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THE FIELDING H. GARRISON LECTURE

“Bedside Manners in the Middle Ages”

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The title of this paper is a deliberate echo of another one, the title of an article published just fifty years ago by Henry Sigerist in the *Quarterly Bulletin of the Northwestern University Medical School*. There Sigerist translated and discussed a short Latin text, attributed to the late-thirteenth-century physician Arnald of Villanova, that set out some of the ways in which physicians needed to behave toward their patients. Sigerist saw no real reason to doubt this attribution, although I will try to explain why it seems to me more likely to be a picture of the medical world as it was in the twelfth century, and even earlier, than of the late thirteenth. What clearly intrigued him about the treatise was its opening section, where the author explained to his readers certain precautions they should take when examining urine specimens brought to them for diagnosis—it was accepted that a patient's condition could be determined by studying the color, sediment, and so forth of his urine.<sup>1</sup> These precautions will intro-

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1. Henry E. Sigerist, “Bedside Manners in the Middle Ages: The Treatise *De Cautelis Medicorum* Attributed to Arnald of Villanova,” *Quart. Bull. Northwestern Univ. Med. Sch.*, 1936, 20: 135–43; reprinted in *Henry E. Sigerist on the History of Medicine*, ed. Felix Marañón (New York: MD Publications, 1960), pp. 131–40 (page numbers in subsequent citations refer to this edition). Sigerist distinguished four parts in the text (known collectively as *De cautelis medicorum*), of which the first contained the microscopic advice mentioned here.

duce us to the question of the interaction between healers and patients in the Middle Ages, and of how this changed in the twelfth and thirteenth centuries. The description may seem to confirm all our worst preconceptions about medieval medicine—most people are convinced that it must have been ludicrous, bordering closely on farce—but we need to have a sense of the healer-patient encounter that it reveals. In the fifty years since Sigerist called attention to this text we have considerably expanded our understanding of the social and institutional setting of medieval medical and surgical practice, and that understanding should help to give the text some historical perspective.

Actually, Sigerist's title is quite misleading, at least as regards the part of the text that most interested him, because these precautions do *not* show the physician studying the urine at the bedside; he only encounters the patient by proxy. The author takes it for granted that the physician is being brought the urine by an intermediary, a messenger from the patient. You need to determine at the beginning, the text explains, whether the urine is human, or of another animal, or another fluid altogether—stewed thistles, perhaps; stare hard at the person who brings it to you, and if she blushes furiously, accuse her immediately of trying to trick you. If you think that she may be trying to fob you off with white wine, pour out a little of it in such a way that some gets on your finger; then stop and pretend to blow your nose with the same hand, sniffing the finger as you do so, and if you smell wine, tell her you know that she's trying to mislead you. If it really *is* urine that you have been given, and you can't learn anything from it about the patient, says our text,

say that he has an obstruction in the liver. [The messenger] may say: "No, sir, on the contrary he has pains in the head, or in the legs or in other organs." You must say that this comes from the liver or from the stomach; and particularly use the word, obstruction, because they do not understand what it means, and it helps greatly that a term is not understood by the people.<sup>2</sup>

And so on: the author offers many such nuggets of advice, all very much of a piece, and all immediately suggesting to a modern reader that medieval medical practice was no better than an elaborate charade without any intellectual content at all. Yet on the contrary, this physician-patient exchange over a urine-flask has something serious to tell us about medical relationships in the Middle Ages.

If there is any one stock image of the medieval physician in the public mind today, it is one showing him gazing deeply into a urine-flask, and the same thing was true in the Middle Ages: medieval manuscripts show

that scene over and over again. And whereas for us the scene is good for a condescending giggle or laugh, medieval readers reacted differently. To them the urine-flask had the iconic significance of a modern physician's white coat: it represented the expertise, the specialized knowledge possessed by the physician, and the respect that that expertise deserved. From the fluids emitted from the body the physician could judge its health and could offer a prognosis for its future that the patient could confidently accept. Today, of course, that expertise and that trust are grounded in a system of medical education, examination, and licensing that patients scarcely ever question; they take for granted that the framed diploma on the wall will prove the competence that the white coat implies. In the early Middle Ages, however, before about 1200 or so, no such system of education existed. There were no formal medical schools; aside from those monks and priests who might offer medical care, most healers were probably illiterate and had learned their trade by apprenticeship or on their own. Patients certainly could not assume that someone calling himself a physician had the expertise of learning, and so bringing urine to a practitioner for interpretation necessarily had certain elements of a test about it: it was not simply an objective examination of a material fluid, it was a kind of subtle, probing, broad inquiry that helped a patient's representative be sure that a physician was clever enough to deserve his trust. And it is this context of patient-physician negotiation that helps explain what seem at first no more than the tricks of a couple of entertaining charlatans: the patient had to make sure that the physician knew his business, while the physician had to reassure the patient that he really did deserve to be given the case.

These relationships may seem more real in the light of a story set down by a monastic chronicler of about the year 1000. At that time, one of the most famous physicians in the West was a monk at the monastery of St. Gall named Notker. The duke of Bavaria, worried about his health and aware of Notker's reputation, decided to consult him; but to make sure that Notker's reputation was really deserved, the duke sent emissaries to St. Gall, not with the ducal urine, but with the urine of a pregnant servant girl in the palace. Notker studied the urine carefully, his eyes widened, and he fell on his knees, praising God loudly—for, he said, "Within a week the Lord will perform an unheard-of miracle: the duke will give birth to a son!" The messengers went back to Bavaria, where they found that in the meantime the servant girl had been delivered of a boy, and a few weeks later they returned to St. Gall with the duke's own urine.<sup>3</sup>

3. Loren C. Mackinney, *Early Medieval Medicine with Special Reference to France and Charters* (Baltimore: Johns Hopkins Press, 1937), pp. 45–46, 162–63; Johannes Duff, *Notker der Arzt* (St. Gall: Oeschelweiz AG, 1972), pp. 45–46.

2. Translated by Sigerist, "Bedside Manners" (n. 1), p. 135.

The Bavarian court was approximately a hundred and fifty miles from St. Gall, which suggests both how scarce physicians were in the early Middle Ages and why it was often easier to bring the urine to the physician than to bring the patient. But the same sort of defensive jockeying to maintain an intellectual edge took place when the physician could actually visit the patient. A twelfth-century text advises the physician: Find out as much as possible in advance about the patient's symptoms, so that even if you can't tell from pulse and urine exactly what is wrong with him, he will still believe in your powers when, without any prompting, you tell him how he is feeling. You should promise him health, with the Lord's help, but whatever his condition, tell his friends privately that it is very grave, so that if he recovers your reputation will be the greater and if he dies they will be able to bear witness that you had despaired of him from the first.<sup>4</sup>

There are a great many such short deontological texts that were circulating by the twelfth century, some of them dating to late antiquity. A theme even more common in them than this defensive posture *vis-à-vis* the patient is their portrait of proper medical comportment—one with strong Hippocratic echoes, suggesting *Decorum* or *Precipis* (although these texts themselves did not circulate in the Middle Ages):<sup>5</sup> Be modest (don't be first to choose a seat when you're invited to eat); don't be haughty (praise the food even if it should be coarse), or lustful (don't eye the women in the household), or talkative.<sup>6</sup> It is not hard to see their insistence on these traditional practices as part of the same occupational strategy, meant to keep the patient from turning against the physician.

4. The text has been published as "Anonymi Salernitani De adventu medici ad agrorum libellus" in *Collectio Salernitana: ossia documenti inediti, e trattati di medicina appartenenti alla scuola medica Salernitana*, ed. Salvatore de Renzi, vol. 2 (Naples, 1853), pp. 74–80; it was discussed by Loren C. Mackinney in "Medical Ethics and Etiquette in the Early Middle Ages: The Persistence of Hippocratic Ideals," *Bull. Hist. Med.*, 1952, 26: 1–31, esp. pp. 24–26. As Sigerist later pointed out, it was subsequently incorporated into the *De causis* attributed to Arnald of Villanova as its third part ("Beside Mannes" [n. 1], p. 133; the text is translated on pp. 137–38). The work is treated by Pearl Kibire, *Hippocrates Latinus: Reportorium of Hippocratic Writings in the Latin Middle Ages* (New York: Fordham University Press, 1985), pp. 232–33, under the title of [ps.-Hippocrates'] *De visitando (visitatione) infirmorum*.

5. Vivian Nutton, "Beyond the Hippocratic Oath," in *Doctors and Ethics: The Earlier Historical Setting of Professional Ethics*, ed. Andrew Wear, Johanna Geyer-Kordesch, and Roger French (Amsterdam: Rodopi, 1993), discusses "the fate of Hippocratic deontology" in late antiquity and the early Middle Ages (pp. 22–26).

6. Many of these texts are printed or summarized in Ernst Hirschfeld, "Deontologische Texte des frühen Mittelalters," *Archiv für Geschichte der Medizin*, 1928, 20: 353–71; and Mackinney, "Medical Ethics" (n. 4), pp. 1–31.

Now at the same time that the last of these early deontological texts was being compiled, medieval medicine was on the verge of a dramatic change. It was foreshadowed by the translation into Latin during the twelfth century of a large number of medical and scientific writings by Greek and Arabic authors of the past. New sciences like astrology seemed to offer the possibility of even *more* control over diagnosis without actually having to study the patient. One of the earliest Western treatises on astrological medicine was William the Englishman's *De urina non visa* (On unseen urines, ca. 1217). Here William explained that it was not really necessary for the physician to see a patient's urine, much less the patient himself: a knowledge of astrology would allow you to say readily enough what a patient's urine would have looked like if it had been brought to you.<sup>7</sup>

But William was writing just at the moment when medieval medicine was beginning to undergo an institutional and intellectual transformation that would alter the physician-patient exchange. Before the year 1200, as we have seen, virtually all medical education was practical; but medicine was very early grafted into the faculties of the new European universities that were founded at the beginning of the thirteenth century, and learned medical graduates began to acquire some of the same kind of prestige that adhered to the other professions shaped by the universities, law and theology. The sudden availability of Latin translations of classical medical works meant that, like lawyers and theologians, the new academically trained physicians could claim their own standard authorities—Avicenna and his *Canon*, to begin with, on account of its comprehensiveness and organization, but by the end of the thirteenth century Hippocrates and especially Galen: these authors were the models for the learned physician, who was gradually becoming something of a social ideal. Empirics were still common throughout medieval Europe—medical schools were so few in number and produced so few students that it could hardly be otherwise—but academic medicine was at least becoming a largely unquestioned goal.

This new Galenic ideal had two consequences for practitioners that need to be emphasized, the first of which concerns a new approach to diagnosis or prognosis. Galen and Hippocrates were careful and subtle clinical observers, something that was implicit or explicit in almost everything they wrote. Uroscopy as such was only a small part of the physician's observations in Galen's teaching; above all, the physician had to observe

7. I have used the text of William's work provided in the unpublished paper by Charles W. Clark, "William of England and Astrological Medicine in the Early Thirteenth Century," which Professor Clark has generously shared with me.

the patient directly and closely, and in addition take his history.<sup>8</sup> It seems to be true that by the later thirteenth century, while the lay public still thought of uroscopy as somehow central to what physicians did, to learned physicians brought up on Galen's writings uroscopy was far less important than it once had been; medicine was now an enormously intricate technical subject, and direct observation of the patient was of the first importance in gaining the necessary knowledge about his condition. Moreover, the twelfth-century recovery of European civilization, including improvement in communications and the growth of towns, had both increased the number of practitioners and made it much easier for them to see patients in person. Empirics might still depend on urine alone for their diagnosis; university-trained physicians could boast that their bedside consultations gave them a superior insight into their patients' condition. (And modern cynics might think that bedside medicine naturally made it rather harder for patients to substitute white wine for their urine.) The delicate jockeying over a urine-flask described in Sigerist's text was gradually becoming a thing of the past.<sup>9</sup>

The second consequence of this new Galenism that should be emphasized was the rising status of university-trained physicians, who by virtue of their education could confidently assert a kind of intellectual superiority and distinction that—because they understood medical “science”—set them apart from empiric healers and, of course, from the ordinary laity, the *vulgus* or *vulgar*. But this new sense of their proper status and its foundation in learning had to be reconciled with the emphasis that their Galenism placed on examining and questioning the patient. Remarks at the beginning of Hippocrates' *Regimen acutorum*, as commented upon by Galen—a work incorporated into the first curriculum of the medical faculties, the so-called *ars medicine* or *artificella*, in the early thirteenth century—raised the question whether it might not be superfluous and a waste of time, even detrimental, for physicians to ask patients about their

8. Excellent accounts are Luis García-Ballester, “Galen as a Clinician: His Methods in Diagnosis,” in *Aufstieg und Niedergang der Römischen Welt*, ed. Wolfgang Haase and Hildegard Temporini, part 2, vol. 37.2 (Berlin: De Gruyter, 1994), pp. 1636–71; and Vivian Nutton, “Galen at the Bedside: The Methods of a Medical Detective,” in *Medicine and the Five Senses*, ed. W. F. Bynum and Roy Porter (Cambridge: Cambridge University Press, 1993), pp. 7–16.

9. Cf. the criticism of uroscopy in the *Aphorisms* of “Johannes Damascenus” or Mesue, one of the newly translated texts that was widely quoted by thirteenth- and fourteenth-century physicians: “Gloriosorum superbiam et ad urine multiloquium, si sapias, contempnas, nec te egrum per omnia interrogare pudeat; urina enim, nisi cum motus in ura veras exiterit, fallax est” (Yūḥanna ibn Māsawayh [Jean Mesue], *Le livre des axiomes médicaux* [*Aphorismi*], ed. Danielle Jacquart and Gérard Trouppeau [Geneva: Droz, 1980], pp. 148–49).

symptoms. After all, a truly scientific medicine would be founded on things that the learned physician will understand but that the laity cannot possibly appreciate; anything a vulgar patient can tell his physician should be obvious to the physician already.<sup>10</sup>

Taddeo Alderotti, who established the tradition of Galenism at the university of Bologna in the last quarter of the thirteenth century, resolved the question as follows:

In talking with the patient we need to ask about everything, but of course it is not all worth writing down. From his symptoms we *can* learn the things that trouble the patient in his illness, and also the things that make him feel worse or better: for example, if he has a raging fever and drinks cold water, he may tell the physician that he feels better or that he feels worse. . . . The things that the physician must know are the indicators by which we know what the illness is but of which the patients remain unaware, like this or that urine or pulse or quality of the body. . . . As Hippocrates has said, the way in which symptoms vary from patient to patient in the same disease causes great difficulties in diagnosis, difficulties that physicians are aware of but that patients do not appreciate—for example, how the same kind of fever looks different in a choleric or a phlegmatic patient, in a boy or in an old man, in a smith or in a fisherman; a layman [*vulgus*] understands nothing of all this.<sup>11</sup>

As he goes on to explain, the same is true of therapeutics:

10. Nancy G. Sirasi, *Taddeo Alderotti and His Pupils: Two Generations of Italian Medical Learning* (Princeton: Princeton University Press, 1981), pp. 124–25.

11. “De omnibus inquirendum est a medico in colloquationibus ad investigandum essentiam morbi, sed non sunt omnia scribenda in libris tanquam artis principia. . . . Per accidentia possumus intelligere nocumenta que sentiunt infirmi ab egritudinibus suis, et etiam iuvamenta et nocumenta que sentiunt infirmi a rebus sibi oblati vel approximatis, puta si aliquis habens causonem et bibi aquam frigidam, refert medico interdum quod contulit, interdum quod nocuit. . . . Illa quidem que debent fieri nota medico absque inditio egrī sunt significationes quibus egritudinem cognoscimus, et quibus super illam pronosticamus non percipere ob infirmis, sicut urina talis vel talis et pulsus talis vel talis et qualitas corporis talis vel talis: per has enim significationes ignotas infirmis cognoscit medicus speciem egritudinis et eius causam et sic pronosticari super ipsam. Item significationes curative per quas cognoscimus res cum quibus fit cura et qualiter proximari debeant debent esse note medico absque inditio egrī. . . . Vult hic Hippocras quod diversitas accidentium eiusdem egritudinis in diversis corporibus faciat difficultatem in arte, que difficultas est ignota vulgo et nota medico—verbi gratia in febre continua alia accidentia possunt apparere in cholericis et alia in phlegmaticis et alia in puero et alia in iuvene et alia in senes et alia in fabro et alia in piscatore, ex quibus fiunt diverse cognitiones et pronosticationes et curationes. . . . Talis enim diversitas aliquando habet magnam difficultatem quam non cognoscit vulgus: *Taddeo Fiorentini in præctarum regiminis acutorum morborum Hippocraticis volutariis expositio* (Venice, 1527), comm. to Lib. I Textus ii, fol. 247ra–b. Also discussed in Sirasi, *Taddeo Alderotti* (n. 10), p. 124.

If someone is suffering from bladder-stone, everyone knows that removal of the stone is indicated . . . but not everyone possesses a knowledge of what will expel the stone, only those expert in the art.<sup>12</sup>

So Taddeo not only justifies bedside medicine—and it is worth pointing out that an inspection of the urine is only one of the many routes to an understanding of an illness that he recognizes—he suggests that it can be the sphere in which the physician asserts his authority over the vulgar patient by demonstrating that he knows more than the patient does.

As bedside medicine became routine it raised new questions about medical behavior. By around the year 1300 much of the public had become predisposed to believe that a learned physician had an advantage over any other, but it remained important for the individual physician to protect that advantage; he had somehow to maintain *in person* the credibility that in an earlier age would have been gained, at a distance, by a triumphantly successful uroscopy. How was he to do that? It remained true, of course, that a decisive diagnosis and accurate prognosis at the bedside would still guarantee the patient's confidence. This point was made in another fundamental text learned virtually by heart as part of the new curriculum by every student in the new medical faculties, Galen's commentary on Hippocrates' *Prognostics*:

Hippocrates shows us here [Galen wrote] how the first benefit . . . that comes from a knowledge of prognosis is that it leads the sick to trust in the physician and to put themselves in his hands; since he knows how their condition has developed, it must follow that he is worthy of their trust. . . . When the sick hear the physician tell them something that no one told him about their condition, they defer to him, which is entirely appropriate.<sup>13</sup>

12. "Puta si aliquis habeat lapidem in vesica, essentia huius morbi indicat ablatonem lapidis et hoc notum est omnibus. . . . Scientia vero rerum cum quibus debet lapis expelli et quomodo et rerum cum quibus debet fieri unio partium solutarum, non est nota omnibus, sed peritis in arte, unde in quantum illa que sunt nota vulgo sunt fundamentum eorum que sunt nota solum sapientibus, dico quod talia nota vulgo debent in arte poni, quantum sint levata." *Thaddæi*. . . *expositio* (n. 11), comm. to Lib. I Textus ii, fol. 247vb.

13. "Tam narravit Hippocrates in hoc sermone iuramentum primum ex tribus iuramentis que acquiruntur ex scientia pronosticationis in sermone suo ita ut provocet infirmos ad confidendum et committendum se in manibus medici propter sanitatem que antecessit et quam indicat eis et consequitur illud ut sit dignus quod de eo fiducia habeatur quod ipse est potens scire res infirmorum scilicet naturam egritudinis et causam facientem ipsam. Erit ergo conclusio demonstrationis super illum secundum modum hunc quando antecessit medicus et infirmus illud quod futurum est indicat et creditur de eo quod est potens scire res scilicet naturam egritudinis secundum veritatem et de quo habetur fiducia quod ipse est potens scire naturam egritudinum. . . . Quando ergo audiant infirmi a medico aliquid horum preter quod ipsi nuntiaverunt et illud admirantur de eo et dignum est ut admittentur

But how should the physician act in the patient's presence before he has come to a conclusion about the illness? At this point, while the patient is silently assessing him and before he has proved his prognostic skill, his manner, his behavior, is crucial. It is surely not just by chance that the theme of bedside behavior suddenly appears independently in the writings of a number of academic physicians in the last quarter of the thirteenth century and the first quarter of the fourteenth. I think they were trying to explain to their colleagues what kinds of behavior were required by the new academic medicine, and I want to examine that behavior by looking at the advice of four different writers: William of Saliceto, physician and surgeon at Bologna, writing ca. 1280; Arnald of Villanova, physician at Montpellier, writing ca. 1300; Henry de Monderville, physician and surgeon at Montpellier and Paris, writing ca. 1315; and Albert de Zancaris, physician at Bologna, writing ca. 1325. They make up a representative collection of practitioners spanning half a century just a hundred years after the beginning of university medical education: two physicians, two surgeons with medical credentials; two French, two Italian figures. How do they tell their readers to behave toward their patients? Some of these texts have been looked at briefly by historians, but usually decontextualized, set into a modern framework where their appearance of enchanting naïveté gives them good entertainment value. If we remember that these men were writing at the moment when the very character of medicine was changing, we can appreciate their texts as serious attempts to rethink the physician-patient encounter, from the moment the physician is called into the case to the point where the appropriate treatment has been decided upon and is under way, and we can see them trying to accommodate it to these new circumstances.<sup>14</sup>

de eo": *Galenus*. . . in *Pronostica Hippocratica*, Lib. I textus 2-3, in *Articula* (Venice, 1523), [fol. 141ra-b. On the genesis of such attitudes, see Ludwig Edelstein, "Hippocratic Prognosis," in *Ancient Medicine*, ed. Owsei Temkin and C. Lilian Temkin (Baltimore: Johns Hopkins Press, 1967), pp. 65-85.

14. My sources for these authors are as follows:

(1) William of Saliceto, *Summa conservacionis*, capitulum generale, in MS Cambridge, Trinity College 1202, fols. 1rb-2va (folio numbers in subsequent citations refer to this source); printed in *Summa conservacionis et curacionis magistri Gulielmi Placentini* que Gulielmina dicitur: noviter impressa diligenterque correcta (Venice, 1502), fol. 2ra-4b.

(2) Arnald of Villanova, *Repetitio super canone "Vita brevis"*, in MS Munich, CLM 14245, fols. 13v-38v. A very defective text of Arnald's *Repetitio* can be found in the various sixteenth-century editions of his *Opera medica*. I am presently preparing a critical edition for the *Opera Medica Omnia* being published by the Universitat de Barcelona.

(3) Henry de Monderville, *Chirurgia*, ed. Julius Leopold Pagel, in "Die Chirurgie des Heinrich von Monderville (Hermondaville)," *Archiv für klinische Chirurgie*, 1890, 40: 153-311, 653-752, 869-904; 1891, 41: 122-73, 467-504, 705-46, 917-68; 1891, 42: 172-228, 426-90, 645-708, 895-924. Pagel subsequently published a corrected version of the text as

We need to acknowledge at the beginning that that encounter was still shaped by the practitioner's need to keep a certain intellectual edge or moral advantage over his client. Yet while these texts of 1300 often repeat particular recommendations from the earlier deontological literature, their overall orientation is now rather different. University training was beginning to give practitioners a certain initial moral authority in their dealings with patients, but not necessarily enough to override all the patients' doubts about them. So physicians had to shape their behavior toward patients in such a way as to keep reinforcing that authority and to maintain patient confidence, and the new Galenic literature allowed physicians to claim that this was not just a matter of self-interest, it was a medical necessity, an important part of therapy—whether the patient appreciated that fact or not. Galen, commenting on the beginning of Hippocrates' *Prognostics*, made this very clear: "The trust of patients in committing themselves [to a physician] is essential, and he to whom patients entrust themselves cures the most illnesses."<sup>15</sup>

To begin with, the physician of the year 1300 should not ordinarily look for clients—he should not visit the homes of the sick, for example, to offer his services, as had been common enough in antiquity; rather, he should wait for the patient to either come to him or send a messenger to him asking for his help. For if you drop in on the patient, says William of Saliceto, "your visit means that you're putting yourself in the patient's hands, and that is just the opposite of what you want, which is getting him to express a commitment to you by putting *himself* in yours."<sup>16</sup> If he is a relative or a friend and doesn't call on you, he clearly doesn't trust you to improve his condition anyway. If he is unknown to you, and you drop in

*Die Chirurgle des Henri de Monderville* (Berlin, 1892)—but because this version is difficult to obtain, and because the changes to the second version are few and relatively minor, my references are all to the first, as well as to the French text published by E. Nicaise, *Chirurgle de maître Henri de Monderville* (Paris, 1893).

(4) Manuel Morris, *Die Schrift des Albertus de Zancanis aus Bologna* (inaug.-diss., Leipzig, 1914).

Some of these texts have been briefly considered by Mary Catherine Welborn, "The Long Tradition: A Study in Fourteenth-Century Medical Deontology," in *Medical and Historical Essays in Honor of James Westfall Thompson*, ed. James Lea Cate and Eugene N. Anderson (Chicago: University of Chicago Press, 1938), pp. 344–57.

15. "Est fiducia etiam infirmorum de eo committendi se illi vehementior, et de quo confident infirmi et in cuius manibus se committunt ipse sanat plus egritudines." *Galenus... in Pronostica Hippocratis* (n. 13), Lib. I text 2, fol. 1411b.

16. "Per hanc enim tuam visitationem iam habes quod infirmus per fidem quam habebat de te non se committit in manibus tuis sed potius tu te committis in manibus suis, et sic eius fides revolvitur in contrarium tue intentionis." Saliceto, *Summa consensationis* (n. 14), fol. 2ra.

and offer advice, you can't win: if he gets better, he and his friends will say that your treatment was just a coincidence, that he was already on the way to recovery, while if he gets worse everyone will be convinced you were responsible, whether you were or not. So wait to act until the patient puts his faith on record by asking you to come.

Sometimes, in this new age, the vulgar will still show up with urines for inspection. Do not be in any hurry to agree to the request, but see what sort of person is asking you. Some people will obviously be trying to trick you, and we already know how to deal with them. Then there will be women trying to find out if a pregnancy is indicated so that they can procure an abortion—you say to them that you simply can't tell. But if the person who brings you the urine is respectful and deferential, do the best you can, simply and briefly.<sup>17</sup> Again, the impression from our authors is that by 1300 the negotiation via uroscopy is no longer a very important element in choosing a physician, though it remains a useful technique in diagnosis.<sup>18</sup>

Now let us assume that messengers have arrived and have asked for your services. If there seems to be no great urgency about the case, you begin by asking them for information about the patient, his age and condition and general state of health, inquiring particularly about his senses and understanding, his breathing and heart, and his digestion; and about his personal history, how he lives, what he does, what kind of a person he is.<sup>19</sup> Or, if you have no time for all this, you must at least inquire about his symptoms so that you can begin to try to eliminate certain possibilities as you go to him:

If the messengers say that he has lost consciousness, [for example,] you should immediately run through the various possibilities, . . . what the symp-

17. Morris, *Zancanis* (n. 14), pp. 13–14.

18. This general trend, and the fact that uroscopy is virtually ignored in Arnald of Villanova's *Repetita*, is the reason why the first part of the *De caulis* translated by Sigerist now seems to me not to date from the late thirteenth century—or at least not to be the work of an academic physician of that period, like Arnald. I should perhaps emphasize that I have no intention of minimizing the role of uroscopy for medieval diagnosis, which persisted for centuries; my point is simply that for the academically trained physician (if not for empirics), the relative importance of the information supplied by it diminished. Carole Rawcliffe, *Medicine and Society in Later Medieval England* (Stroud, England: Alan Sutton, 1995), pp. 46–50, stresses the continuing place of uroscopy in diagnosis in the later Middle Ages, especially for the beginner ("the rudiments could easily be mastered with the help of a coloured chart and some practical guidance from a senior colleague" [p. 49]). so does Nancy G. Stratis, *Medieval and Early Renaissance Medicine: An Introduction to Knowledge and Practice* (Chicago: University of Chicago Press, 1990), p. 125.

19. Villanova, *Repetita* (n. 14), fols. 28v–29v; Morris, *Zancanis* (n. 14), pp. 14–16.

toms are that distinguish one from another. In apoplexy, every sign of life has stopped except breathing; in syncope and suffocation of the womb breathing stops too, but in syncope the extremities become cold and the face is discolored . . . and the forehead is covered in cold sweat, while none of this occurs in suffocation of the womb. In epilepsy the face, the eyes, and the lips are contorted, or at least the lips or the eyes, and not in the other conditions. In stupor a patient can respond to stimuli but has no fever; in lethargy he is feverish but cannot be aroused.<sup>20</sup>

When you arrive at the patient's bedside, you should bear in mind what Galen has said, that the symptoms of an illness are damage to bodily function, some qualitative change in the body, and other indicators that can be inferred from the excreta, and you should explore all these things. Begin—if he is conscious—by taking a history, asking him about his condition, things that he alone can describe, such as falling senses or loss of appetite. (This, it will be remembered, was Taddeo Alderotti's advice too.) Then proceed to a physical examination of the body's functions; examine the patient yourself as far as modesty allows, and get an agent or friend of the patient to report the remainder to you. At this point you can take the pulse; Arnald tells his readers, "don't take it when you first get there, [since it may be abnormal,] especially if the patient is conscious and has been eagerly expecting you. Of course, if he isn't conscious, then he won't react with joy or fear to the arrival of a physician and his pulse won't change at all."<sup>21</sup> William of Saliceto adds the recommendation that the physician should seem very intent on the pulse, because this builds up a lot of confidence in the patient, which will be very useful as the treatment progresses, and at the same time creates a good impression on the bystanders.<sup>22</sup>

Next you continue with an examination of the body—odor of breath, feel of skin and body, and so forth. And finally consider the excreta:

20. Villanova, *Repetitio* (n. 14), fol. 28r; English translation slightly adapted from Michael R. McVaugh, *Medicine Before the Plague: Practitioners and Their Patients in the Crown of Aragon, 1285–1345* (Cambridge: Cambridge University Press, 1993), p. 231.

21. "Non enim statim cum accedit ad patientem debet tangere pulsam, maxime si patientes expectaverit medicum cum magno desiderio et habet salvam cognitionem; nam si amisisset eam, tunc propter adventum medici vel presentiam neque gaudium neque tristitiam pateretur, nec per consequens pulsus immutaretur". Villanova, *Repetitio* (n. 14), fol. 29v.

22. "In pulsu vero debet medicus cum maxima instantia et boatu quo ad laycos considerare sed veritatem ignorare non convenit astute tangere et quiete pulsam infirmi est conveniens; et est bonum videre ut medicus multum sit intentus de hac re, nam omnia talia de medico hominibus fidei faciunt, que est valde utilis in convenienti operatione medicinali, et per istud astantes habent bonam presumpcio de medico". Saliceto, *Summa consensations* (n. 14), fol. 1rb–va.

discharges from the nose and ears, saliva, urine, feces, sweat. (In this examination, we may observe, uroscopy appears, but it plays a very minor role—and comes late.) The personal encounter, the consultation as a whole, has now absorbed the functions of the earlier uroscopy-at-a-distance, because it not only provides a range of information about the patient's condition, it makes it abundantly clear that the physician is a person of impressive learning and skill and ensures that the patient will have confidence in his treatment: as William goes on to assure us, "this kind of deliberate inquiry establishes the physician as knowledgeable and authoritative to laymen, the friends of the patient, and it confirms the patient and the bystanders in their trust of him, especially if they know little or nothing about medical science anyway; and thus the patient's mind will be set at rest."<sup>23</sup>

If after this examination you are able to make a diagnosis, all that remains is to decide on the appropriate treatment. But what if you are not immediately able to decide what your patient is suffering from? What if you need to study the medical literature or want to consult with colleagues? Something has to be done in the meantime to maintain the patient's faith in you; this, remember, is something that can never be taken for granted. Therefore, so that the patient will not be depressed and despair, you should prescribe *some* kind of regimen for him (one possibility is a bland and innocuous diet, designed according to your sense of the disease—broth and almond milk when it looks as though it might clear up soon, light meals when you are afraid that it will not), and you should leave him with positive assurances while you hurry home to look at your books and decide on a more active course of treatment. There you may find it helpful to draw up a chart, setting down the essentials—sex, age, lifestyle, length of illness, symptoms—to help you focus your thoughts as you settle on a diagnosis.<sup>24</sup>

And what do you do if all your study leads to no firm conclusion? Arnald of Villanova suggests that you may want to encourage the patient or his family to get a second opinion; but in the meantime you should continue to talk with the patient and monitor his progress, because your attention

23. "Nam talis inquisitio cum deliberatione reddit medicum auctoritabilem et scientem inter laycos et amicos infirmi et facti de se et scientia sua per talem inquisitionem fidem infirmo et astantibus—etiam si ipse debilis aut parve scientie fuerit; et per hoc confortatur mens infirme super eius operationem et fit operatio medicinarum nobilior et confortatur in tantum anima infirmi per hanc fidem et ymaginationem quod operatur qua infirmitatem forcius et nobilius et subtilius quam faciat medicus cum instrumentis et medicinis". *Ibid.*, fol. 1va.

24. Villanova, *Repetitio* (n. 14), fol. 30r–v.

will reassure him that you want to do what is best for him.<sup>25</sup> If he is the kind of patient who wants to be convinced not by words but by actions, or if his friends are importunate, then in order to quiet "their mutterings and the patient's mental anguish," as Arnald puts it (*murmur illorum et patientis angustiam atque languorem mentalem*), you can prescribe a medicine that may possibly do some good and that you know cannot possibly do any harm.<sup>26</sup> Not all the authors are as confident as Arnald that you can let the patient see you conferring with a colleague. The others agree that such consultations with other physicians are often essential, but they seem to feel that these are better held in private, since they too can weaken your authority and the authority of learning in general. Mondville prudently describes the precautions that should be taken in such cases:

First, [the practitioners] should discuss the case in the patient's presence, while they all carefully examine him, examining and probing the patient carefully, . . . one after another. Then if necessary they should point out to each other the various signs and other considerations that bear on the illness and the patient. Finally one of them—let it be the leading figure [*magis autenticus*] in the group, especially if he is a physician—should say to the patient: "Sir, we have studied your case and it seems straightforward to us. You should be gratified that there are so many good practitioners in our group, enough even for a king; the least of whom should be able to discuss, treat, and carry through your case to a conclusion." He should go on to ask him about the symptoms of his illness, first saying: "Sir, I hope it will not offend you if I ask when your illness began?" and thus he can continue on into further questions. . . . But at the end, when they have asked the patient all the questions necessary, they should all leave the patient's room and go into another where they can be private, since in every consultation masters disagree with each other in the course of arriving at the truth, and sometimes in the debate they burst into such language that a bystander would think they were quarreling with each other—as indeed they sometimes are.<sup>27</sup>

25. "Infirmi confidentia de medico vigoretur propter illius legatitatem et diligentiam manifestam et ut ab eius animo excitandi tedium excludatur"; *ibid.*, fol. 31v.

26. "Si tamen adverteret medicus quod infirmus esset ex suo more naturali vel acquisito impatiens aut fessimus, vel quod amici eius essent impetuosi et importuni, et ipse molletur aut commode et honeste non posset eum deserere, debet ad vitandum murmur illorum et patientis angustiam atque languorem mentalem ordinare aliqua medicamina que virtute aliqua possent prodesse infirmo quantum ad aliquid, licet ad morbum pellendum non habeant directum aspectum"; *ibid.*

27. "Primo debent discutere de morbo praesentū videndo diligentissime et palpando. . . . Et hoc faciant omnes, unus post alterum; deinde advertant, si expediat, iterum simul omnes considerando sibi invicem signa morbi et particulares consideraciones notabiles et etiam patientis; postmodum aliquis eorum, et sit ille, qui est magis autenticus inter ipsos et maxime, si est medicus, dicat patienti: Domine, bene vidimus factum Vestrum et bene videtur nobis, et multum debetis gaudere et laetari, quia sumus hic tot et tanti, qui debemus sufficere uni

William sums up his colleagues' concerns by concluding that "when physicians disagree, it convinces laymen . . . that the medical art is vanity, and they say that physicians follow chance, not science, in their practice, and that there are more physicians who are ignorant of what medicine is than there are who are not."<sup>28</sup>

My remarks about "positive assurances" and the like must not lead you to suppose that the medieval physician treated "truth-telling" lightly. On the contrary, one of the issues that most preoccupies our academic authors is how much, and in what tone, the physician tells the patient, his family, and his friends under various circumstances. Your manner matters quite as much as what you say, of course, because that is one of the elements that can maintain your authority: in general, you should not get too friendly with your patients, should maintain a certain aloofness; looking thoughtfully at the ground, saying little, lets them see that you are thinking hard and builds up their faith in you. If you discuss too much of your reasoning with them, they may start to believe they know as much as you do.<sup>29</sup>

But no matter how hard you try to keep your distance, you are bound to be pressed by the patient or his friends for a prognosis. This is awkward when you are still uncertain what the illness is, but under no circum-

regi, et quorum minor deberet sufficienter discutere, prosequi et perficere curam Vestram. Deinde quaerat ab ipso circumstantias suas morbi dicens: Domine non displicet Vobis nec habeatis pro malo, quamdiu est, quod Vos arripuit primus ille morbus, et sic deinceps ab ipso multas faciat quaestiones. . . . ; deinde facit a patiente diligenter omnibus quaestionibus conferentibus ad intentum, exeat omnes camera patientis et subintrent altam, in qua non sint aliqui nisi ipsi, quoniam in omni collatione magistris disputant inter se, ut melius discant veritatem, et quandoque grata disputationis prorumpunt in verba, quare videretur extraneis assistentibus, quod esset discordia vel litigium inter ipsos, et ita est aliquando". Mondville, *Chirurgia* (n. 14), 1890, 40: 723; Nicaise, *Chirurgie* (n. 14), p. 190.

28. "Nam omnes layci propter discordiam repletam inter medicos solum sermonibus et aliquando inquisitione causarum et egritudinum artem medicinalem reputant vanitatem, et dicunt medicos non rationabiliter contra egritudines sed ut plurimum casualiter operare, et hoc est quia numerus ignorantium veritatem in arte medicinali verum non ignorantium excedere consuevit". Saliceto, *Summa consorvationis* (n. 14), fol. 1vb. Cf. Morris, *Zanarati* (n. 14), p. 20: "Si medicus tibi in cura consocius sit plebejus, cum illo non conferas, ne hoc sibi in signum aliquis scientiae redundaret, cum totaliter sis privatus. Si vero medicinali scientia fuerit doctrinam, qui sociantur in cura, cum eis plane et benivole et in secreto circa infirmum confaris de gerendis."

29. "Inhonestum et indecens est communicari infirmo et laycis de causis infirmitatis et operationibus disputando determinare, nam et isto modo inquisitionis layci tanquam veritatem ignorantem et veritatis causas sapientem depriment et ignorans multotiens ab eisdem pro phisico reputatur. . . . Taciturnitas cum humilitate et facie depressa in qua videatur cogitatio cum sollicitudine facit fidem hominibus". Saliceto, *Summa consorvationis* (n. 14), fol. 1vb. Cf. Yūhanna ibn Māsawayh, *Aphorismi* (n. 9), p. 149: "Si interrogatus semper velociter respondeas, dubitandus es."

stances should you give in to this pressure. If you are unsure what the future holds or how long the illness is likely to last, on no account commit yourself to a specific prediction, because if the date comes around and the patient has not been cured, he is bound to despair and his friends are sure to accuse you of incompetence. Arnald tells us: "The prudent physician should always tell the patient and his family that he is using this or that drug to cause this or that condition in the patient, so that he and his friends will always be looking for something new to happen [in the short term] and won't worry [about the more distant future]";<sup>30</sup> and if in the meantime he begins to show improvement, you can—guardedly—take the credit.

If all this sounds cynical, I do not mean it to do so. These authors were well aware that one of the strongest weapons they had in therapy was the patient's attitude, and they did all they could to keep him in a positive frame of mind without (if possible) actually lying—though Henry de Monderville cheerfully admits he would be quite ready to lie if his patient's life depended on it.<sup>31</sup> Remember: if the patient has confidence in the treatment he is undergoing and in the physician in charge, he is likely to get better. In connection with this well-established point, both Henry and Arnald refer their readers to a part of the newly available Arabic medical literature, Qusṭā ibn Lūqā's little treatise *On Physical Ligatures* (originally written in the mid-ninth century, translated in the twelfth, but now suddenly in vogue at the beginning of the fourteenth); this text on psychosomatic medicine explains that incantations and charms and amulets help cure illnesses because patients believe in them, and the mind helps govern the body.<sup>32</sup> Arnald and Henry extend this argument to the physician's practice more generally, and Arnald points out that by bearing this principle in mind, one can practice in a manner that will work to the patient's best advantage while not diverging *too far* from honesty.<sup>33</sup>

30. "Et ideo medicus prudens semper dicit infirmo et aliis quod ordinet usum talis aut talis antidoti ad talem vel talem preparationem introducendam in egro, ad hoc ut ipsum egro et alios reuineat semper in spe ulterioris et necessarii operis, ut animo non fatigetur aut perturbetur": Villanova, *Repetitio* (n. 14), fol. 32r.

31. Monderville, *Chirurgia* (n. 14), 1890, 40: 692, 694-95; Nicaise, *Chirurgie* (n. 14), pp. 144-45, 148.

32. The treatise has recently been studied and edited by Judith Wilcox and John M. Riddle, "Qusṭā ibn Lūqā's *Physical Ligatures* and the Recognition of the Placebo Effect," *Mediev. Encount.*, 1995, 1: 1-50.

33. "Nunquam deseri veritatem et semper tendit ad commodum proximi": Villanova, *Repetitio* (n. 14), fol. 32r. See also Monderville, *Chirurgia* (n. 14), 1891, 41: 934; Nicaise, *Chirurgie* (n. 14), pp. 480-81.

But then the obvious question becomes, What do you do if you are convinced that the patient is threatened with death? How candid can you be with the family and friends who press you for additional information? These are recurrent questions in all our treatises. William thinks you should never say anything to the patient, or even in his earshot, that might lead him to despair, because his positive outlook is so important in getting medicines to work.<sup>34</sup> Albert says that if you think death is probable, you should avoid saying so outright; say something ambiguous, like: "It seems to me that if what appears to be the case is true, and nothing changes (and nothing seems to be changing), in such a case some people might live and some people might die."<sup>35</sup> To the family, if they press you, you can be more definite if you feel sure that the illness is mortal, but if you are not sure whether the patient will live or die it is better to admit uncertainty than to be wrong. On the other hand, Albert concedes, it is safer to bet on death than on life, since if the patient does then die, you will be held less to blame, and if he lives you will get the credit for bringing him back from the dead. Here is an example of the earlier deontological advice surfacing in the new academic context.

It is a little surprising that our authors almost never refer to the provision in canon law that physicians, before beginning treatment, should always require a patient to make his confession to a priest. The idea occasionally crops up in the twelfth-century deontological literature, but it was made the law of the church by the Fourth Lateran Council in 1215. Physicians were certainly aware of the rule, but they clearly resisted implementing it because they were afraid of the psychological consequences to the patient: if he were immediately told to confess when his physician walked in, he would imagine that the practitioner had already given up on him.<sup>36</sup>

Once your diagnosis is established and communicated to the patient and an outline of treatment is prepared, most of your difficulties are

34. "Nullo modo presumas coram infirmo neque ipso audiente aliquam debilitatem de ipsis natura proferre neque aliquid mali de eo, etiam si de eius salute fueris desperatus; sed medico semper conuenit infirmo salutem promittere in ymaginacione bone dispositionis et salutis firma in infirmi anima remaneat; nam tibi firmatas ymaginacionis de salute operationem medici iuua in omni re, et effectus medicinarum contra infirmitates melior et nobilior reperitur": Saliceto, *Summa conseruationis* (n. 14), fol. 1vb.

35. "Si vero econtura de morte providet, semper tamen in tali casu alloquens medicus sit dubius, in sermone ipsum conditionans sic dicens: 'certe mihi videtur, quod, si consistat, quae apparent, et aliquid non superueniat, quod praesentem non superuenire videtur, sanabitur hic, vel morietur aliter'": Morris, *Zanarvis* (n. 14), pp. 17-18.

36. Darrel W. Anundsen, *Medicine, Society, and Faith in the Ancient and Medieval Worlds* (Baltimore: Johns Hopkins University Press, 1996), pp. 201-2, 273-77. Anundsen quotes

over, but not all: patients (and their friends and attendants) still have to be carefully monitored to make sure that they have enough confidence in you to continue to follow your instructions to the letter—to guarantee “compliance,” if you like.<sup>37</sup> Here surgeons and physicians had somewhat different concerns. Surgeons on the whole needed to be more sensitive to their patients’ state of mind *during* treatment. There were several reasons for this. One was that surgery had traditionally been a manual craft and by 1300 had been giving itself academic pretensions for only a generation or so; patients must still have found it hard to accept unquestioningly a surgeon’s claims to possess the calm certainty of “scientific” knowledge. Another reason, as the surgeon Henry de Mondville remarked sourly to his readers, was that physicians, practicing internal medicine and prescribing drugs for their patients, ran less risk of close scrutiny and second-guessing than did surgeons, whose operations and procedures were upon the surface of the body.<sup>38</sup> And finally, probably most importantly, a surgeon’s more invasive procedures were sure to be more painful, more dangerous, more terrifying, than a physician’s; surgeons needed to be attentive to patient psychology; not only before treatment but during its course as well, if their patient’s trust was to override his fears.

Guy de Chauliac, a learned surgeon trained at Montpellier and Bologna in the 1320s, underlined the need for this sensitivity more than once in his famous *Great Surgery*. His account of the operation to cure indirect inguinal hernia exemplifies his attitude particularly well. He assumes the need to seal the inguinal canal with a scar—a scar that can be produced by severing the canal with a scalpel, searing it with a white-hot cautery, or corroding it with a three-week application of caustic chemicals like quicklime. Surgeons need to give their patients the choice to pick the procedure they fear the least, Guy explains, so that they will undergo the treatment as staunchly as they can; he says he himself generally uses caustics because patients become absolutely irrational with terror when you talk to them about the cautery.<sup>39</sup> Even after the

choice has been made, however, it is still advisable to help the patient keep control of his fears. Adopt whatever procedure the patient thinks he would prefer, caustics or the cautery or the knife; but whichever he opts for, apply it carefully so that he does not actually see the instrument. Keep him distracted as far as possible, in these and similar situations. If a patient is hemorrhaging, tell him to keep his eyes shut, or carry him into a dark room so that he cannot see the blood flowing; cannot even look at red things that might make him *think* of blood; keep telling him that it isn’t flowing any longer, or if it is, that it’s good for him that it’s still flowing.<sup>40</sup> And so forth. Issues like these were far less important to the physician, for whom the diagnosis was crucial in establishing the patient’s trust, and the treatment almost something of an anticlimax; as long as the recovery was steady, all should be well.

But suppose a medical recovery does *not* go as anticipated, and you are forced to change your treatment unexpectedly? You have to be able to reassure the patient that the setback is not an indication of your lack of knowledge, or of the imperfection of academic medicine, but rather that this sort of thing often happens and that it is precisely your training that will allow you to deal with it. Arnald of Villanova suggests an image for his students to pass on to their patients:

The physician’s situation is like that of a ship captain, because both are in charge of a situation that is governed not by necessary laws but by contingencies. The captain has to shift the sails and steer the boat as the changing winds determine; the physician has to shift his tactics as the changing circumstances of the patient make necessary, and his assistants, like the ship’s crew, must be ready to follow his commands, because he alone knows how to respond.<sup>41</sup>

(p. 202) a paragraph from Sigerist’s translation of the “Arnaldian” *De cauditis* to show that it

echoes this provision of Lateran IV. As it happens, however, that passage is omitted from the Latin text published in de Renzi, *Collectio Salernitana* (above, n. 4), and this suggests that the third section of the *De cauditis* in its “Arnaldian” form is indeed a compilation of the thirteenth century, though not necessarily by Arnald himself. See also McVaugh, *Medicine* (n. 20), p. 171 n. 13.

37. Morris, *Zanarvis* (n. 14), pp. 19–20.

38. Mondville, *Chirurgia* (n. 14), 1890, 40: 671; Nicaise, *Chirurgie* (n. 14), p. 112.

39. “Verum quia ignis est terribilis et multi in opere insaniantur pro timore ipsius ignis,

elegi michi illum de cauterio potenciali”: Guy de Chauliac, *Inventarium*, VI.2.7, ed. Michael R. McVaugh, vol. 1 (Leiden: Brill, 1997), p. 375. Cf.: “Et licet extirpacio cum ferris sit securior (cum cito facta sit et cito transeat illata impressio) quam cum medicinis, que sunt acue et longo tempore dolorem et febrem inferentes, nichilominus quia multi sunt timidi et plus velent mori quam sustinere ferrum—et cum hoc, in aliquibus locis est periculosa incisio—oportet uti medicinis extirpatis”; *ibid.*, VII.1.6 (ed. McVaugh, I, 443).

40. “Sextum documentum est quod claudantur oculi patientis, aut stet in loco obscuro ut non possit videre sanguinem suum neque inspicere res rubras; ymmo semper dicatur sibi quod amplius non fluit et si fluit quod est ad utilitatem ipsius, et ita confortatur virtus naturalis per conturiam ymaginacionem. Et propter hoc dicebat Avicenna quod generis accidentium animalium movencium ymaginacionem est motus sanguinis et consuetudo eius qui preparatus est ad eum, cum multum intentus fuerit ad considerandum res rubras”; *ibid.*, III.1.3 (ed. McVaugh, I: 168).

41. Villanova, *Reperchio* (n. 14), fol. 33r; discussed in McVaugh, *Medicine* (n. 20), p. 167.

If the patient can be made to understand this, Arnald concludes, he will not be dismayed when the physician has to change medication or regimen.

We can scarcely leave an account of the physician-patient encounter without saying something about fees, especially since anyone who has read Chaucer will have a firm sense that medieval practitioners were generally grasping, and that learned medicine was priced out of the reach of the poor.<sup>42</sup> I will not pursue that second point except to say that I am not convinced there is universally strong evidence for it; but the first point, the supposed greed of the medieval physician, needs to be addressed.<sup>43</sup> First of all, it is not a universal theme in these treatises we have been considering. William and Arnald do not mention the fee at all in discussing the encounter with the patient. Albert says very little beyond reminding the physician of the need to collect payment, and of the saying that

the physician shows the patient three faces: divine, diabolical, and human. Divine when the patient is suffering from his illness and begs his physician to return him to health; diabolical when, recovered, the erstwhile patient flees his unpaid physician like the devil himself; and human when the patient has finally paid his bill and can acknowledge him as his master and friend.<sup>44</sup>

It is only Mondeville who writes at length about the subject of fees, and it is his apparently cynical commentary that has furnished most scholars with the detail they have used to justify their picture of medical greed: comments about the surgeon's need to demand payment in advance if at all possible, for example, and to adapt his fees to the depth of his

42. Hailing E. Ussey, *Chaucer's Physician: Medicine and Literature in Fourteenth-Century England* (New Orleans: Tulane University, 1971), pp. 99–117, supplies a convenient survey of the way in which Chaucer's physician has regularly been perceived by commentators, though Ussey himself tries to defend the character against many of their charges.

43. Recent discussions of this topic are Carole Rawcliffe, "The Profits of Practice: The Wealth and Status of Medical Men in Later Medieval England," *Soc. Hist. Med.*, 1988, 1: 61–78; and Luis García-Ballester, "Medical Ethics in Transition in the Latin Medicine of the Thirteenth and Fourteenth Centuries: New Perspectives on the Physician-Patient Relationship and the Doctor's Fee," in Wear, Geyer-Kordesch, and French, *Doctors and Ethics* (n. 5), pp. 38–71.

44. "Reclatur fabulose vel historice ab antiquis, quod medicis respectu patientis triplex vultus ostenditur: divinus, diabolicus et humanus. Divinus quidem dum infirmus vehementi languore vexatur, ipsum humiliter deprecatur de resituenda corporis sospitate. Diabolicus vero, dum sanatus infirmus medico non satisfecerit condecet, ipsi non obvians, illum figat velut diabolicis vestigiis consignatum. Sed humanus, dum curatus infirmus sananti satisfecerit, ut oportet, illum sibi reputans velut dominum et amicum." Morris, *Zanarvis* (n. 14), p. 19.

patient's purse.<sup>45</sup> Again, however, we need to pay attention to the context. It is probably not by chance that these comments come from an academically trained surgeon, conscious not only of the new status enjoyed by academic medicine, and of the changes it was bringing, but of the difficulties faced by surgeons if they wished to share in that status and to gain acceptance, along with physicians, as learned professionals. Mondeville needed to stress behavior that would promote such acceptance, and to convince the public that the best surgeons were just as good as the best physicians—indeed better, because they added manual skills to medical learning.<sup>46</sup> Manual artisans like masons and skimmers might properly be given a fixed daily wage; but the new surgeon, Mondeville argued, was no longer such an ignoble, illiterate artisan and should insist on being paid differently. Certainly there was economic self-interest involved in his insistence on being paid at the outset, but as Mondeville says, here heart and hand go together: a patient who has paid you your fee will be less likely to second-guess you, to question your treatment and perhaps go to another surgeon. You will *know* he believes in you if he has paid up-front.<sup>47</sup>

So from bedside to billing, if I am right, the new academic medicine of the thirteenth century promoted new forms of behavior on the physician's part—and indirectly (though I have not stressed this point) on the patient's part too, by encouraging a kind of passivity in the face of the authority of learning. This bedside behavior that our authors are recommending, and that I have suggested was evolving in the context of the new university medicine, proved so useful that it enjoyed an extraordinarily long life—even late-twentieth-century readers might admit privately to feeling a twinge of familiarity at one or two of the practices I have described. Groping for a way to make sense of these practices in modern terms, some historians have read them as essentially ethical instructions, so that in the form in which very similar practices were presented at the end of

45. For example, Rawcliffe, "Profits" (n. 43), p. 62; García-Ballester, "Medical Ethics" (n. 43), pp. 51–52; Welborn, "Long Tradition" (n. 14), pp. 355, 356–57; and E. A. Hammond, "Incomes of Medieval English Doctors," *J. Hist. Med.*, 1960, 15: 154–69, esp. pp. 155–56. On the other hand, Sigerist's assessment of Mondeville's sardonic comments was, typically, nonjudgmental; see Henry E. Sigerist, "Sidelights on the Practice of Medieval Surgeons," *Proceedings of the Annual Congress on Medical Education, Hospitals, and Licensure*, February 1953, pp. 18–19, reprinted in Martí-Ibañez, *Henry E. Sigerist* (n. 1), pp. 141–45.

46. "Perfectus chirurgicus est plus quam perfectus medicus et . . . ad ipsum plura requiruntur, scilicet operatio manualis." Mondeville, *Chirurgia* (n. 14), 1890, 40: 657; Nicolson, *Chirurgia* (n. 14), p. 91.

47. Mondeville, *Chirurgia* (n. 14), 1890, 40: 694; Nicolson, *Chirurgia* (n. 14), p. 147.

the fifteenth century by Gabriele Zerbi at Padua they have actually been called "the first practical treatise of medical ethics."<sup>48</sup> This may perhaps be appropriate for Zerbi, but it seems to me less satisfactory to think of Arnald of Villanova and his contemporaries as having been writing about ethics. For one thing, ethics seems to me to imply the disinterested values shared by a self-conscious community: by Zerbi's day, around 1500, medical guilds had emerged in the larger European towns and had created just such communities of practitioners—but at the moment we have been concerned with here, two hundred years before, almost no such communities existed. The behavior I have described was far from disinterested; but it was instrumental in consolidating acceptance for academic medicine in the years when that was first establishing itself.

It may seem curious that medieval medical practice should at first look highly peculiar, if not farcical, and then, on closer inspection, seem not at all unfamiliar, so that we actually have to be on guard against the temptation to modernize it out of its historical setting. But of course what makes it seem so familiar is our recognition there of ageless themes, the themes of medical authority and patient trust: physicians have to prove themselves, somehow, to every generation. It looks peculiar simply because authority and trust are social products that are reconfigured, differently, in every generation—there is no one immutable way to create them. The Middle Ages found that sending a urine specimen out for expert analysis—what we might perhaps call laboratory medicine—was less conducive to authority and trust than was bedside medicine; but who knows? another age might reverse the status of laboratory and bedside medicine, for quite different, contingent, historical reasons.<sup>49</sup> Medieval practices that seem farcical *or* familiar to us can equally well have been natural products of a cultural or social framework that we do not share and must continually work to fully understand.

Henry Sigerist had cut his scholarly teeth on medieval texts, and he understood these issues very well. When in 1946 he published his transla-

48. L. R. Lind, *Studies in Pre-Vesalian Anatomy: Biography, Translations, Documents, Memoirs of the American Philosophical Society*, vol. 104 (Philadelphia: American Philosophical Society, 1975), p. 151. See also Roger French, "The Medical Ethics of Gabriele de Zerbi," in *Wear, Geyer-Kordesch, and French, Doctors and Ethics* (n. 5), pp. 72-97.

49. This is not simply a rhetorical possibility. See Andrew Cunningham and Perry Williams, eds., *The Laboratory Revolution in Medicine* (Cambridge: Cambridge University Press, 1992)—in particular, the editors' introduction, which gives a general survey of the rise of laboratory medicine (pp. 1-13), and the chapter by John Harley Warner, "The Fall and Rise of Professional Mystery: Epistemology, Authority, and the Emergence of Laboratory Medicine in Nineteenth-Century America," which deals with the emergence of laboratory medicine in nineteenth-century America as shaped, precisely, by its distinctively American context (pp. 110-41).

tion of "bedside manners," the text that gave me my starting point for this paper, he commented mischievously that earlier historians had protested indignantly that those uroscopic instructions were obviously the work of a crook, an "unworthy clown," and could not possibly have been written by a great physician like Arnald of Villanova. Sigerist himself made no attempt to defend Arnald by giving the instructions a modern gloss; instead, he concluded by saying simply and neutrally, in what sounds like deliberate understatement: "Medieval physicians and surgeons held views that were in many ways different from ours."<sup>50</sup>

50. Sigerist, "Bedside Manners" (n. 1), p. 132.