformed into liturgical spaces for the Christian departed. Kevin Robbins also shows how the founder of the great hospital of Beaune, Chancellor Rolin, made sure that he continued to control his institution from the grave. He laid down that his coats-of-arms should be visible on all the buildings as a constant reminder of his presence and patronage. As for Italy, Matthew Sneider demonstrates that a significant proportion of the expenditure of the four most affluent hospitals of Bologna was devoted to commemorative masses and other religious activities.[68]

The role of religion in hospitals in medieval and early modern Europe went far beyond the provision of masses. The aim of the hospital was to cure the soul of the patient and not just the body. Indeed, the vital role of religion in the treatment of the sick has been underlined by a series of major studies, not least the books by Carole Rawcliffe on the hospitals of late medieval Norwich and John Henderson on the Renaissance hospitals of Florence.[69] Rawcliffe demonstrates the fundamental role of images in healing, from altarpieces to stained-glass windows and sculpture, stressing how the commissioning of major works such as Roger van der Weiden's *Last Judgement* or the Isenheim Altarpiece played a fundamental role not simply in commemorating the patron but also in the hospital's everyday life.[70]

Splendid altarpieces and sculptural or fresco cycles in hospital churches and wards, as well as important collections of relics, performed an essential role in promoting the profile of the hospital and thereby encouraging almsgiving. Indeed, the maintenance of a constant income was vital for the flourishing of any hospital. As we noted above, Georgian England saw a flowering of hospitals and infirmaries for the sick poor supported by voluntary subscriptions. By 1800 there were thirty general infirmaries outside London and seven in the capital. In the following century, London became the centre of a hospital boom generated by the growth of medical schools: by 1850 there were forty-five hospitals with 26,000 beds.

Such initiatives were clearly expensive. One way to finance them adopted in eighteenth-century England was to distribute to potential subscribers prints 'proper to shew to Gentlemen': prints of, for example, St Bartholomew's rebuilding programme under James Gibbs or the elevations and plans of St George's in London. Great Ormond Street was also a voluntary hospital, and its founder, the physician Charles West, mounted a sizeable campaign to raise cash. It is significant that at this time there were no children's hospitals in Britain, partly because the medical establishment opposed children's hospitals for fear of competition, and partly because physicians did not take children's ailments seriously. West therefore involved important people on the hospital's Board. They included Charles Dickens, who had done so much to raise contemporary awareness of the plight of poor children, and Queen Victoria herself, who was persuaded to become the patron. Also, following a tradition of gracious ladies distributing their bounty to the poor in hospitals (a tradition that goes back to late antiquity), West encouraged visits from society ladies and female journalists, who were to spread the good news that Great Ormond Street was a means of inculcating middle-class values into working-class families. The 'catechism' of cleanliness and godliness became a leitmotif in the moral improvement of both mothers and children. As Andrea Tanner has shown, these women's role was vital in day-to-day fundraising, including the year-round bazaars, collections, and tea parties, as well as in raising subscriptions towards the hospital and in urging London female 'society' to visit the wards as part of their social round. Most significant was Queen Victoria's support; she was a regular visitor, and on one occasion sent hundreds of toys from a German toy factory that she had visited.[71]

The physical structure of the hospital is another recurrent topic of the more recent scholarship.[72] Few scholars, however, have followed the example of Thompson and Goldin's classic study of 1975, which traced the developing structure of the hospital in western Europe across the centuries.[73] Indeed, a theme which emerges from their book is the extent to which the physical form of the hospital was adapted to changing contexts and circumstances and yet also how far architectural models were imitated across time and space. A classic example of that imitation is provided by cruciform ward design, which became standard in some of the major Renaissance hospitals of central and northern Italy and was copied in other parts of both the Mediterranean (Spain and Portugal) and northern Europe.[74]

A common assumption of many hospital historians is that form followed function. Once we move away from the narrow vision of the 'medicalisation model', it becomes increasingly apparent that every hospital building responds to a variety of interrelated pressures, including those of patrons, governments, and patients as well as other interest groups. As Annmarie Adams reminds us, 'medical change does not necessarily inspire new architectural forms', even in recent years.[75] Rather, hospital architecture is more culturally than medically determined. Hospitals in nineteenth-century

Canada looked like Scottish castles, and interwar and postmodern hospitals like luxury hotels and shopping malls, while modern hospitals tend to resemble office buildings. Both the exterior elevations of hospitals and their disposition of space have responded not just to demands of medical science, but also to the grandiose concerns of patrons, as in the splendid example of Greenwich Hospital.

None of this is to deny that form was ever related to function. But it is important to distinguish between exterior and interior. Frequently the appreciation of the literate classes, these gentlemen on their Grand Tours of Europe, was excited above all by the outward design; such observers were less concerned with the interior. It was rather the role of master masons, architects, and medical authorities to consider how space should be used. There was, for example, a long-held belief in the need to promote airiness for the dispersal of the noxious fumes of disease. This can be discovered just as much in writers of the Italian Renaissance, like Marsilio Ficino, as in the designers of voluntary hospitals in the eighteenth century or of the pavilion style of the age of Nightingale. St Bartholomew's Hospital in London, for example, was planned with four detached wings around a square, large windows in the wards, and separate isolation facilities for contagious disease such as smallpox.

Up to this point, we have followed the lead of much of the literature in the field and examined the hospital principally as an urban phenomenon. Just as it is necessary, however, to ensure that the hospital is not detached from the wider social and political patronage networks of the city, so in some cases it is equally essential not to divorce it from the rural context. Indeed, in his study of English hospitals between 1100 and 1300, already cited, Max Satchell concludes that one in five of them can be defined as 'rural' (although it should be stressed that in this period England was indeed a rural 'backwater' in comparison with Italy). With the advantage of the *longue durée*, we can trace the origins of the whole hospital movement in Western Europe to the countryside. Some of the earliest Middle Eastern hospitals were attached to rural or suburban monasteries. Their medieval European successors have left visible reminders of the scale and importance of these monasteries' infirmaries, such as the vast wards of Ourscamps and Tonerre, while some of the numerous pilgrim hospices on the routes to Compostella or Rome expanded in time into substantial hospitals.

Some hospitals in the smaller urban centres and villages seem to have declined in the early modern period, partly because they were seen as centres of local solidarity and resistance to central authority. An example of this has been seen above at Beaune, but was also more generally true of France in the sixteenth to seventeenth centuries, as Daniel Hickey has shown.[76] Yet curiously, as so often in hospital history, the trend came to be reversed. The reversal happened in the nineteenth century, at least in northern Italy and southeast England, as Sergio Onger and Steve Cherry have shown.[77] Onger's

study of health facilities in the Brescian territory reveals that there were a number of factors involved in the creation of new rural hospitals and the reduction of those in the main conglomerations. They were established to cope with the spread of disease, both endemic pellagra, the main cause of hospitalisation until the end of the nineteenth century, and epidemic typhus and cholera. It was also believed that new hospitals lent prestige to local communities and promoted social harmony in a period when the countryside was undergoing great economic change. The Brescian example confirms the general contention of this chapter that changes in hospital history can be understood only in relation to wider factors which often have little to do with medicine, and which undermine any teleological narrative.[78]

Finally, under this rural heading, we should invoke an English initiative in health care, the cottage hospital. Because of the high levels of poverty, those at the bottom of the social pile would have been unable to pay for professional medical treatment unless they were fortunate enough to belong to friendly societies or workers' clubs. Cottage hospitals were particularly significant for rural areas because they addressed local needs. These hospitals were run by GPs, who performed simple operations in them and, along with competent nursing staff, offered patients the necessary periods of recuperation that they would have been unlikely to enjoy in larger city hospitals.

Whether in urban or rural contexts, the one constant of all these hospitals was the patient. So far in this discussion he or she has remained obscure, the object of patrons, administrators, priests, doctors, and nurses, rather than self-determining. Largely due to the influence of Roy Porter, much has been done to redress this long-standing imbalance in the historiography and restore the viewpoint of the patient to the historian's purview. The publication of a number of studies of patients in early modern Europe based on analysis of letter collections, diaries, and trial records is part of a wider scholarly trend to explore the narratives of everyday events.[79] Rarely, however, does this type of evidence survive from the hand of the *hospital* patient. He or she normally remains silent since, before the nineteenth century, surviving documentation relating to patients tends to consist only of entry and death registers. These, as will be seen below, provide invaluable information on demographic events and social background, but little on the patient's personal experience of the hospital.

Petitions are one type of source that does allow us to come closer to understanding when and why the sick wanted to be hospitalised, as is demonstrated by Louise Gray's study of those seeking admission to a hospital in rural southern Germany in the seventeenth and eighteenth centuries.[80] Even though the 'voice' of the poor was mediated through the hand of the scribes who actually wrote the petitions, accompanying witness statements from priests, administrators, and doctors did confirm the veracity of their claims. These patients were, however, unusual in that they suffered from chronic conditions, excluded from the average general

hospital. The petitions reveal that men and women applied to the hospital as a last resort, for their sickness had made it impossible for them to survive by any other means. Some of them, however, declared their willingness to work in the hospital, and they were given light tasks, such as cutting wood for the kitchen and harvesting fruit. Indeed, work was encouraged since it was seen as combating idleness and diabolical temptation; only prisoners and the bedridden were exempt. Emphasis on work was also an important aspect of the British treatment of TB patients in the nineteenth century. Flurin Condrau describes such treatment as 'graduated labour therapy' for the working class; the aim was to return the patient to his job.[81] That this did not always happen is attested by the early twentieth-century case of the young worker Moritz Bromme, who kept an autobiography of his repeated visits to the sanatorium. Though each time he was discharged as 'cured', the necessity to support a family of four children meant that he had to return to his factory job, only to get worse again and to have to return to what his foreman described as the 'cougher's castle'. Bromm recorded a growing scepticism of the therapy offered him.

We should not generalise too readily. Sometimes the hospital was indeed a last resort, as Gray shows. On other occasions, as Sandra Cavallo's work on early modern Turin has demonstrated, it was a strategic resource of the family or individual in managing what we might call the patient's career – a resource to be drawn on in some phases of illness or economic need, and by no means necessarily the final phases.[82] This is also reflected at Great Ormond Street. Parents were not simply passive and unthinking recipients of charity. It was not unknown for them to remove their offspring early because of perceived poor treatment or the unhappiness of their children, whom they were rarely allowed to see. Thus 800 patients were removed by families between 1852 and 1899, often against medical advice. That behaviour reminds us of the power of the family to reject or accept hospital treatment, contradicting a prevalent view of the London poor as helpless and unable to evaluate the medicine provided by professionals. Such manifestations of patient power further undermine Foucault's twin conceptions of a great confinement and the power of the clinical 'gaze'.

Physicians' diagnoses and their disease terminology nonetheless underlay the selection of patients for some of the more specialised hospitals. Did the term 'incurable' mean the same in the sixteenth century as in the eighteenth? Did the terms 'healed' or 'cured' change over time? The condition 'cured' was often taken to mean that an individual was again fit to work. Through her examination of the petitions of the poor, Gray also shows that disease categories and labels could even change from day to day and according to the person who was recording them. Condrau points out that, although some sanatoria claimed high success rates, in fact 50 per cent of those who left as 'cured' died within five years of discharge.

Levels of mortality have long been a major concern for hospitals: they affect their public reputation and ultimately the willingness of both private and public sponsors to continue financial support. Mortality was especially a preoccupation for anybody running a foundling home, given the general recognition throughout pre-industrial Europe that up to a third of all babies born would die in infancy. The constant tension between available finance and required services has been brought out by Alysa Levene in her discussion of the famous Innocenti hospital in Florence, which in the eighteenth century saw both an expansion in its facilities for orphans and an increase in the rate of abandonment.[83] Given that wet-nurses were the most expensive part of the operation – despite their notoriously low pay – various experiments were introduced to save money. A cheaper alternative adopted in the 1740s was to feed infants with cows' milk. Indeed this was also recommended by the famous Florentine medical reformer, Antonio Cocchi. But the practice was abandoned because, as had been discovered elsewhere, it led to an increase in infant mortality.[84] This was also the effect of a second innovation, an attempt to reduce the number of wet-nurses employed. Their supply was always prone to shortage, particularly in the summer, when agricultural labour proved a more profitable alternative. However, as Levene concludes, the only solution to ensuring the long-term survival of infants was to place them promptly with external wet-nurses.

An overarching theme of some of the more recent historiography on the subject is the imperative of examining the hospital within a wider context to understand its impact, whether in terms of its effects on the local population or of its major role in the local economy as a purchaser of goods or an investor in property or banks.[85] The importance of the hospital as a local employer has also begun to be examined. That extends the analysis of its charitable role to include employing the able-bodied poor, as exemplified by the 'corrodians' of many medieval hospitals, who entered into a lifetime contract; board, lodging, and care in sickness was provided in return for their labour and property. All this leads to a reconsideration of the relationship between formal (institutional) and informal (domestic) systems of support. And that in turn raises wider questions about the changing relationship between in-patients and out-patients, seen in the context of demographic regimes and social and family structures.[86]

Superficially, it might be possible to conclude that there was a certain uniformity of experience over the period examined here, from late antiquity to the present day. This stems partly from the very nature of the subject: we are examining a single institution (or a 'family resemblance group' of institutions). Yet, another way of interpreting the phenomenon is that the traditional Whiggish vision of hospital history has been abandoned. In other words, we are not seeing here a form of progressive development towards the triumph of modern biomedicine in hospitals. Rather, the very repetition

of the same themes in different periods points to a long series of reactions to previous forms of 'indoor' solutions to the problems of poverty and sickness, though these reactions in their turn might lead to the imitation of past models, just as post-modern hospitals contain architectural elements of earlier designs. But even when earlier models or those imported from other countries were being adopted, the process led to transmutation, whether in terms of hospital regulations, therapies, or design. As the English Baroque may have been inspired by Italian architecture but was altered in its transplantation to England, so the Savoy Hospital and the London Foundling Hospital were different from their original models, the Florentine hospitals of Santa Maria Nuova and the Innocenti.

In the post-postmodern age in which we now live, globalisation is everything. For the old hospital history, the subject is narrowly conceived. For the 'new' hospital history, which goes back to Granshaw and Porter and their fellow scholars, the world must be the limit.

Notes

1 What follows is an essay in overview and interpretation. References are therefore minimal, offering only some background and guidance through controversies. [This chapter was originally co-written with John Henderson and Alessandro Pastore. With their kind permission, I have reproduced substantially unchanged the main historical sections for which I was primarily responsible, that is, sections I–V; and I have compressed section VI by my co-editors while adding full references to some of the other contributions in the collection that this chapter introduces, *The Impact of Hospitals*. That volume was published by Peter Lang for the International Network for the History of Hospitals, and more recent work on hospital history can at least be sampled through its latest outputs, such as C. Bonfield, J. Reinarz, and T. Huguet-Termes (eds), *Hospitals and Communities, 1100–1960*, and L. Abreu and S. Sheard (eds), *Hospital Life: Theory and Practice from the Medieval to the Modern* (both Oxford, 2013). I have not made the attempt to update systematically the references that follow. I will, however, allow one exception and highlight *From Western Medicine to Global Medicine: The Hospital beyond the West*, cited in n. 29 below, which covers the nineteenth and twentieth centuries and which in scope is an indispensable complement to the present survey.] For the section that follows, see G. B. Risse, 'Before the Clinic Was "Born": Methodological Perspectives in Hospital History', in N. Finzsch and R. Jütte (eds), *Institutions of Confinement: Hospitals, Asylums, and Prisons in Western Europe and North America, 1500–1950* (Cambridge, 1996), pp. 75–96, at 87–91 (to which I am heavily indebted); Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York, 1999), pp. 257–88; A. Cunningham and R. French (eds), *The Medical Enlightenment of the Eighteenth Century* (Cambridge, 1990); P. P. Bernard, 'The Limits of Absolutism: Joseph II and the Allgemeines Krankenhaus', *Eighteenth-Century Studies*, 9 (1975–6), pp. 193–215; D. Jetter, *Wien von den Anfängen bis um 1900*, Geschichte des Hospitals vol. 5 (Wiesbaden, 1982); B. Pohl-Resl, *Rechnen mit der Ewigkeit: das Wiener Bürgerspital im Mittelalter* (Vienna, 1996). I do not know of a monograph for Austria comparable to M. Lindemann, *Health and Healing in Eighteenth-Century Germany* (Baltimore, MD, 1997).

2 Though see T. H. Broman, *The Transformation of German Academic Medicine 1750–1820* (Cambridge, 1996), pp. 59–63, for some qualifications of the conventional narrative.
3 The introduction of clinical hospital teaching is now normally attributed to Giambattista da Monte; see J. J. Bylebyl, 'The School of Padua: Humanistic Medicine in the Sixteenth Century', in C. Webster (ed.), *Health, Medicine and Mortality in the Sixteenth Century* (Cambridge, 1979), p. 348.
4 See Risse, 'Before the Clinic', pp. 92–3, for medical and surgical education in the Hôtel-Dieu at the time.
5 *System einer vollständigen medicinischen Polizey*, 4 vols (Mannheim, 1780–88), trans. E. Vilim from 3rd revised edn as *A System of Complete Medical Police* (Baltimore, MD, 1976).
6 See n. 3.
7 See A. Pastore, *Le regole dei corpi: medicina e disciplina nell'Italia moderna* (Bologna, 2006).
8 The best brief overview is still L. Granshaw, 'The Hospital', in W. F. Bynum and R. Porter (eds), *Companion Encyclopedia of the History of Medicine* (London, 1993), pp. 1180–1203. The various monographs of D. Jetter contain much valuable detail. See e.g. his *Das europäische Hospital: von der Spätantike bis 1800* (Cologne, 1986) and *Grundzüge der Krankenhausgeschichte, 1800–1900* (Darmstadt, 1977).
9 For what follows, see P. Horden, 'The Earliest Hospitals in Byzantium, Western Europe, and Islam', in M. Cohen (ed.), *Journal of Interdisciplinary History*, special issue, 'Poverty and Charity: Judaism, Christianity, Islam', 35 (2005), pp. 361–89 [reprinted in the present collection]; T. S. Miller, *The Birth of the Hospital in the Byzantine Empire*, 2nd edn (Baltimore, MD, 1977).
10 For western European overviews, see J. Imbert, *Les hôpitaux en droit canonique* (Paris, 1947); M. Mollat, *The Poor in the Middle Ages* (New Haven, CT, 1978); B. Bowers (ed.), *The Medieval Hospital and Medical Practice* (Aldershot, 2007).
11 P. Mitchell, *Medicine in the Crusades: Warfare, Wounds and the Medieval Surgeon* (Cambridge, 2004), ch. 2, and the new interpretation and survey of F.-O. Touati, 'La terre sainte: un laboratoire hospitalier au Moyen Age?', in N. Bulst and K.-H. Spiess (eds), *Sozialgeschichte Mittelalterlicher Hospitäler* (Ostfildern, 2007), pp. 169–211.
12 J. W. Brodman, *Charity and Welfare: Hospitals and the Poor in Medieval Catalonia* (Philadelphia, 1998), pp. 94–8.
13 J. Henderson, *The Renaissance Hospital: Healing the Body and Healing the Soul* (New Haven, CT, 2006); J. Arrizabalaga, J. Henderson, and R. French, *The Great Pox: The French Disease in Renaissance Europe* (New Haven, CT, 1997).
14 C. Rawcliffe, *Medicine for the Soul: The Life, Death and Resurrection of an English Medieval Hospital* (Stroud, 1999).
15 See T. J. McHugh, 'Establishing Medical Men at the Paris Hôtel-Dieu, 1500–1715', *Social History of Medicine*, 19 (2006), pp. 209–24.
16 C. Jones, 'The Construction of the Hospital Patient in Early Modern France', in Finzsch and Jütte, *Institutions of Confinement*, p. 68; L. Brockliss and C. Jones, *The Medical World of Early Modern France* (Oxford, 1997), pp. 689–700.
17 For brief synthesis and further references, see S. De Renzi, 'Policies of Health: Disease, Poverty and Hospitals', in P. Elmer (ed.), *The Healing Arts: Health, Disease and Society in Europe 1500–1800* (Manchester, 2004), pp. 150–60.
18 Granshaw, 'The Hospital', p. 1195.
19 H. Marland, 'The Changing Role of the Hospital, 1800–1900', in D. Brunton (ed.), *Medicine Transformed: Health, Disease and Society in Europe 1800–1930* (Manchester, 2004), p. 239.