HEALERS AND HEALING

IN EARLY MODERN ITALY

David Gentilcore
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Healers and Healing in Early Modern Italy

David Gentilcore
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1 Frontispiece to Serafino Montorio's *Zodiaco di Maria* (Naples, 1715). Courtesy of the Biblioteca A. di Leo, Brindisi.


3 Physician on horseback and apothecary, frontispiece to Giulio Cesare Croce's *Secreti di medicina* (Bologna, 1635). Courtesy of the Cambridge University Library.

4 Barber-surgeon letting blood from a nun's foot. From Cintio d'Amato's *Nuova et utilissima pratica di tutto quello ch' al diligenze barbiero s'appariente* (Naples, 1671). Courtesy of the British Library.


6 Orvietan handbill, outlining its virtues and giving instructions on how it is to be taken, with a range of venomous animals in the margin and the coats of arms of the Roman and papal authorities (1649). Courtesy of the Archivio di Stato, Bologna (Fondo Studio, 214).


8 St Camillo de Lellis performing a miracle with a man on crutches, engraving by C. Klauber (eighteenth century). Courtesy of the Wellcome Institute Library, London.

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SERIES EDITOR'S FOREWORD

Benvenuto Cellini, the noted Florentine, goldsmith, silversmith, sculptor and murderer, wrote in his autobiography that in 1523: 'The plague had broken out in Rome. While it was raging a very great surgeon called Iacomo da Carpi appeared on the scene. Among his other patients this able man took on some who were in a very bad way from the French pox [...] he claimed that in the use of certain fumigations he had a splendid cure for the disease. He insisted, however, on the payment being settled before he began the cure, and his fees were reckoned not in tens but in hundreds. [...] He was a very learned man, and he could talk marvellously about medical matters. The Pope, in fact wanted him to stay in his service, but he said he had no intention of entering anyone's service, and that anyone who wanted him would have to come to him. He was a cunning devil, and he knew what he was doing when he left Rome, because, not many months later, all those he had cured fell so ill that they were a hundred times worse than before. If he had stayed he would have been killed.' Cellini later calls him a *ciarnadore* (charlatan).2

This charlatan was probably none other than Jacopo Berengarius, humanist, Practicus of surgery in the University of Bologna, who had written a scholastic commentary on the *Anatomia* of Mondino de' Liuzzi, which he dedicated to Giulio de' Medici in 1521 when he was still a Cardinal. If this is so then there is a chasm between his reputation as a learned theorist and the way his activities as a practitioner were viewed by his patients. Cellini's comments do not stem from personal animosity towards him, indeed quite the contrary, yet he had little love for the professional physicians of his day. When he contracted syphilis he only recovered when he treated himself and ignored their advice. Another illness turns out to be immune to all the medical ministrations as it was a case of demonic possession, and Cellini was only cured when the evil spirit was exorcised, even if unconventionally.3 He also indicates that the best medical care was not available to all. A friend had to call in a quack to treat his daughter as he did not know how to find a good surgeon. Even when one was found, it was the artist who had to make an appropriate surgical instrument. Cellini's approach to medicine was pragmatic. He took different categories of treatments and sought different kinds of help depending on the circumstances and nature of the illness.

Treatment of the sick was a lucrative trade that led to abuses. Cellini's patron in Rome, Pope Clement VII (Giulio de'Medici) sought to curb the power and independence of the Roman apothecaries with the Bull *In Superne Dignitatis Culiniae* (1531). He put the control of the corporation of apothecaries within the province of the Proto Medico (protophysician) in order to regulate and control their activities. The apothecaries were to be the only people authorised to prescribe medicinal compounds, but only under the supervision of the medical Tribunal. A regular piecet was also set up to be attended by representatives from the
about what constituted illness, its causation, the methods of treatment, the social divisions in medical provision and the access to care, with conclusions that can be extended, with modifications, to the rest of Europe.

Human nature does not change. In the past, as today, when illness strikes, men and women turn to available provision, both orthodox and unorthodox, in a desperate search for cures. These in turn are subject to control by the authorities to protect the patients and vested interests. In some a sense their recourse to magic, astrology and religion was much more rational than some of our present remedies. The world view that legitimised such beliefs was sanctioned by an illustrious philosophical tradition which saw its roots in the wisdom of Moses. The existence of demons, occult (hidden) properties and the influence of the stars were accepted by the Fathers of the Church such as Aquinas and by the Universities and the theologians. Given the plethora of help available, the sick, in many cases, chose the remedy which best fitted what they thought ailed them. The fact that they chose to consult a wise woman or an exorcist rather than a qualified doctor tells us much about the state of knowledge concerning disease as well as about the organisation of medical care.

NOTES


2 Benvenuto Cellini, Vita, II, viii.

3 Benvenuto Cellini, Vita, I, lxvii.


5 For the astrological programme see Janet Cox-Rearick, Dynasty and Destiny in Early Renaissance Astrology, University of Oxford, 1975.


7 Bartolomeo Masi, Ricordanze (Florence, 1906), p. 17.

At its heart this book is a study of medical pluralism. It explores the range of healers and forms of healing in the southern half of the Italian peninsula that was the kingdom of Naples. It analyses the features that constituted medical pluralism in this Catholic society, between (approximately) 1600 and 1800. I have not sought to write a conventional medical history, surveying great names and intellectual developments (although these, too, form part of the story). Rather, as much as possible, I have sought to adopt the point of view of the sick people themselves. In this context, religious and popular ideas about disease, its causation and cure, can be considered alongside learned ones. The emphasis is on the interaction and, indeed, competition between these three overlapping ‘spheres’. The training, preparation and practice of all healers is discussed, against a backdrop of ongoing attempts by the medical and ecclesiastical elites to limit their activities within bounds considered acceptable.

For a plurality of healing, I have consulted a plurality of sources: medical and demonological treatises, hagiographies, guild statutes, hospital records, government edicts, chronicles, books of ‘secrets’, local histories, episcopal visitations, canonicalization processes, trials for magic, diabolism and simulated sanctity, Jesuit mission accounts, and the records of the kingdom’s medical magistracy, the Protemedico. I have yet to come across either personal diaries or the case books of southern Italian physicians or surgeons, which have proved so useful to social historians of early modern England, France and Germany. Indeed, the sources are never as even as the historian would like, and this is especially so in the case of Naples, whose archives have suffered much over the years. Rather than try to cover every possible aspect of a vast topic, I have chosen a thematically approach. It is also comparative, frequently straying beyond the kingdom’s boundaries.

The book begins with a new approach to medical provision. In line with the pluralistic theme, chapter one charts the therapeutic landscape of the kingdom, considering all sources of healing. That is to say, the densities of physicians, barber-surgeons and apothecaries are considered alongside those of midwives and itinerant practitioners, churchmen, cunning folk, saints (living and dead) and healing shrines. These figures are discussed in the context of the different explanatory models for illness which existed in this Catholic society. These are labelled ‘medical’, ‘ecclesiastical’ and ‘popular’, for want of better terms. Throughout, I stress the fact that these three forms coexisted, overlapped, competed and contributed to one another. In their search for understanding and for sources of relief, the sick could make use of one or all of them. In this regard, the mechanisms shaping individual choices are also discussed.

The reason so much can be said about the kingdom’s licensed medical practitioners is due to the existence of a medical tribunal, the Royal Protemedico. Its activities are examined in chapter two. The Protemedico was headed by the kingdom’s ‘first physician’, the protomedico (whom I shall call the protophysician). It was responsible for overseeing the activities of practitioners, making sure they operated within their ‘professional’ boundaries. Apothecaries were subject to annual visitations or inspections, and barber-surgeons and midwives were examined for their basic competence. Primarily, however, the Protemedico endeavoured to collect the annual visitation fees from each and every practitioner, this activity being farmed out to tax collectors. That is, with the exception of graduate practitioners—physicians and surgeons—who were outside its jurisdiction until the Napoleonic reforms of the early nineteenth century. As an organ of the state, the Protemedico was confronted with a range of jurisdictional limitations. The protophysician had an important advisory role, and enjoyed a prestigious place at the top of the kingdom’s medical hierarchy, but his actual power was limited. The Protemedico had only a small role to play in the public health of the kingdom.

In chapter three we turn to the practitioners themselves, their training and education, their practice and the demand for their services. The role of each, in this rigid corporate structure of medical colleges and guilds, is examined in turn. Each type of practitioner had his recognised place in the hierarchy of the medical order. This extended to those who had no corporate representation, but who none the less had a recognised place: the midwives and the itinerants (the latter variously known as charlatans, mountebanks and empirics). While these boundaries were important to both the medical and ecclesiastical elites, the sick were less fussy. As a result, practitioners often transgressed these boundaries, in a contradiction typical of early modern society.

A particular paradox is that posed by the charlatan. He was at once reviled and recognised by the medical elites. To understand why this was so, and why charlatans were so popular with the public, chapter four examines one charlatan and his remedy: the self-styled ‘Orvietan’, Girolamo Ferrari, and his anti-poison electuary known as orvietan. We are able to reveal (for the very first time!) the contents of this drug, exploring why a medical ‘secret’ should capture the imagination of an entire nation, that nation being France. The chapter follows this Neapolitan in his meanderings through the Italian states and France, looking at the role played by the fear of poison, the transformation of snake-charmers into charlatans, medical secrets and recipe collections, teriac and the commedia dell’arte along the way. Far from being on the fringes of medicine, charlatans thrived at the intersection of the book’s popular, religious and medical spheres.

Existing at another intersection – this time that of the ecclesiastical and medical

Portions of this book have previously appeared in print and I would like to thank the following journals and publishers for allowing me to incorporate the material here: Dynamis (for parts of chapter two, originally published in Italian), Obchki (parts of chapter three), Routledge (parts of chapters five and six) and Past and Present (chapter seven).

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D.G.

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The twelve provinces of the kingdom of Naples
In June 1704, in the town of Oria, Antonia Jurlaro's daughter Domenica became 'seriously ill' with severe pains in her genitalia, accompanied by fever. Antonia fetched the town's community physician, who examined and treated the girl, but without any improvement in her condition. She was also bled three times by a surgeon, Simone Papatodero. Several days later Antonia was washing clothes at one of the town wells, despairing of her daughter's health. A woman named Onofria Bufalo overheard and said it was like an illness she had suffered for a whole year, adding that she might be able to get her the same remedy she had taken. Such was Antonia's anxiety that, she recounted, 'having heard this it seemed to take a thousand years to finish washing the clothes'. She immediately went to Onofria's house and beseeched her to give her the remedy. At this point her account takes an unexpected twist. Onofria, with a local reputation as a healer or 'wise woman', went to examine Domenica. She identified it as the same affliction and said she would go to Papatodero for the remedy, though he did not give it to everyone. She warned Antonia not to tell anyone about it.

The next morning she told Onofria that she had been unable to find Papatodero and so would have to go to the nearby town of Francavilla for the remedy. She asked for seven carlini and five grana in payment. This was a substantial sum: what a peasant labourer might receive for three or four days' work. Later, Onofria gave Domenica some of the remedy with honey, and prepared an enema of rue and sage which she administered — acting like a physician, surgeon and apothecary combined. Domenica slept the whole night through and seemed better the next day. But at this point some kind of disagreement ensued between Antonia and Onofria. Onofria shouted that Antonia and her daughter should be grateful for what she had done. Unfortunately Domenica's condition began to worsen. Onofria said she required more medicine which Antonia said she could not afford. Onofria offered to take something as a pledge if Antonia could not scrape the money together. But friends of Antonia's were becoming suspicious and advised her to stay away from the 'vile Onofria' and place her daughter's health in God's hands. Domenica's
condition continued to get worse. Such was the stinging pain in her genitals that it was 'as if there were a sea urchin there'.

Mother and daughter became convinced that Onofria had put a spell on Domenica (wise women were reputed to know how to harm as well as heal), especially in view of the fact that Domenica had had a run-in with Onofria the previous May. They were both part of a group of women out gleaning barley when Onofria had the idea of hiding one of the sacks. The other women agreed and did so, despite Domenica's opposition. When the estate factor found the hidden bag, the women blamed Domenica. Later, Domenica recalled Onofria's words to her: 'I'll make you sorry for this and I'll be damned if I won't put a spell on you that will have you chewing your fingernails.' Antonia and Domenica decided to go and see their parish priest to 'heal the spell'. He gave Domenica a blessing and advised her to denounce Onofria to the bishop for 'superstitious acts'. Papatodos also suggested the same course of action, 'since we are the doctors and not her'.

The resulting deposition before the episcopal court is the only reason the illness episode has come down to us. Yet it introduces many of the aspects of medical pluralism that I wish to explore in this book, outlining as it does Antonia's strategies in searching for a cure for her daughter's illness, the causation of which she diagnosed first as natural and then as supernatural.

When confronted with the inevitable reality of disease, how did the people of early modern Italy react? Of the different forms of healing available, what factors determined which ones they turned to? In this therapeutic calculus, availability was certainly one such factor, but we must also consider others as diverse as the cost of the healer's services and treatment, their reputation, their suitability to the disease and its underlying causation, as well as the past experience of the sick themselves, their family and friends. This can be approached in different ways. In studies of England, the 'medical market-place' model has tended to dominate since it was first used by Harold Cook. It is certainly useful as a way of accounting for the range of services available, especially in the relatively unregulated English situation. Then again, it too closely resembles the health-care developments of the 1980s to be uncritically applied to the past. Laurence Brockliss and Colin Jones have chosen to focus on a 'new medical history' on university medical learning and its influences. They write of a 'medical community', consisting of trained practitioners, and a 'medical penumbra', including charlatans and women. The book successfully explores nothing less than the entire 'medical world' of early modern France. The model they use is based around relations of power. Popular forms of healing are considered to be entirely dependent on learned ones or impossible to ascertain because of the lack of sources. Matthew Ramsey, exploring a later period of French history, manages to find a place for folk healers in his model, which is admittedly more economic in structure. He divides practitioners into folk healers (part of a traditional economy), physicians (dominated by corporatism) and empirics (part of the market economy). Ramsey's model has the advantage of implying 'a set of social as well as economic relationships': the folk healer being part of popular culture, the physician of urban-bourgeois values and the charlatan as the outsider, trading on his exoticism. But it does not take account of religious forms of healing or the different categories of disease causation of which the sick made use. The model I propose for the chapters that follow is one of three concentric and permeable rings, labelled 'medical', 'ecclesiastical' and 'popular'. The rings refer not only to the types of healers and sources of healing, but to aetiological categories. It allows us to give due attention, where possible, to the attitudes and actions of both healers and the sick. The model is admittedly anthropological; but it does allow for historical change. Indeed, the circles are continually shifting in relation to one another, as are the places of individual healers and sources of healing. Certain kinds of charlatans, for example, move from being quasi-sacerdotal snake-charmers to secular entrepreneurs selling famed patent remedies.

Medical pluralism model: healers and disease categories

In order to explore the implications of this model, the availability of healers is perhaps the logical place to start. It is certainly the most straightforward area to explore, dealing as it does with the supply side of the equation. So, in this chapter, I shall construct a therapeutic landscape of the kingdom of Naples. This is more than just counting the number of physicians and surgeons and calculating their relative densities, as a way of determining medical provision or, as it has been called, medicalisation. To take account of the plurality of therapeutic resources, I shall consider, as much as the data allows, all forms of healing. Thus in the medical sphere this will include apothecaries, midwives and itinerants; in the ecclesiastical sphere it will consider priests, exorcists and healing shrines; and in the folk-medical sphere it will take into account the presence of cunning folk. This will enable us to see how the spheres overlapped in concrete situations.

Views of the kingdom

Nothing in Antonia's account of her daughter's illness and her response to it is typ-
ically southern Italian. Similar illness episodes could doubtless be traced throughout early modern Europe. The kingdom’s inhabitants suffered from the same range of diseases as the rest of Europe. Hunger and famine were permanent, ‘structural’ threats, as were recurrent epidemics of plague and ‘fever’ (typhus, cholera, malaria). Even in the second half of the eighteenth century, when plague was but a horrific memory, life expectancy in the kingdom was only thirty-two years — low, but little different from other European rates. We are used to hearing the southern half of the peninsula referred to as the ‘Mezzogiorno’; but the term is not generally used to refer to a specific geographic and social unit, worthy of further study. Rather it is used as the negative incarnation of something posing an obscure problem, like some shameful social disease. The stereotypes of a picturesque peasant folklore and Mafia become the ‘other’, or are fitted into improvised journalistic categories such as ‘Mediterranean’. This shorthand view of a backward South offers a dangerous enough distortion when interpreting present-day realities; it is even more false when regressive applied to previous centuries. Economic underdevelopment and exploitation were certainly features of the kingdom of Naples during the ‘decadence’ of Spanish rule, especially in comparison with the apparent liberty and merchant capitalism enjoyed by the Florence and Venice generally favoured by Anglo-American historiography. But these caricatures cannot be allowed to shape our exploration of other aspects of the kingdom, where it shares in the great themes of early modern European history as a whole. For this reason a history of medicine and healing within the kingdom, and in particular the characteristics of medical pluralism, is not meant to highlight something peculiar to the kingdom, but reveal its typicality within early modern Europe.

In order to explore therapeutic provision as a resource, and how this resource was used, a few words about population patterns within the kingdom of Naples are necessary. The kingdom, primarily agricultural, was dominated by its capital, Cervantes, who spent some time in Italy, has one of his characters refer to Naples as ‘the richest and most delightful city in all the world’. With a population ranging around four hundred thousand, it was one of Europe’s largest cities, and one in ten of the kingdom’s inhabitants resided there. This number was kept up by the constant influx of people from the kingdom’s twelve provinces. It helps to explain the growth of the city in the late sixteenth and early seventeenth centuries. It also enabled Naples to recover, albeit slowly, from the catastrophic plague epidemic of 1656. Some estimates put the losses at half the city’s population, and those for the kingdom overall at twenty per cent, some nine hundred thousand people.

Throughout, Naples remained the focus of political, economic, religious and cultural life. It was the place where most of the agricultural production ended up and the site of aristocratic consumption and display. People came in search of work, most settling in the crowded southern part of the city, which included the port and main market. During times of dearth many more came because of the city’s food provisioning. Its grain dealers had first call on all the kingdom’s grain and the city authorities at the Tribunal of San Lorenzo set the price of bread. Of people settling in the city, just under one-third came from the surrounding towns and the province of Terra di Lavoro, itself very densely populated. Numbers tended to diminish the further one got from the capital, especially in areas offering viable alternatives. The province of Terra d’Otranto, with the lively city of Lecce as its capital, was thus the source of only 1.4 per cent of immigrants. As an important Spanish dominion, Naples attracted large numbers of immigrants from Spain (5.7 per cent) and Sicily, its sister dominion (5.5 per cent). However, all this growth went uncontrolled and no measures were taken to respond to it. Eventually what had been considered an indication of the city’s grandeur and pre-eminence came to be regarded as a sign of the kingdom’s weakness. In a complaint that echoed around rapidly expanding capital cities, like London, Naples’ very size was seen to suck the life-blood of the kingdom. Its unabated growth threatened the kingdom’s survival. Gaetano Filangieri adopted a bodily metaphor: ‘if the head grows too much, if all the blood rushes there and comes to a stop, the body becomes apoplectic and the entire machine falls apart and expires’. Indeed, after Naples, no town managed more than twenty thousand people, even though places like Lecce and L’Aquila did serve important regional functions. It was only with the French reforms at the beginning of the nineteenth century that the kingdom was decentralised to a degree and certain powers devolved to the provincial capitals. These reforms did bring a relative decline in immigration.

The kingdom was characterised by small and medium-sized towns: close to one-quarter of the population lived in towns of under two thousand inhabitants and one-half in towns with populations of between two thousand and seven thousand. What were conditions like? According to the statistical investigation of the kingdom ordered by Joachim Murat in 1811, town streets were often very narrow and unpaved, tortuous, irregular, reduced to mire by water already used for domestic purposes, full of mud, stones, and into which pigs, stables and sheep pens stick out, with all their filth. The foulest and most stinking butcher’s shops and slaughter-houses are found right in the middle of the street. Immense dung-heaps surround the settled areas, where they throw not just the sweepings and excrement from the stables, pigsties and houses, but the corpses of unburied animals as well.

It was a blessing in disguise that these towns tended to be rather distant from one another, separated by difficult terrain. The kingdom was shaped by the Apennines, with three-quarters of the population living in mountainous and hilly areas. Communication was very difficult, especially in those areas outside modern-day Campania and Apulia. Particularly in the case of the two Calabrian provinces, the Abruzzi and Basilicata, the inhabitants were dispersed in a myriad of small mountain towns, cut off from one another, with only slightly larger regional centres. In the mountains of Molise, for example, ‘people live in the countryside far from the towns and the assistance of physicians. If you add to this the generally poor nature of the dwellings, the very bad nutrition and personal hygiene, you will understand the great influence poverty has on disease and the slow and difficult recovery.’ Only a fifth of the kingdom’s population lived along the coast, and most of this was in the capital.
Natural illness and medical practitioners

Antonia's first response to her daughter's suffering was to diagnose it as falling into that category of causation known as 'natural'. This meant a disease caused by natural factors, such as an imbalance in the four bodily humours (bile, blood, phlegm and black bile). The humours were said to be 'peculiar' when balance was lost, corrupting the whole, from the Latin pecare, to sin. Conversely, health was linked to holiness (words that are themselves semantically related), wellbeing to salvation, both salus in Latin. Lifestyle also played a role: factors like diet, evacuations, exercise, air, sleep and strong emotions. And this was all to be managed according to one's own 'temperament' or constitution. At the beginning of our period, towards the end of the sixteenth century, this university medical knowledge concerning the body and disease was still based almost entirely on Galen. By the end of the period under study, the beginning of the nineteenth century, Galenic medicine had declined, replaced by a range of chemical and mechanical explanations of the body. This was accompanied by an increased stress on 'environmental' or hygiene factors in disease. Over the course of the two centuries the use of chemical remedies became increasingly widespread. However, medical practice and its efficacy in the face of disease - judged from a modern biomedical standpoint - changed very little.

The diffusion of medical knowledge throughout society is something that social historians of medicine have only begun to explore. With everyone responsible for their own health, a certain amount of medical knowledge was regarded as indispensable. This much is obvious. Just what forms this knowledge took is another matter. The wide range and success of popularising medical books, health manuals and recipe collections, both printed and hand-written, suggests a generalised desire to learn about medicine, or at least have access to self-help remedies. Yet, as we shall see in chapter four, the material covered in these collections varied greatly, from the medieval Salernitan tradition through to magical remedies. And we still know very little about how these eclectic texts were used by their owners. The sick not only diagnosed themselves, but expressed their diagnoses to the medical practitioners they called in, who proceeded accordingly. A certain shared language about the body and disease was thus necessary. To a certain extent this revolved around the humoral imbalance theory of pathology and the role of a person's individual temperament. Galen found its way into all strata of society, where the precepts of the School of Salerno on regimen and the preservation of health were transformed into well-known and oft-repeated proverbs. This is summed up in one proverb from an eighteenth-century Gallipoli collection: 'La deiesta sana li lazari' (roughly, 'diet heals even the lazars/lepers/layabouts'). Hospital medicine was another means of channelling elite medical practice throughout society. But to what extent changes in medical theories at university level made their way out into society at large is still a largely unexplored area.

As in Antonia's case, then, it was usual for the sick to make their own diagnoses and, if they were unable to treat the disease themselves with domestic remedies, fetch a healer, according to the nature of the disease. Illness narratives reveal that such choices were part of the fabric of everyday life. As Mary Lindemann has observed: 'People sought healers where they went to market, solicited advice from those who gave it in other instances, and blended health and illness into the familiar pulse of life.' Most treatment was carried out in the home. Antonia's initial choice of healer was made easier by the fact that the town authorities had hired a community physician, responsible for treating the poor free of charge. The stereotypical view of the presence of university medicine in early modern Europe is that of a high concentration in the cities and a medical desert in the countryside. It persists despite numerous studies to the contrary. Carlo Cipolla has demonstrated that in the Tuscan countryside in the 1630s there was a ratio of around one physician and just over one surgeon to every ten thousand people. Moreover, some smaller communities actually had higher physician-to-population ratios than the larger towns, due to the small size of their population. Finally, he also noted that that there were almost as many university-trained physicians as there were surgeons, whereas it is often assumed that the latter were much more prevalent because of their apprenticeship-based learning of practical skills.

Just how many physicians were there outside the two universities of Naples and Salerno? Not many, according to one seventeenth-century study on barbering. In the words of its author, Cintio D'Amato, 'the diligent barber is virtuously the sole means of treatment, since, in the small walled places and in the villages, where one hardly finds learned physicians, he, with the turn that his art demands, takes care of all problems and treats all kinds of ailments that occur in indisposed bodies.' Cipolla quotes this passage in support of the significantly lower provision in the 'much poorer and less developed' South, in many areas of which 'physicians were rarely encountered'. Yet D'Amato's words may be interpreted as arguing the importance of the 'diligent' barber's role and his acquired knowledge of the body, rather than a reliable indication of medical provision. Of course, a large number of physicians would have been concentrated in the capital, as was true in all the Italian states at this time. But many more would have returned to their native regions, in search of patronage or some sort of engagement. The reasons for this will be explored in chapter three. Neapolitan archives have suffered more than their fair share of damage over the centuries, most notably in the course of the Second World War. So the picture that follows is complete only towards the end of the period covered by this book.

To begin with, an idea can be had by looking at the numbers of physicians who were granted doctorates each year by the Naples College of Doctors. During the first half of the seventeenth century an average of eighteen doctorates were granted each year, a figure that does not include the School of Salerno. By the 1780s, according to Giuseppe Maria Galanti, the number of medical doctorates granted at Naples each year had increased more than threefold, to around seventy, plus an additional fifty issued at Salerno. Based on this, he calculated that there were some 2,400 physicians and physician-surgeons in the kingdom. In fact, the number of Salerno graduates was far higher than Galanti estimated. The annual average went from seventy-seven in 1717 to 152 in 1778, though most of the increase took place in the
final decade of the century. If this increase is taken into account, Galanti was not far off. When the Protomedicato assumed authority over graduate physicians as part of the Napoleonic reforms of Joachim Murat, in 1809–10, they were counted at 3,178 (the two Calabrian provinces are missing). By this time the kingdom's population was just under five million, almost double its seventeenth-century average. It appears therefore that there was a slight increase in the overall density of physicians throughout the kingdom, which probably occurred in the latter half of the eighteenth century. However, there is little to suggest that generalised patterns of medical density would have changed much over the early modern period. For, although the content of the medical curriculum had shifted considerably over the years, the need to find sources of patronage or local clientele had not. Some figures change hardly at all, if compared to anecdotal evidence for earlier periods. Thus Francavilla (Terra d'Otranto) had twelve physicians in 1686; in 1809 it had thirteen. Another continuing feature was the municipal hiring of community physicians and surgeons. Unfortunately it is impossible to estimate what proportion of practitioners they represented and to what extent this may have changed over the period. In any case, we can follow the protophysician — or rather the tax farmer who had successfully bid for the right to collect the dues that each medical practitioner had to pay — as he and his deputes toured the kingdom collecting money, conducting inspections and checking diplomas. The 1786 Protomedicato list (which includes midwives, barber-surgeons and apothecaries) and the 1809–10 list (which also has graduate physicians and surgeons) thus provide the best opportunity we have for mapping the medical landscape. The following discussion is based primarily on the later list, because of its greater precision and thoroughness; but the numbers contained in the two lists, where they can be compared, do not vary widely, even accounting for an ever-increasing population. The source has limitations. It was a tool for collecting revenue: its compilers were not concerned with levels of practice. Thus factors such as invalidity or old age are only rarely mentioned. Nor can it tell us anything about those who sought to evade the annual licence or 'inspection' fee, and whose numbers might be quite considerable, especially amongst itinerant practitioners. But the findings are worth discussing here nevertheless.

In 1809–10 more than ten thousand people practised the 'healing arts', as the list put it, including physicians, surgeons, physician-surgeons, barbers, apothecaries, grocers, herbalists and midwives. The physicians alone numbered just over three thousand, as has been noted, meaning a kingdom-wide ratio of 6.2 physicians for every ten thousand people. This high figure is no longer surprising; what is unexpected is the relatively low density in the capital compared to the rest of the kingdom. While Naples had a respectable 4 physicians for every ten thousand people, medium and small-sized towns could expect more than twice that amount. The town where this chapter began, Oria, with just over five thousand inhabitants, had five physicians. A town of one thousand people could expect to have at least one physician. But it did not end there. This same random town of one thousand people could also expect to have one surgeon or, more likely, barber (also known as bloodletters or phlebotomists), one apothecary and one midwife. As this sug-

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gests, the numbers of physicians, surgeons and barbers, apothecaries and midwives are roughly equal to one another, each of the four 'arts' representing, more or less, a quarter of the total. This finding contrasts notably with France at the same time, where lower-level surgeons predominated over physicians in all areas, especially rural ones, by anything from three-to-one to ten-to-one. In provincial England, too, physicians made up but one-tenth of practitioners, which includes surgeons, apothecaries and druggists.29

Another interesting pattern, in this case reflecting Jean-Pierre Goubert's findings for France, is the prevalence of the highest ratios of the kingdom of Naples in the smaller towns. All the peaks on the diagram below are provincial ratios for towns under two thousand people, and the troughs for towns between seven thousand and twenty thousand people. The ratios are fairly consistent from province to province. They do tend to be higher, however, in the wealthier agricultural provinces of Terra di Lavoro and Terra d'Otranto, with their higher population densities overall and better communications. The mountainous areas are the least well served by medical practitioners, though the difference is a relative one.

What can be said about the demand for medical services? The provision of community physicians was meant to meet the needs of a town's poor, at least according to the official rhetoric. But those who stood to benefit most were probably those of the same class as these practitioners, both economically and culturally. The very poor would not have been able to afford the remedies prescribed by the physician. Certainly, the physician's complaint that 'the people reduced to abject poverty . . . either call the practitioner at the very last moment of life or never' was a very common, almost timeless one.30 There is doubtless some degree of exaggeration in this sort of comment, as they (like this one) are often made in time of epidemic. But in such cases the sick may have regarded intervention as futile, even fatal, thinking it best to let the disease run its course. It is possible that, outside of epidemics, consultation with a physician may have been more common than the records suggest. After all, Antonia Jurlaro, with whom this chapter began, had recourse to a community physician for her daughter's illness, despite being quite poor. Where more than anecdotal evidence is available the tendency was for most people to make use of the more practical services of the barber, apothecary and midwife. People also bought medicines from itinerant practitioners, variously known as charlatans, mountebanks or empirics. As a group they are under-represented in the official records, due in part to their travelling nature. While the physician's regular clientele might have consisted only of the town's notables and their families, the others' reached out to the entire community. Here we enter into the realm of public attitudes and shared mentalities, as well as the important consideration of cost. These, like accessibility, all had a part to play in determining contact with medical practitioners.

A further aspect of therapeutic provision in early modern Europe consisted of hospitals. It must be said, however, that these institutions were as much concerned with the health of the soul as with that of the body. They were as much concerned, and in many cases more so, with taking in the poor, wayfarers and pilgrims as they were with the sick. Italian hospitals were more akin to monasteries than the modern institution, with large numbers of resident clergy and with a chapel at their heart. Nevertheless they did employ physicians and surgeons and often had an apothecary's shop as part of the hospital structure. As such, they represent part of the overlap between learned and ecclesiastical healing.

As befitted its size, Naples had numerous such institutions. During the seventeenth century it had eleven hospitals, plus ten conservatories for women, eleven for girls, five for boys and one for the aged. In all, they were said to assist some six thousand people every year.31 One of these was the Casa Santa dell'Annunziata, Europe's richest and largest hospital, a source of amazement to travellers from northern Europe. However, hospitals were sparse in the rest of kingdom, though this is consistent with the very much smaller sizes of towns. Only towns like Lecce and L'Aquila had populations large and variegated enough to endow and support more than a single institution. In the two Calabrias, for example, only Cosenza, Castrovillari, Catanzaro, Tropea and Crotone had hospitals with more than a handful of beds.32 And by the end of the eighteenth century they were all in a perilous state, surviving on ever-decreasing legacies. There was not much change in hospital numbers during the early modern period, although the larger institutions did witness a shift in the latter half of the eighteenth century towards a more medical emphasis. Such services as existed were still intended mainly for the poor, and they made them part of their strategies for dealing with disease and hard times. From the point of view of the sick, hospitals were a resource, which the sick used much as they would any other form of healing. They diagnosed the need themselves, often admitting and discharging themselves as they saw fit. The remedies learned there could also find their way into eclectic popular healing traditions.

Preternatural illness and ecclesiastical remedies

As 'mixed' institutions, from a modern perspective at least, hospitals are a useful way of introducing ecclesiastical attitudes to illness and forms of healing. The role of the Catholic Church increased substantially during the Counter-Reformation. In 1566, three years after the close of the Council of Trent, a papal bull informed physicians that thenceforth they would have to ensure that the sick had made confession before they began treatment. It was a strict application of long-standing Catholic tradition, that care of the soul had to accompany that of the body. Some physicians warmly embraced the new order, like the early writer on medical ethics Battista Codronchi. Confession, he argued, not only alleviated the fear of mortal sin, but could be considered a 'physical medicament' because of the link between body and soul.33 The purging of sins would cleanse the body, preparing it for the application of physic — analogous to the purgatives and vomitories preceding treatment and considered to make it all the more effective. However, the impact of such advice on private practice may have been minimal. Physicians may have found it difficult to regard confession as their responsibility. It was said of the physician-surgeon Marco Aurelio Severino in Naples that 'when he goes to visit some sick person, even if they are seriously ill, I have never heard him say that they should
make confession, as physicians are obliged to do. Whether or not the accusation was true, it was the kind of thing that was plausible enough to be used to incriminate someone. A practitioner’s reluctance to insist on confession seems to apply even to hospitals—where ‘dual provision’ was written into hospital statutes. On the plus side as far as physicians were concerned, if they were expected to be defenders of religious orthodoxy, the Church repaid them by recognising their heightened legitimacy and status. It made their expert opinion decisive in various spiritual fields. They were consulted in cases of witchcraft, to determine whether demonic spells were involved, and in the almost infinite number of healing miracles, to evaluate their authenticity.

With regard to illness itself, in addition to natural causation there was the preternatural. God and the saints could send disease as a punishment for sin, a reminder that death was fast approaching and opportunity for repentance limited. If disease brought suffering, it also provided an opportunity to turn to a more pious life. The confrères of the religious brotherhood of the Santissima Annunziata in Lecce, when visiting and serving in the local hospitals, were encouraged to console the sick with the following message: ‘They will speak of the fruits which are received from sickness and tribulations, which can serve as a beacon to separate the wheat from the chaff, or the dust from our clothes, when they are patiently borne.’ An early history of the activities of the Society of Jesus in the kingdom revealed God’s use of disease to punish and bring individuals to repentance, in this case a victim of the ‘French disease’ (the name given to syphilis and similar illnesses):

There was a person oppressed by a rash suffering for a trying disgrace, when it is only proper to be ashamed both of the shamelessness in committing it and the repugnance in making the sin public. He also suffered from the falling sickness. I know not whether [this was] a disease of nature or punishment for his sin, for which he was doing penance during his life rather than after death. He overcame this shame during the course of a mission and, having vomited all the poison of his soul at the confessors’s feet, seemed thenceforth to be healed of every bodily ill as well. Whether it was the work of nature or of grace, he was never more wasted by his usual epilepsy, at least for the next three years about which we have knowledge. This gave occasion fully to believe that, with the favour of his bodily health, the Lord God wanted to establish more completely in him the cure of his spiritual health.

Just as God could punish and then heal individuals, he could deal with entire communities. God’s wrath was frequently judged the cause of plague epidemics, as it was of any natural calamity. For the Jesuit Antonio Possevino, ‘the more principal causes of plague’ were different types of sin. Of much lesser importance was secondary causation— for which God was also responsible— such as ‘from the bad quality of the humours, from corruption of the air or from contagion’. And the remedies? ‘On hearing of the approach of this visitation sent by the hand of God [Possevino advanced], you should at once put your mind on his Divine Majesty, retire to some place apart, and place yourself completely and with great hope in His compassionate hands.’ He urged people to pray, perform acts of charity, make

confession, take communion, fast, hear masses and sermons, and perform the ‘spiritual exercises’ (he was a Jesuit, after all). Doubious financial affairs should be ended and any licentious books, playing-cards and dice destroyed. Possevino proposed that what he called primary remedies, like processions with saints’ relics, could have an effect on both the primary causes of plague, by placating God’s wrath, and the secondary causes, by purifying corrupt air.

But Possevino’s view of the unique role of the divine was an extreme one. Even his fellow-Jesuits shared the prevailing belief in both primary causes (divine providence) and a range of secondary or natural ones. It followed, too, that remedies should take two forms, religious and secular, both of which were generally believed necessary to deal with plague. For instance, the 1562 directives of Jerónimo Nadal on how Jesuit colleges should respond to an epidemic began by recommending prayers and masses. But they proceeded to practical advice on the fumigation of rooms, the buying of medicines, the consultation of physicians and the segregation of the sick, as well as the apparently uncharitable recourse to flight in order to avoid infection.

Physicians could concentrate their efforts on natural secondary causes, while allowing that these ultimately derived from divine primary ones. Contemporaries, in fact, performed an ongoing balancing act between religious and secular options. The Naples plague of 1656 was one such occasion. At its height hundreds of people were dying every day, ‘causing a fear so great in the hearts of the citizens that, naturally inclined towards piety, they turned to God’, in the words of the actor, writer and publisher Domenico Parrino, who chronicled the events. ‘In processions of men, women and dishevelled young girls they came together by the thousands to implore divine mercy in various of the city’s churches... Many miraculous images were taken out, amongst which the most holy crucifix of Santa Maria a Piazza.’ Before her death in 1618, the nun Orsola Benincasa had prophesied a great calamity for the city because of God’s mounting ire, which only the construction of a hermitage could counter. The viceroy himself was the first to go to the site, digging twelve baskets of earth. The contradictions, or at least ambiguities, inherent in distinguishing between natural and supernatural causation are revealed in Parrino’s interpretation of the effects of this very public piety. The short-term effects were harmful. As a result of the ‘just judgements of divine providence they miscarried into an increase of the disease which, with the union and coming together of so many people, continued to spread and gradually communicate itself from quarter to quarter’. But the longer-term effects were positive, prompting the Virgin’s intervention to end the plague. Parrino had no doubts about this, since the plague began to subside in mid-August, on the vigil of the Assumption. Others were not so sure. The Jesuits gave the credit to their own St Francis Xavier, the Theatines to St Gaetano da Thiene and the Cistercians to St Bruno.

Antonia Jurlaro made use of two ecclesiastical remedies in combating her daughter’s illness, having exhausted the other forms available: a priest’s benediction and recourse to the episcopal court. The first was part of a whole battery of sacramental rites administered by the clergy, a spiritual pharmacopoeia which ranged from
making the sign of the cross and reading a passage from the Bible over the sufferer to exorcism designed to counter the powers of the devil in causing illness. Denouncing the wise woman Onofria Bufalo before the episcopal court was another bargaining tool in her war of words with the suspected culprit. This avenue was opened up by the Counter-Refomation Church's ongoing campaign against 'magic and superstition': a category of rituals believed to gain their efficacy - and their very efficacy was rarely questioned - through the intervention of the devil. If a spell caused illness, it was the devil which gave it its power and God who allowed it to happen as a way of testing the sinner. And only the Church's remedies, the ecclesiastical authorities argued, could safely combat it.

Every ecclesiast in the kingdom was a possible healer because of the remedies at his disposal. And their total number easily reached into the tens of thousands. Naples was, of course, the focus of the kingdom's religious life. At the end of the seventeenth century there were 140 monasteries and convents, housing some five thousand male religious and six thousand nuns. The Franciscans alone had twenty-five monasteries in the city, the Dominicans seventeen, whilst newer arrivals like the Jesuits and the Theatines had seven religious houses each. And there was certainly no lack of parish clergy with the city's thirty-nine parishes at the end of the 1600s. The kingdom was divided into 148 dioceses, twenty-one of which were archbishoprics and 127 bishoprics.

Clerics responsible for the conducting of parish missions seem to have been a class apart, with sacred powers that far exceeded the average parish priest. This might have been partly due to the climate of tension and anxiety created during the course of a mission, with its emphasis on the pains of hell and the temptations of the devil. In the minds of the laity, the missionaries must have constituted the only way out. The Jesuits, as one such order responsible for missions, did nothing to discourage a widespread belief in the sacred presence they represented. Indeed, they were only too happy to record it for posterity in their mission accounts. Their parish missions were accompanied by good omens, visions and miracles. Lay people were recorded cutting off pieces of the Jesuits' habits which they kept 'not just out of reverence for the merits of others, but [as] a remedy for their own illnesses.'

Miracle cures that occurred were the result of devotions introduced and were not carried out by the Jesuits directly. Thus, during a 1657 mission to the town of Casarano, a man was cured of his sores as he knelted down to kiss those of Christ during a procession. In another an inhabitant of Lecce was cured of articular pains which the local physicians had been unable to ease. When the sufferer approached the altar of St Francis Xavier the devil was forced to reveal a magical charm in the man's stomach, which he eventually vomited up, and was cured. Such episodes reinforced the knowledge that charms could cause disease and that only the Church had the power to counteract them. Ecclesiastical remedies had powers that the physicians lacked. They could overturn the natural order of things, go against nature, which was not an avenue open to physicians. The Jesuits proudly recorded the case of a convent that, during a mission, went without the physician's regular visit, secure that the Jesuits' presence provided some sort of divinely sanctioned protection.

In 1734 two missioners from the Jesuit College in Lecce carried out thirty missions in the towns of Terra d'Otranto, the central feature of which was an image of St Francis Xavier borne aloft by one of the missioners. The Jesuits missed no opportunity to encourage devotion to their missionary saint: in some areas water blessed in the saint's name was proving to be a popular and effective remedy. In this case they recorded a series of healing miracles that occurred. What is interesting is that they went to the trouble of having them all notarised, sure of their place in history. The missioners thus introduced a source of healing that was not there before. Because of the sacramentals at their disposal ecclesiastics often branched out into other more secular forms of healing. Physic and surgery were off limits to them, as far as Church teaching was concerned, because of contact with human blood, but they were permitted to run apothecary's shops inside monasteries. In Naples, in addition to the city's eighty-seven apothecaries, there were eighteen monasteries dispensing drugs. Monastic apothecary's shops were partly under the control of the protophysician (a relatively recent 'conquest' on the part of the secular authorities), partly under the control of the respective religious orders and partly under the control of the bishop. However, with a multiplicity of overlapping jurisdictions and with so many ecclesiastics present in the kingdom, from fully ordained clerics to tertiary friars, it was impossible to keep track of them all. One third-order Franciscan from Calafata (Terra di Bari), Fra Carlo Geremia, told the Protomedicato authorities in Bologna that he was there to confer with the cardinal legate to try and get an audience with the pope to discuss some Church business. In the meantime he was going around treating 'cancers, fistulas, scrofulas, nel di fornica' [syphilitic ulcers], and other ailments', based on his thirty years' experience all over Italy. Previously he had been in Brescia, having been awarded a licence there by the medical authorities. He affirmed that he only treated the sick externally, and not internally, according to what was allowed any lower-level surgeon. He remarked: 'I have many secrets for incurable diseases with me, in particular a very marvellous one for consumptives [called] Polignano Powder', which he taught to a local apothecary. The Bolognese Protomedicato allowed him to continue treating people, as long as he did nothing illegal or against their edicts, his habit offering him some degree of protection. What the Church authorities made of his activities is impossible to say since, as a tertiary friar, he maintained certain liberties.

Otherwise the Church was very strict when it came to prosecuting clerics involved in healing, especially if magic was involved. Many such cases appeared before the kingdom's episcopal tribunals, since there was no separate Inquisition as such. Laymen accused of performing improvised exorcisms were also examined by these courts, for exorcists could only be undertaken by trained and licensed clergy. Given the licensing involved it should be possible to determine the number of exorcists in the kingdom and calculate ratios per head of population, as we have done for the medical practitioners. Also, the licences themselves, if they were ever more than verbal permissions, have not survived, and so the number of exorcists must remain unknown. Occasionally, several exorcists are named in the course of eccle-
siastical trials, which can give us some idea of provision. In 1675 a desperate Neapolitan man named three alternative exorcists living in his immediate vicinity, after accusing a Dominican exorcist of an excess of zeal in performing eight exorcisms on his five-year-old son. But this is no more than a sample. What we do know is that it was increasingly becoming a clerical sub-discipline 'restricted to a few select priests and very rare exorcists, of whom many qualities are required.' Due to the fact that it was a clerical specialization, and given the occasional references in ecclesiastical trials to exorcists having to be called in from larger neighbouring towns, the supply never seems to have met the demand. Group exorcisms became commonplace. And from the late sixteenth century the demand was ever increasing, as the Church pressed home its message that only its operations could combat the devil, whether his involvement was through a spell cast by a wise woman or a full-fledged possession. One authority on exorcisms, the friar Girolamo Menghi, concluded that most cases were caused by spells, on the basis of the maleficent charms that came to light during the exorcisms. Menghi's identification with possession and magical spells and his close to forty years' experience 'healing' the possessed led him to propose a kind of 'community exorcist' in each diocese, salaried by the local church.

Especially during the seventeenth century, when fear of the devil was at its peak, the exorcist's conjurations may have been as well known as the physician's purgatives. And with exorcists commonly making use of strong medicines to purge the victim's body of the possession-causing charm, as an accompaniment to their rites, the two worlds were quite close together — so close that Menghi warned exorcists not to venture into the physician's realm, by giving oral medicines without a physician's orders.

Instead of the exorcists that they should be, they turn themselves into herbalists, physicians or charlatans. This they do by searching for this or that herb against demons. And they give syrups and medicines, powders, pills and other similar things to the possessed and the bewitched, without the advice of physicians and against the commandments, rules and orders given them in books, presumptuously usurping the role of the physicians. With these things they occasionally chase the very soul out of the bodies along with the [evil] spirits.

It was presumption that allowed these exorcists to act as they did. This was the same accusation made against surgeons, apothecaries and, especially, charlatans who trespassed over professional boundaries by practising physic. That is to say, they made use of oral medicines without knowing how they worked, what amounts were required and whether or not they were appropriate for the sick person's particular constitution and temperament. In addition to the presumption of the charlatan, some exorcists shared with them their itinerant ways. A Sardinian exorcist, resident in Naples at the end of the sixteenth century, admitted performing exorcisms in people's homes on request, going 'around the houses of Naples... wherever I was fetched.' Francesco Salinas recounted how he practised exorcisms on victims of spells, following Menghi's treatises. He would identify the presence of spells by seeing if any [possessed person] had a pain in the neck, stomach, kidneys' and claimed to have 'healed many [spells] by the grace of God.'

While the medical authorities sought to keep separate the various branches of the medical arts, the ecclesiastical courts worked to separate clerical and lay. Lay or improvised exorcists were charged with taking on the status of the trained and licenced ecclesiast, in addition to imitating his specialist knowledge. It was presumption of another sort. In the 1580 case against the Neapolitan fisherman-turned-exorcist Giacomo Marsicano this element of his activities on behalf of the bewitched figured prominently. For instance, where a witness recounted how Marsicano proceeded to identify the number of demons possessing a person's body, ordering that person to lick the ground, an ecclesiastical hand has written 'impertinence' in the margin. Only authorised specialists were entitled to make such assertions.

Theologians stressed that God put the remedies for illness at man's disposal, both natural and supernatural. Devotion to the saints and the expectation of miracles was a fundamental part of Counter-Reformation religiosity, shared by all elements of society. Saints, dead and living, ecclesiastically recognised or unofficially sanctioned, were an unfailing source of miracle cures. Once again, Naples was the focus for the kingdom's saints, as it was for the religious life in general. It attracted those drawn to the religious life just as it was a magnet for the country's aristocracy and the thousands of immigrants who flocked there every year in search of work and food. Of the kingdom's 105 canonised saints born during the years 1540-1750, two-thirds died in Naples, though less than one-quarter were born there. Only the centres of Lecce and L'Aquila were able to withstand this attraction because of the strong religious traditions and institutions of their own.

In addition to those saints officially recognised by the Church authorities through the processes of beatification and canonisation, there was also a category of people which historians have referred to as 'living saints.' As we shall see in chapter six, these were women and men (primarily the former) known and venerated locally for their piety, mystical experiences and wondrous deeds. The ambiguity lies in the fact that canonised saints began this way and eventually achieved official recognition; but many more were never so recognised. Indeed, they were often examined by the ecclesiastical courts under suspicion of 'simulated sanctity,' their powers believed to have come from the devil, risking perdition for both themselves and their followers. Whether their experiences and accomplishments were labelled divine or diabolical depended on the interpretation of the Church authorities. But for the devotees of these living saints what counted more than orthodox behaviour was the ability to work wonders, first and foremost miracle cures. Naples had its fair share, but most large towns could boast of at least one living saint during the early modern period. It would be premature to suggest a statistical profile, as new cases are continually emerging from the local ecclesiastical archives. However, findings so far suggest that there may have been a periodisation of cases against living saints, with a concentration in the first fifty years or so after the Council of Trent. In any case, trials against living saints tell us more about Counter-
Reformation concerns with enforcing orthodoxy than the reality of the phenomenon itself (which continued well beyond the chronological bounds of this book).

The healing powers of saints were available in other forms, such as relics, images and shrines. Saints’ relics tended to be concentrated in towns: in churches, religious institutions and private collections. No local history published during the period was complete without a self-congratulatory list of the relics possessed by the town’s churches. The 1634 work _Lecce sana_, following in the footsteps of similar book about Naples, set out to describe all the city’s religious institutions. The city saw itself as a second Naples, and books like _Lecce sana_, though more painstakingly detailed than propagandistic in tone, helped to bolster this image. Some relics, such as the corpses of local saints, were on display in churches, where they were available to all worshippers. Such was the case of the cadaver of St Irene, one of Lecce’s patron saints and the pride of the city’s Theatine church. Other smaller relics, housed in reliquaries, were carried by the clergy in procession on relevant feast days. One such was a relic of St Vitus, contained in a wooden statue and carried in procession on the saint’s feast day by the confraternity named after him. Some developed specifically healing functions, such as a ‘piece of the altar where St Peter the Celestine celebrated [mass], the powder of which, when drunk by the sick, who are suffering from chills caused by tertian or quartan fever, ordinarily receive health’.

The powder was limited in quantity and the Celestine monks of Santa Croce must have kept a close guard on its use, determining to whom it should be dispensed. But most of the numerous relics were probably too small, mounted with too many other tiny fragments and kept in areas off limits to the laity to attract much in the way of devotion.

Religious images were another matter, especially where they came to form the basis of healing shrines. Saints’ shrines and their relative success in attracting pilgrims were a direct response to popular demand, largely unmediated by the clergy (try as they might). Shrine narratives relate how most images came to be found outside towns, often in open countryside, in woods or a cave, by a peasant or herdsman. This has been seen as an attempt by the average Catholic to provide sources to the sacred over which they had some control, independent of the bishop or the cathedral clergy. By the same token, shrines were never very far from towns, for they needed to be readily accessible. In the kingdom, few peasants lived in open countryside but tended to gather together in the towns, commuting to their outlying fields. There were some exceptions to this general rule, such as the shrine to the Archangel Michael, perched high in the mountains of the Gargano peninsula (Capitanata). Despite its isolated position, or perhaps because of it, the shrine attracted devotees from throughout the kingdom and beyond. The town of Monte Sant’Angelo that surrounded it in fact sprung up long after the shrine had come into being: in this case it was the shrine that gave birth to the town and not vice versa.

The kingdom had a veritable network of shrines. Even at the time, shrines dedicated to the Virgin Mary were presented in such geographical terms, as in Wilhelm Gumppenberg’s _Atlas Marianus_ of 1672. The most detailed description of the phe-
nomenon for the kingdom of Naples was made by the Dominican Serafino Montorio, in his Zodiaco di Maria of 1715.62 Montorio organized his discussion along astrological lines, linking each of the kingdom’s twelve provinces to a sign of the zodiac, of which the Marian images constituted a galaxy of stars (figure 1). While the existence of shrines was widespread, they were by no means of equal status. Prevailing devotional fashions and the shrines’ ability to deliver miracles determined whether they were ‘active’ or not: whether they attracted pilgrims and devotees, and whether they achieved local, regional or even national status. None the less the degree to which their spread reflects the kingdom’s population density is quite striking. Despite their usual location in semi-rural areas, the shrine landscape corresponded to patterns of urban settlement, benefiting from the presence of large towns. The shrines discussed by Montorio were all active and the author was confident that he had reliable and detailed information about their foundation and subsequent development. Of the 120 Marian shrines Montorio discusses, 14 were to be found in Naples, a further 23 in the kingdom’s most populous province, Terra di Lavoro, and so on, down to 3 each in the sparsely populated provinces of Molise and Abruzzo Citeriore and 2 in Basilicata. There are numerous limitations to his list, not least of which is the prevalence of miraculous images situated in Dominican monasteries; but it does give us a broad outline.

Although the original impetus for shrine development was lay and semi-rural, they did depend on initial episcopal approval. But unlike the miracle cures investigated during the course of canonization processes which are the subject of chapter 7, the Church was not concerned here with the miracles themselves. First and foremost the episcopal authorities wanted to ascertain how the money was being raised for the shrine and the related possibilities for fraud, including the publicising of false miracles and the misuse of alms. Episcopal investigations also highlighted the matter of jurisdiction over the shrine and its day-to-day management. Issues such as these may seem of only minor importance, but the sums of money generated by a miracle-working shrine could be enormous. The shrine of Santa Maria dell’Arco, for instance, just outside the gates of Naples, went from having no source of income at all in 1561 to a value of twenty-eight thousand ducats in 1594.63 The early years of Montorio’s own monastery of Santa Maria della Sanità (Our Lady of Health), established to take charge of a shrine of the same name, were more notorious. After the image was unearthed in 1571 and miracle cures followed, archbishop Paolo Burali entrusted the nascent shrine to the Dominican friar Antonino da Camerota. With great entrepreneurial verve he began to publicise the miracles and sell holy souvenirs, including oil from the self-renewing lamp that burned before the image. People and money soon began to flow in from various part of the kingdom and the Dominicans were forced to keep the shrine open day and night. But at the height of its success Fra Antonino was charged with extorting some 6,000 ducats from visitors to the shrine by ‘moving’ them with his rhetoric. When a miracle cure was reported he made sure that everyone knew about it. As one witness testified: ‘When any person brings some votive offering to his church of Santa Maria della Sanità, he takes the ex voto into his own hands in the middle of the church and, shouting amongst the people, says: See this, see this, sisters! Here, here the Virgin works [miracles]! Come here, recommend yourselves here.”64 Fra Antonino’s links with the city’s curia may have afforded him some protection, for two years later he was free. The church was once again attracting large numbers of devotees and was well on its way to becoming one of Naples’ foremost healing shrines.

The miracles themselves were not an important aspect of the trial. But when miracle-working images were housed in private chapels, then the episcopal authorities were more wary. In this way the miracles generated by the image of Santa Maria delle Grazie (Our Lady of Graces), in a shrine belonging to the Pagluca family, were investigated in 1596. Physicians were called in to report on the presumed miracles, which they failed to convalidate. The archbishop’s vicar-general ordered the shrine closed except for religious services and that all ex votos and illuminations be removed from around the image. Nevertheless, when miracles continued to be reported, he set up a commission of Dominican theologians to study the events. It was their conclusion that the conditions necessary to describe the cures as miraculous did not exist. They might have reached similar conclusions about the majority of miracles then being reported in shrines throughout the kingdom, had they been requested to investigate them. In any case, the city’s vicar-general had not counted on the support for the image of Santa Maria delle Grazie by those who most benefited from it: the people of the neighbourhood. Following a rumour that the archbishop wanted to remove the image and close the shrine, about two hundred of them proceeded to the chapel carrying banners and sounding trumpets and drums. At this point the authorities withdrew and, despite the stabling of an episcopal guard by the angry crowd, ended their investigations.65

Images of saints abounded in Catholic cities and any of these could produce miracles when the saint interceded on behalf of a devotee. From the sick person’s point of view, however, miracle cures came at a cost. They were by no means free. The devotee’s request for a cure was usually accompanied by some offer of payment, for example, an ex voto or monetary donation to be left at the shrine. There had to be tangible evidence of the saint’s positive response. This bargaining was not a question of bribing the saint into action. Rather it was akin to the healing contract often drawn up between a medical practitioner and the patient. According to this arrangement, the agreed payment would be forthcoming when the agreed treatment had been performed and the cure achieved. The practice continued, though by the early sixteenth century doubts had begun to emerge in Neapolitan legal circles as to the validity of such agreements as far as the law was concerned.66

Social causation and popular healing forms

All of the above could come under the rubric of ‘popular’ healing in the sense that all levels of society participated in it to some extent. Antonia Jurlaro made use of the community physician’s services, as well as the surgeon’s bleedings, which were most likely part of the former’s treatment. But when these failed, in her eyes, to
improve her daughter’s condition, she turned to another form of healing. This was based on a changed diagnosis of the cause of her daughter’s affliction, from one we might classify as ‘natural’ to one we could call ‘social.’ The healer she chose, the wise woman Onofria Bufalo, was the one she believed responsible for the disease. This may seem rather paradoxical, but popular culture had it that such people could both harm and heal. The person responsible for the spell that lay behind an ailment was thus the best able to undo it. Because of increasing attempts by the Church authorities to limit their activities, as part of the ongoing Counter-Reformation, we know quite a bit about cunning folk, how they functioned, and their clientele. What we still know very little about is their numbers. Doubtless every town had its compliment of wise women, for in the kingdom of Naples they were primarily women, but establishing the kinds of ratios we can provide for medical practitioners is impossible.

The frequent recourse to cunning folk for the treatment of a whole variety of ailments was one example of the medical pluralism of early modern Italy. This included diseases ascribed to nature as well as supernatural causation. Cunning folk could be specialised to a degree which we might find surprising: one healer might be considered expert in treating fevers, another headaches, still another pains in the joints. Techniques and rituals were quite varied, the prayers (onazioni) and conjurations (scongiuri) accompanied by simple herbal remedies, or even forming the sole means of treatment. An important part of the healing ritual thus consisted in the use of the sign of the cross on the afflicted part, or of holy water or oil taken from a church. The practitioners of these healing rituals were most often women. Healing and health were a natural part of the female domain in southern Italian society, a part of the woman’s concern for the wellbeing of the family. Furthermore, poor, often widowed women were frequently driven to the margins of society, and so came to depend on such services for their livelihood and development of a social role. Their power came from the ability to distinguish naturally occurring maladies from those caused by the supernatural. It was only once the causation had been determined that an effective cure could be found.86

Cunning folk – or jamare, magare, fattuchiere, as they were variously called in the kingdom – did share elements of medical knowledge with the medical elites. In addition to this, there were many improvised healers, who practised their cures, learned perhaps by observing medical practitioners or after a time in hospital, in response to a recognised need and following a reputation for success. In terms of efficacy, once again from a modern biomedical perspective, there is little to distinguish their activities from those of the most learned physician of the day. This was recognised on occasion by the sick who made use of their services. In 1569 one Neapolitan dyer commented that children in the city had been treated ‘with greater satisfaction by old women and experienced matrons than by physicians.’88 But to regard their treatments and remedies as merely less sophisticated varieties of learned medicine, as is sometimes done,89 is to miss the point. In fact, their approach to disease causation, and necessary remedies, could be radically different. While it is true that there was a large herbal component to their operations, tempered perhaps by practical experience, their theories of disease causation and their healing rituals had an underlying supernatural basis that was quite alien to university medicine.

The reason we know so much about the services of such women is because the Catholic Church claimed jurisdiction over those who used incanti, for whatever purpose, from locating buried treasure to treating disease. Even natural magic, with its learned, Renaissance pedigree, was now seen as diabolical, dependent on demonic forces for its success. This Counter-Reformation stance was expressed as early as 1565, according to a Neapolitan church synod celebrated by archbishop Alfonso Carafa, which left forgiveness for such offences in hands of confessors. Two years later the offence was deemed serious enough to become a matter for the archbishop.89

It is too often assumed that people sought the services of cunning folk because they came relatively cheap. However, in Antonia’s case there was little saving to be made and money did not seem to figure in her initial decision. In fact, a wise woman’s services could be quite expensive. There was often much hard-headed bargaining between healer and client, with the additional risk of blackmail if the sick person did not comply. The wise woman could always threaten worse injury and harm if their requests for money and assistance were not met.

I have referred to this causation as social, for instance the use of spells to harm other people, and as such an expression of antagonism and tension within the community. But this is a modern label. People of the time, while recognising the social elements, would have categorised the disease causation as ‘magical’, that is to say, diabolical. If the charms and spells worked, then it was the devil who gave them their power to do so. The efficacy of such maleficent magic was recognised by all levels of society at the beginning of our period, though to different degrees. If physicians discussed spells, it was to admit to the powerless of natural remedies to affect them. The Sicilian protophysician Giovanni Filippo Ingraffia supported the conclusions of Catholic theologians that neither natural remedies or counter-magic would work. Writing in 1570, just seven years after the Council of Trent had drawn to a close, he concluded that victims would have to make reparation with God, making a complete confession of their past sins, giving alms generously, fasting and, if necessary, by means of exorcisms and other ‘spiritual remedies.’90 But the first detailed account of the phenomenon by a Catholic physician came twenty-five years later. Battista Codronchi was prompted to write his De morbis veneficiis et veneficos (On diseases by witchcraft and witches) when his ten-month-old daughter became seriously ill as the result of a spell.91 He admits to giving the reality of such spells very little credit before her persistent illness and, indeed, it is his wife who firstsuspects a supernatural rather than natural cause and searches the baby’s bed for evidence of a charm. It is only after these have all been retrieved and destroyed by an ‘experienced exorcist’ that their daughter recovers. Their response was as the Church taught: to put their faith in ecclesiastical remedies against magic, and not counter-magic nor natural remedies alone. Such was the importance of the event in Codronchi’s life that it occasioned not only a book, but a votive painting (‘The magical powers of witches and the clergy
and the physician's doubts," now in the Imola art gallery. Several decades later another Catholic writer on medical ethics, Paolo Zacchia, expressed similar scepticism, quoting the disbelief of most ancients (with the exception of Galen), while at the same time acknowledging the opinion of Catholic authorities as to the efficacy of charms. He adopts a vague compromise position, saying: 'I, who would otherwise have no faith in such matters, would not dare simply to deny incantations.' Zacchia's conclusion is similar to one he adopts regarding miracle cures: an acceptance of the possibility tempered with a suspicious approach to individual cases. It was a scepticism destined to increase over our period, at least amongst the educated elites. It is, however, all but impossible to gauge the opinions of the rest of the population. Accounts of miracle cures and magical charms certainly show no sign of disappearing, and the people involved continue to take the reality of both for granted.

Writing around the same time as Zacchia was another proto physician, Pietro Piperno, in the papal enclave of Benevento. His conclusions about the role of physic in treating what he terms 'diseases of transnatural origin' were radically different. His approach was very much hands-on, proposing medical remedies that could counter magical illnesses, describing in detail how they are to be prepared and administered. His treatise, written in Latin, implies that such matters were, in fact, relevant to the physician just as much as the exorcist (though not, apparently, to the public at large). His case in dealing with such matters derived from his own experiences as a physician, but he does mention in passing his exorcist brother, the Capuchin Fra Bartolomeo, originator of a mouthwash to treat the loss of voice by magic. Piperno can be said to be the medical version of Menghi, in seeing disease-causing malefic around every corner and in advocating very practical, not to say eclectic, responses to it. As we shall see in chapter six, it takes Piperno forty pages to list and describe the various diseases that could be caused by spells.

Another example of an illness best analysed in its social context is tarantism. Here we have an example of a malady and its treatment which existed entirely outside the realms of university medicine. Tarantism was a culture-bound disorder, in the sense that both the illness and its treatment were unique to local culture, a single system of behaviour. Associated with the bite of the Apulian tarantula spider, tarantism can be defined in modern biomedical terms as a structured and ritualised response to deep psychological malaise, which included the evacuation and discharge of the crisis by traditional forms of music and dance. In the early modern period tarantism was a battleground, where popular, ecclesiastical and learned forms of healing competed to define and thus take possession of it. When forces outside its original Apulian habitat sought to appropriate it they marginalised it locally. Neapolitan physicians, such as the proto physiologist Francesco Serao, eventually dismissed it, when they determined that the local tarantula was not poisonous. The malady therefore had no natural, no 'real' cause. Its victims were fakes. (Paradoxically, where enlightenment medics found poisonous spiders to exist, as in central Spain, tarantism's music ritual was actively encouraged and fostered by them.) In southern Italy, however, the Church also criticised the popular ritual, though for different reasons. Local churchmen considered it licentious and possibly demonic, and endeavoured to Christianise it and bring it within accepted devotional categories. In the growing separation between elite and popular cultures that occurred during the eighteenth century, the conservative local church found itself increasingly siding with the latter.

In broader terms, the Council of Trent brought with it a strengthened episcopacy with the duty to investigate and regulate all aspects of diocesan religious life. This included popular healing rituals, living saints and sites of miracles occasioned by newly discovered saints' images. The intention was not to discourage devotion but to channel it into accepted practices. The same can be said of the Congregation of Rites and Ceremonies, based in Rome, which had ultimate control over the saint-making process. And whilst the kingdom's religious authorities sought to regulate what they defined as coming under their jurisdiction, its medical elites attempted to regulate in their areas of operation. Typically of the Baroque, there were conflicts and ambiguities in jurisdiction which were never ironed out, until the rationalising reforms of the Napoleonic government. A midwife, for example, could find herself before the proto physiologist's court if she practised without a licence, especially if she treated the sick, but before the bishop's court if that treatment included words defined as 'magical.' More important, however, is the fact that neither tribunal could function without the denunciations of the public. And these only came when there were other factors involved: a personal score to settle or a death following the treatment. The proto physiologist's court was no more successful in eliminating unlicensed practice than the bishop's court was in wiping out magical healing rituals.

These attempts at regulation are, however, a boon to the historian because of the records they generated (a few of which have survived). They allow us to say something about therapeutic provision within a country during the early modern period, on the one hand, and how these resources were actually used, on the other. For being bereft of sources of healing, the kingdom of Naples was awash with them; a pool of remedies which the sick could choose from according to the nature of the illness and reputations of success, however the latter might be defined.

**NOTES**

1 'Whoever wishes to keep his beloved one healthy / not a miser in blood, medicine or magic be.' Carlo Occhilupo, 'Veri morti, buoni consigli, e giusti avvertimenti lasciati da savi, letterati e plebei, e villani huomini', 1774, Biblioteca Provinciale, Lecce, MS 76; published in L. Lazzari Conged, 'Una raccolta settecentesca di proverbi salentini' in M. Paone (ed.), *Studi di storia popolare in onore di Giuseppe Chiarelli,* v (1980), p. 28. All translations into English are my own, unless stated otherwise.

2 Ruggiero Romano, 'Prezzi, salari e servizi a Napoli nel secolo XVIII', *Studi e ricerche di storia economica italiana nell' età del Risorgimento,* iv (1965), p. 49.


7 High infant mortality – as many as 300 deaths per 1,000 – was the main reason for the low life expectancy. Massimo Livi Bacci, *Italia e Europa* in L. Del Panta et al., *La popolazione italiana dal Medioevo a oggi* (Rome and Bari, 1990), p. 232.
12 Giuseppe Coniglio, *'Annoma e calmiere a Napoli durante la dominazione spagnuola*, *Archivio storico per le province napoletane*, b.s.v (1940), pp. 117–128.
33 Battista Codronchii, *De christianae ac tuta medendi ratione libro duo doctrina refert* (Ferrara, 1591), p. 48–9.
46 *Ibid.*, 76 I, fol. 41v.
CHAPTER TWO

THE ROYAL PROTOMEDICATO AND PUBLIC HEALTH

On 23 April 1530 Charles V, two months after being crowned emperor, issued an imperial ‘privilege’ to the then protophysician (protomedico) of the Kingdom of Naples, Narciso Verdugno. Verdugno was having difficulty enforcing his powers and was granted the ‘faculty to examine, recognise and castigate all non-graduate physicians, surgeons, apothecaries, grocers, alchemists, barbers, bone-setters, healers, midwives and any other subject and annexed persons.’ He was to be in charge of an office and magistracy – the Protomedicato – responsible for supervising the practice of all forms of healing. Like other similar bodies elsewhere, the activities of the Neapolitan Protomedicato were conditioned by the ‘political, institutional and internal legal framework of the larger society’ in which it operated. As was little in the way of documentation survives to indicate the actual day-to-day activity of the Neapolitan protophysician during the early modern period. What we do know is that in 1609–10 the annual collecting of dues that each practitioner had to pay the protophysician was farmed out to tax collectors. From this date the protophysician was accountable to both the Chamber of the Sommaria, the kingdom’s highest administrative and fiscal body. This shaped the office’s activities for the next two centuries, leading Giuseppe Maria Galanti to remark in 1786 that its object ‘seems to consist only of the collection of dues, which for the apothecaries is virtually arbitrary.’ Though its impact on public health was therefore minimal, the office of the protophysician can nevertheless tell us quite a lot about healers in early modern Naples, attempts to regulate their activities, and the extent to which public offices were conditioned by the state of which they were a part.

Origins and nature of the office

Although health legislation and mechanisms for supervising the day-to-day practice of medicine in the Italian states certainly existed during the Middle Ages, they gained force in the sixteenth century, with the establishment of specific structures, like the Protomedicati. These took three basic forms: royal (or Spanish), collegial and municipal. Due to a relatively strong central administration in the kingdoms of Naples, Sicily and Sardinia, royal ordinances regulated the medical profession.
from early on. All three kingdoms owed the first appointment of protophysicians to Aragonese kings. Initially, the protophysician’s role as ‘first among physicians’ was an extension of his status as the personal physician of the king. In 1397 King Martin II of Sicily appointed the first protophysician, Ruggero da Camina, with authority over the whole island. The ‘Capitula et ordinaciones’ of the Sicilian Protomedicato were compiled in 1429 by the protophysician Antonio d’Alessandro and approved by King Alfonso the Magnanimous, according to Giovanni Filippo Ingrassia, who revised them. The same king instituted the office of protophysician in Sardinia in 1455, to be based at Cagliari. It was also Alfonso who appointed the first protophysician for the kingdom of Naples when he became king there in 1444, though Naples was not lacking medical organisation. In fact, Alfonso’s immediate predecessor, Queen Giovanna II, had set up a College of Physicians in the city of Naples, naming her personal physician, Salvatore Calenda of Salerno, as its prior. From the start, one of the Neapolitan protophysician’s primary concerns was the regulation of apothecaries. King Alfonso granted the guild of apothecaries its statutes in 1455, which were renewed in 1498 by the then protophysician Antonaci de Sanato. More formal recognition of the office of protophysician in Naples came with the above-mentioned imperial ‘privilege’ of 1530. In Naples, from the very start, the office of protophysician was distinct from the College of Physicians, itself part of the College of Doctors (which consisted primarily of the much more powerful lawyers). As befitted the person who was chosen from amongst the ranks of the kingdom’s most esteemed physicians by the viceroy, the protophysician was occasionally prior of the medical college as well, but this in no way united the two positions. In fact, one has the impression that in Naples the office of protophysician was essentially ceremonial, bringing with it a great deal of prestige, but little real power. Though a great deal was made of the protophysician’s jurisdiction over all non-graduate practitioners, the emphasis seems to have been on the collection of licence and inspection fees from them, which was contracted out, as we shall see below. Real medical power was in the hands of the College, responsible for the granting of degrees.

There is no doubting the prestige that went with being protophysician, for it was the highest office to which a Neapolitan physician could usually aspire. He received an annual salary of one thousand ducats from the state, derived from the money rendered by the tax contractor. He had to be a native of the kingdom, a requirement shared with most public offices. The appointment could take the form of recognition of royal service and intellectual achievements, as in the case of the humanist physician, writer and physician Antonio de Ferraris (1444–1517), intimate of both King Ferrante and his son Federigo. At this point the appointment was still for life, though it would eventually consist of a renewable three-year term (and was to revert back to a permanent one by the 1780s). As the most important position in the state’s medical bureaucracy, the appointee was usually at the apex of the kingdom’s medical establishment. For example, the protophysician to whom we owe much of our information about the office, Antonio Santorelli, was already the author of various medical treatises, holder of the chair of theoretical medicine and personal physician to the viceroy, the count of Oñate, when the latter appointed him protophysician in 1651.

The nature of the appointment recognised academic and practical medical achievements as well as the person’s ability to form networks of influential people. These networks combined academic and intellectual environments with aristocratic and political ones. This was typical of academic posts in all the universities of early modern Italy. Santorelli, for instance, owed his nomination to the prestigious chair of philosophy to the duke of Osuna, only to be ordered back to the lesser chair of theoretical medicine by Cardinal Zabata when protests were made that it had been awarded without due competition. By this time, no one dared risk his own career by supporting Santorelli, and he lectured at various Italian universities (Pisa, Florence, Padua, Bologna), until the count of Oñate rescued Santorelli by making him his personal physician in 1648. He died in 1653. But the most obvious example is the medical traditionalist Carlo Pignatari. He was characterised as being ‘rather more political than learned’, suggesting he knew how to obtain and maintain power. Completely immersed in the Neapolitan medical world, he was born in Nocera dei Pagani, near Salerno, the son of an apothecary, and received his doctorate from the Neapolitan College of Doctors in 1644. A short ten years later, still in his thirties, he was awarded the primary chair in medicine at the university and in 1678 he became vice-chancellor of the College, which meant he was head of that part of the College responsible for physicians. When he published the Petitorium, or official pharmacopoeia, in 1684 he was also dean of the university, chamber physician to the viceroy and knight Palatine. He was first appointed protophysician by the viceroy Garcia d’Avelaneda y Haro (count of Castriolo) in 1656, eventually serving five terms in all (1656 to 1665 and 1683 to 1689), the longest of any protophysician under the Spanish viceroys. His death in 1694, and subsequent burial in the Jesuit Casa Professa in Naples, warranted an entry in the chronicle of the notary Domenico Confiuorto, a supporter of medical traditionalists like Pignatari and resolute opponent of medical innovators.

Protophysicians owed their appointment to the reigning viceroy: a change in viceroy or a change in medical fashions could prevent their reappointment. This was the case with Pignatari, who was not reappointed as protophysician by the new viceroy Pedro Antonio d’Aragona, after the previous viceroy’s death in 1665. The Neapolitan office of protophysician, like the Sicilian and Sardinian, was closely linked to Spanish viceregal administration. Given the links aspiring physicians sought to forge with their often Spanish patrons, it is no accident that many of them followed their patrons to Spain or elsewhere in the Spanish dominions. This often incurred the wrath of local physicians who saw their chances thwarted. Domenico Bottori, for instance, was appointed Sicilian protophysician by the viceroy, the marquis of Vilafranca, an office which he continued to hold under the two succeeding viceroys. In 1688 he was nominated protophysician of Naples by the viceroy there, the count of Santo Stefano. For the next four years he was forced to go under a pseudonym – ‘Domenico Cuomo’ is recorded as being protophysician.
at the time — since statute required that the office be filled by a local physician. Bottoni was not the only Sicilian to be offered the Neapolitan post. Several decades earlier, the then vicerey of Naples, Juan Alonso Enríquez de Cabrera, had offered the post to the Messinese Marco Antonio Alaimo. Before becoming Neapolitan vicerey, de Cabrera had been vicerey in Sicily and no doubt came across Alaimo there, the latter having gained renown during the Palermo plague of 1624–25, publishing a treatise on the subject. But Alaimo refused the appointment, preferring to remain in Sicily, thereby avoiding a dispute with Neapolitan physicians. In 1634 he was appointed consultant protophysician in Palermo. It was not unusual for physicians to follow their patrons throughout the Spanish world. The young Andrea Bastelli, a native of Meli (Basilicata), gained the esteem of the vicerey, the count of Miranda, while practising medicine in Naples, and followed him to Spain in 1595. He ended up at Philip III’s court at Valladolid, was awarded a title of nobility, and in 1602 was preparing to return to Naples as protophysician when he died. And nearly one hundred and fifty years later Francesco Buonocore, a native of Iachia, followed the same path, accompanying his patron, the duke of Medina-Celi, to Spain (with an honorarium of 2,000 scudi). Here he was called to the service of the infant, whom he followed back to Naples in 1734 as personal physician and protophysician when the latter became king as Charles III. Occasionally, the vicerey even succeeded in awarding the post to a Spaniard, as in the cases of Andrs Ordoñez (protophysician during the 1620s), Andrés de Gavaz (from 1678) and Miguel Marquez (from 1692), who all went on to serve in various official medical capacities back in Spain.

Despite close links with Spanish administration, the Neapolitan office of protophysician never achieved the authority of its Castilian counterpart. The term ‘Protomedicato’ was only used to describe the fee-collecting aspect; the office did not become a fully-fledged medical bureaucracy or magistracy existing outside the person who was pro tempore protophysician. In Castile, meanwhile, much more so than in Naples, the Tribunal del Protomedicato developed into a vast and powerful bureaucracy. It appointed medical personnel to hospitals and the armed forces, regulated the publication of books on medical subjects, and directed efforts against plague and contagion. It branched out into the other Spanish kingdoms and overseas possessions, though not without jurisdictional conflicts. It is certainly no coincidence that the Neapolitan office most closely resembled that of another Spanish kingdom: Aragon. This should come as no surprise, since the first protophysicians in Naples owed their appointments to Aragonese kings. When the more powerful Castilian form came into being it was not imposed in Naples, perhaps because of local power structures, prerogatives and traditions. After all, the Spanish authorities tried to impose the Spanish form of the Inquisition in Naples, but failed. So the office of protophysician continued to resemble that prevalent in Spanish kingdoms outside Castile. In Aragon, for instance, the presence of Colleges and guilds in all large towns meant that the protophysician was only effective in rural areas and small towns. His urban role was limited to that of a prestigious physician giving his opinion in medical disputes of the time.

Other Italian Protomedicato which owe their creation to Spanish rule confirm this picture. In Sicily local power structures — the universities amongst them — limited the effective powers of the island’s consultant protophysician. This was also true in Milan, characterised by an ongoing tension between royal prerogative and the city’s College of Physicians. When the Duchy of Milan became a Spanish possession in 1535 the post of royal protophysician was established as an imperial appointment. He was normally chosen from amongst the ranks of the Milanese medical college, composed entirely of noblemen; such was Milan’s most famous protophysician Ludovico Settala, appointed to the office in 1628 by Philip IV. This proximity did not, however, guarantee tranquil relations between the two. Only Sardinia came closer to the Castilian model of the strong, centralised Protomedicato, as outlined in the ‘Constituciones Protomedicales’ promulgated by the island’s protophysician Joan Antoni Sanna in 1608. Its wide powers may stem from the fact that Sardinia was closer to the Spanish orbit than either Naples, Sicily or Milan, and the fact that it was without a functioning university of its own — and hence a powerful local medical community — until 1632.

In contrast, the Italian Protomedicato of the collegial type seem to have functioned somewhat more harmoniously, in addition to having more extensive powers. The Protomedicato in both Rome and Siena were of this type, having grown out of the Colleges of Physicians of these cities. In Rome the protophysician general gradually took over the authority of the College’s prior and was elected annually each December from amongst the ranks of the college to be its head. Likewise in Siena, the first protophysician, to judge by surviving records, held office from 1562, while the post of prior became largely ceremonial. The Protomedicato of Bologna was a similar outgrowth of that city’s medical college, which established the tribunal in 1517. Its origins, in fact, lay in the disciplinary norms contained in the original 1378 Statutes of the College of Medicine and Arts, which granted the College jurisdiction over disputes between doctors and patients, over the inspection of apothecary shops and the charging of fines, as well as the licensing of itinerant practitioners.

A third distinct type of Protomedicato existed in Italy, and can be designated the municipal. Here the protophysician was a local physician elected for a short period by the town or city council. In many cases the office was a survival from the days of communal autonomy, as at Gubbio or the papal enclave of Benevento, not far from Naples. The protophysician here was elected by city councillors, and had the authority to inspect apothecary shops, establish fines for malpractice, and issue licences to non-graduate practitioners in the city of Benevento and its immediate vicinity. Although he was independent of the Roman protophysician, serious offences amongst the medical profession had to be referred to the papal legate.

Visitations and licensing

Despite their differences, the activities and responsibilities of the protophysicians and their deputies were remarkably similar throughout the peninsula. There was
the grinding reality of tours of inspection. These 'visitations', as they were called, were the \textit{raison d'\'etre} of the Protemedici. In Naples it was even hoped that the protophysician himself would lead the visitations, though the Collateral Council—the kingdom's main politico-administrative organ—noted in 1577 that 'the previous protophysicians only very rarely involved themselves.' Four years later the viceroy, Juan de Zurita, insisted that the protophysician, Prospero Bove, should lead the visitations in Naples himself. If unable to do so for some reason, he was to suggest three expert physicians 'of the city's best', from whom one would be selected by the viceroy to fill in for him.32 Visitations in Naples were to be conducted every October, lasting 'many months', whilst tours of the entire kingdom were to be conducted every two years. All apothecaries were to be visited. Visitations extended to 'all other people subject to the office of the protophysician according to ancient custom' (meaning, presumably, since the 'privilege' of 1530). This meant everyone without a doctorate who practised 'any action whatsoever for the health of human bodies.'33

The selection of visitors followed an established ritual. Members of the Guild of Apothecaries were to meet 'in a church of the protophysician' (usually one of the important churches such as San Lorenzo, San Domenico or San Pietro Martire). They were to elect two visitors, one from the Guild membership and one from the ranks of the eight Guild officials (the Speciali degli Otto). They, together with the protophysician, would conduct the inspections in the city. With regard to the rest of the kingdom, the procedure was slightly different, since the protophysician was not expected to go along. He was to appoint temporary substitutes for the various provinces, 'graduate physicians, learned experienced and good Christians.' Each physician was to be accompanied by 'a licensed and approved apothecary, knowledgeable and experienced in the recognition of simple and compound drugs.' They were to conduct a tour of a specific province within a stated period of time, reporting back to Naples when finished. As befitted his lower social status in the medical hierarchy, it was the apothecary who had the task of keeping records during the visitations, preparing 'a notebook where he records the conditions of the apothecaries' shops, which, having finished his administration, he presents to the Protophysician.' But before they departed for the visitations, the visitors were to deposit a suitable surtey (\textit{pigna} with the Chamber of the Sommaria, promising to perform their task 'accurately and faithfully.' The surtey was not cashed, but was to remain intact, in case any practitioner might have a complaint regarding duties paid to the visitors.34 This suggests that from a very early date the authorities were as concerned about collecting licence fees from practitioners as they were about certifying their actual ability.

The protophysician, visiting Naples and the towns around it, would generally travel by coach, only rarely going by boat or horse. Those who visited the provinces had a much tougher job. Roads could be bad, especially in the mountains, where there might only be mule-tracks, and most lacked bridges. When we consider that mountains covered fully a third of the kingdom's surface area, and hills another half, we can appreciate the difficulty of undertaking inspection tours. The visitors usually travelled by mule or horse, only in the flat provinces of Bari and Otranto being able to make use of simple wheeled vehicles. Added to this was the fact that, as we saw in chapter one, just under half of the kingdom's population lived in the mountainous areas, often in small isolated communities that had to be inspected nevertheless. Storms or bandits could make travel worse. For this reason members of the inspection team were permitted to bear arms and were accompanied by an armed guard of a handful of soldiers.35 Banditry was endemic in the kingdom, but the visitors may have had just as much to fear from disgruntled medical practitioners as from outlaws. Surviving financial documents record expenditures for stabling and room (listed as 'beds' rather than 'rooms') and board. They also tell us how long it took to visit each of the provinces, including even the smallest villages, usually an exhausting thirty to forty days.36

Upon arrival in a town the visitors were to seek out its governor or captain, syndics and elected officials, to whom they were to show their commissions and explain their wish to inspect the apothecaries' shops, 'for the service of His Majesty and the benefit of the people.' They were to ask the consent of local officials to carry out the inspections, inviting them to participate if they so wished. It was important to make a good impression with the local governors, as they could make life difficult for inspecting protophysicians. And with town after town to visit, it was important that things should go as smoothly as possible. Once they had received their permission, the visitors 'will post an edict in public places' that all those subject to the protophysician's jurisdiction must appear before his substitute.37 In addition to collecting the visitation fee from all practitioners, the visitors were responsible for examining and licensing all aspiring practitioners. In Naples, the aspiring apothecary was to be examined by a schoolmaster on the Latin text of Messu, by the protophysician on how he learned his art and where he served his apprenticeship, and by the deputies of the Guild of Apothecaries on the canons of Messu and the preparation of medicines. (The writings of the Arab physician Messu continued to be central to pharmacology well into our period.) Outside the city, visitors were to send aspiring apothecaries to appear before the protophysician. But if the distance was too great, or there was some other impediment, then they were to be examined locally as they would be in Naples, with signed and notarised declarations sent to the protophysician, so that a licence could be duly issued. But adequate training and expertise were not enough. According to the 'Instruction' of 1581 the protophysician was required to 'find out about the life and quality of the person, as well as the assets he possesses, and how much of these are liquid', with enough to support himself so that he would not be reduced to fraud in order to carry out his trade. By 1652 aspiring apothecaries were required to possess 500 ducats-worth of goods.38

Inspecting apothecary shops was the protophysician's most important activity, to judge by the amount of space devoted to it in both the regulations and surviving registers. The visitation was to take the apothecary by surprise. In the words of the protophysician Santorelli, it was to be like death: 'the apothecary knows it will come, but he does not know the day or time.'39 This was to prevent him from dis-
posing of deficient or inferior medicines, or boring good ones from another apothecary – crimes that nevertheless took place. In fact, Santorelli’s description of 1612 suggests that the inspection routine had been made more rigorous, if we consider that back in 1577 the apothecaries had been given twenty-four hours’ notice of the impending inspection. 40

In addition to the inspection’s formalistic and somewhat ominous nature, it could turn into a real social event, further adding to the ritual.

[The visitors] go to the apothecary’s shop with all those officials and physicians they can muster and, having entered the shop, the substitute apothecary opens his notebook where he records the date, month and year of the visitation of apothecary so-and-so in town such-and-such, in the presence of the following [named] governors, syndics, elected officials, and physicians, and when he asks the apothecary present in the shop under oath to show whatever simple and compound drugs shall be demanded of him.

The apothecary was to present each medicine from the ‘table’ as he was asked to. The visiting apothecary (two within the city of Naples) would then ‘look at, smell, touch and taste as necessary’, before passing it one to the protophysician’s substitute to examine. The presence of so many other people at the inspections was meant to guarantee they were carried out properly. Indeed, one feature of the visitation reports that seems to be unique to the Neapolitan Protomedicato was the fact that the inspected apothecary was to undersign the visitors’ report, noting ‘how they treated him’. And all those present during the inspection – syndics, local physicians – would also sign. 41

Despite these assurances, apothecaries were often reluctant to have their shops inspected and pay the visitation fee of five carlini. According to the 1577 instructions, ‘poor apothecaries’ were not to be subject to the fee, though it is impossible to determine how often this exemption was applied in practice. On occasion apothecaries did seek to escape the fee by pleading poverty. Petitions for exemption included poverty engendered by ‘the high cost of medicines for which the poor cannot afford to pay’, as one apothecary complained. 42 In fact, Santorelli noted that apothecaries were not paid immediately, ‘as are butchers or bakers’, but sometimes after many years, if at all. 43 Hence the need to ensure that apothecaries had other sources of income. In small towns and villages the result could be poverty. Another cause for concern on the part of the protomedicato was the fact that they, and other practitioners subject to the protophysician, were to pay for the visitors’ expenses whilst they were in town (room, board, stabling). This was the ‘ancient custom always followed in the kingdom, in the kingdom of Sicily and all other kingdoms.’ To avoid overburdening the local practitioners, visitors were reminded to stick to their proposed itineraries and not visit other towns en route, ‘so that they are not inspected twice.’ They were not to remain in a town any longer than the time required by the visitations, ‘and this is ordinarily one, two, rarely, three days, according to the number of apothecaries.’ 44 The visitors had to ensure that they got what was due them without upsetting the apothecaries. Yet all the good will in the

world did not prevent an unwilling apothecary from locking his shutters, going into hiding or even seeking sanctuary in the parish church when accused of illegal trading. Moreover, apothecaries had their own guild to protect their interests. It was a source of strength they often made use of, bringing them into dispute with Medical Colleges and Protomedicati up and down the peninsula. Hence the Neapolitan requirement to put the surety aside for just such contingencies.

If, upon examination, a medicine was found wanting in any way it was to be destroyed, ‘so that it cannot be used’; Bad oils or unguals could at least be recycled: ‘they are to be sent to religious institutions for their lamps’ (an unexpected example of the religion–medicine link). Religious institutions were also, originally, the beneficiaries of any fines that might be imposed if an apothecary warranted sterner punishment. 45 This generalised charitable orientation did not last long. By 1583 the proceeds of fines and confiscations were to be divided into three: one part going to the accuser, representing the protophysician, one to the state treasury, and one to Naples’ Annunziata Hospital alone. 46 Nevertheless it must be said that the protophysicians were relatively lenient when it came to fines, although their enforcement may seem somewhat arbitrary. Their bark was always worse than their bite, typical of ancien régime law enforcement. This often came down to levels of bargaining, the final punishment being a compromise between the harshness of the official edicts and the assertions and protestations of the accused.

The protophysician’s difficulties did not merely concern apothecaries. The Neapolitan instructions of 1577 written for visitors were realistic: they realised that practitioners would not all present themselves at once and that they did not reside close to one another in most towns. Visitors could not therefore afford the luxury of examining them by type, but had to proceed as they appeared. Examining barber-surgeons and midwives, issuing licences, and collecting fees was never a straightforward or popular business. Merely carrying out one’s duty was bound to cause resentment. In the kingdom barber-surgeons were separated into two levels of skill and were examined accordingly. On the one hand, non-graduate surgeons were to present their licences to the visiting physician. Then, they were to be examined, ‘privately, in the shop where they practise’, on how they worked, especially with head wounds, ‘nerve punctures’ and ‘bloody discharges.’ On the other hand, barbers were to be asked ‘if they know the veins, where they are and how they are bled.’ In order to emphasise their subordinate position in the medical hierarchy, barbers were to swear to let blood only under doctor’s orders. The visitors were reminded to pay ‘particular attention’ to recording the administration of the oath, ‘so that it can be seen in the next visitation if [the barbers] have transgressed their orders.’ 47 In addition to the relevant licence fees, there were very heavy fines for exceeding the limits of one’s licence as granted by the protophysician.

Similar restrictions not to exceed the bounds of their ‘profession’ also applied to midwives. Women were not to be licensed to treat the sick but only to practise midwifery. Though listed in earlier instructions to protophysicians as being subject to the annual visitation fee, the actual examination which midwives were to undergo was first described in an instruction of 1622. This was at the same time that other
Italian Protomedicati were first becoming interested in supervising midwives. However, like the examinations conducted by their counterparts in Spain, those of the Neapolitan protophysicians were not very demanding. Nor did they change at all over at least the next hundred years. The visitors were to ascertain that midwives were able to explain 'how they assist women who are unable to give birth, [what they do] when the baby comes out with the head first, which is a normal birth, or leading with an arm or a leg, or when they cannot discharge the afterbirth or other evident danger.'

Another important aspect of the activity of the protophysicians regarded the licensing of 'churlatans' and other itinerant practitioners. An edict of 1581 put the emphasis on preventing unlicensed practitioners from practising physic or dispensing remedies. It noted that in the previous few years people had died in Naples and various places in the kingdom at the hands of 'uneducated and inexpert people' and threatened a year's imprisonment to anyone, man or woman, who dared or presumed 'to treat medically, order, dispense or counsel remedies or medicines of any sort or type whatsoever to any person without a licence obtained in writing from the Excellent Protophysician.' It was directed at those who claimed to be able to treat by means of doctrine or experience, despite not having a degree in physic or surgery. Two things are of particular interest. First, that women were not specifically admonished to limit themselves to midwifery alone—though this would come in the next few decades. Second, that the protophysicians were not out to eliminate the presence of churlatans in the kingdom, but to regulate their circulation and the goods they peddled. Once again, however, the lack of surviving records means that little can be said about actual licensing activity. Santorelli indicated that empirics must be tolerated and licensed because, in the case of the 'French disease', many victims would go to them who, because of shame, would not dare go to a doctor or surgeon. In the past, those who had practised without being examined and licensed by the protophysician had been deprived of all their personal property. But from Santorelli's time, proceedings against them had to be launched by a plaintiff, who was usually satisfied with getting back from the empiric the money spent on the medicament. This detached attitude was not shared by all protophysicians, primarily since so many churlatans seemed to escape licensing.

Public health

The fame of certain of the kingdom's protophysicians, as well as their first-hand knowledge of practitioners and medical provision, prompts the question of their involvement in the state's public health organisation. To a limited extent they did participate in issues concerning public health, such as in the Lake Agnano dispute to be discussed in chapter three, where Pignataro took what he regarded as appropriate action to end the fever epidemic. On another occasion, in October 1686, Pignataro and two other physicians were appointed to investigate an epidemic of 'malignant and pestilential fever' in the district of San Giovanni a Carbonara. It had already resulted in many deaths, 'which had caused and causes much fear in the

city', according to the chronicler Domenico Contuerto. The cause was attributed to the monastery's garden, 'which, as it was full of manure, brought there this past summer, and with the autumnal rains having fallen on top of it, had caused the bad air in that district.'

Likewise, their expertise was often sought in times of plague. Pignataro himself furnished advice on remedies and responses during the calamitous plague of 1656. A number of protophysicians elsewhere—Giovanni Filippo Ingrassia in Palermo and Ludovico Settala in Milan, for example—wrote treatises on plague. But their involvement did not usually extend to the health boards set up to deal with plague epidemics, which were generally run by non-medical administrators. The actual administrative and bureaucratic arrangements were left to the boards.

The kingdom's public health legislation was woefully piecemeal and ad hoc, dealing with crises as they arose. Unlike several other Italian states, such as Venice, in Naples there was no central health board or magistracy until the arrival of plague in the spring of 1656 forced the government into creating the Magistrato della Sanità. Earlier plagues had been dealt with in a haphazard way, by entrusting port authorities to enforce quarantine and by the granting of special powers to officials like the capital's 'Eletti del Popolo', responsible, in turn, for the appointing of deputies. Perhaps to an even greater extent than elsewhere in Italy, public health continued to be a matter for local communities to deal with as best they could. For the authorities of the small town of Pomarico (Basilicata) this meant setting up guards at the town gates, drawn from the local inhabitants, as well as making a votive offering of thirty pounds of candle wax to St Michael. National measures banning all commerce and travellers from Sicily, the source of the 1575 plague, proved impossible to enforce. Not only did the Jesuits manage to smuggle letters (including in the ban) into Reggio, they also managed to travel by ship from the infected port of Messina to Naples on several occasions, evading the port guards and disembarking.

The unceasing influx of migrants from the provinces, especially in times of famine, resulted in fears of disease epidemics which were thought to originate amongst the poor. During the famine of 1607 an agent reported to the Grand duke of Tuscany:

The famine is so great throughout the kingdom that whole communities come together into Naples and wander throughout the city shouting: bread, bread. And so many beggars have descended that it is a miracle that the city does not fall victim to plague, because people are dying in the streets, and no measures are taken.

The trio of 'war, famine, plague' seemed to strike together. Naples had not yet recovered from the first two ('war' had come in the guise of the 1647 Masaniello revolt), when plague arrived in April 1656, apparently from Sardinia. At first, the authorities were reluctant to identify the deaths as plague because of the disruption this would bring to trade and the movement of troops. Physicians were, according to the chronicle of Domenico Parrino, 'little experienced in the symptoms of the contagion', but when one physician recognised a case of plague at the Annunziata
Hospital he was immediately locked up by order of the viceroy. The physician died a few days later of plague. For Parrino he is an innocent victim, paying the price of his honesty. Contemporary accounts of plague often assume a kind of dramatic, even mythic tone, and Parrino's is no exception: a mixture of tragedy and morality play. Yet he is unsure how to characterise the unwillingness of the physicians advising the viceroy 'to condemn the pestilential disease': 'whether out of error, fear or evil intent.' In any case, only cosmetic measures were taken. Only when large numbers of people were dying every day did the viceroy give authority to the nobleman Manovel d'Aguilar, regent at the Vicaria tribunal, to organise several physicians, including Pignataro as protophysician, to investigate the matter thoroughly. The physicians demanded that autopsies be performed. These were entrusted to two of the city's esteemed 'anatomicians': Marco Aurelio Severino (who was to die of the plague) and Felice Martorella. When they were certain it was plague, they were entrusted with a response, 'not just to preserve people from it, but also for the treatment of the sick.' The usual steps were now taken: the issuing of passes, the setting-up of guards at all city gates to prevent the entry of suspected goods and people, the taking of the sick to the San Gennaro lazaret, the appointing of physicians and surgeons for each district. But the pontifical nuncio in Naples, Giulio Spinola, was less than impressed by the response of the Neapolitan authorities. Inspected houses were not closed up, 'public commerce' with the victim's families was not prevented, suspect goods were not burned. Even worse, 'if the house of some poor wretch was boarded up, no thought was given as to how to feed him, so that, with even greater scandal, many people died out of simple want.' Money and medicines, Spinola concluded, were only distributed to the poor sick on a sporadic and occasional basis.

Little was done to end the resulting confusion and disorder. Medicines, such as theriac, were found to be in short supply, as was food, since no one could bring it into the city. Exhausted of their supplies, the apothecaries' shops remained closed. According to the Tuscan agent, an 'ordinary man, living near the market,' did a brisk trade in holy water, blessed by himself, following a revelation he had received from Our Lady of Constantinople that it would 'preserve from contagion as well as cure it.' For fear of contagion, there were no private confessions, and the Eucharist was administered to the sick by means of a long cane. In the words of Parrino: 'Physicians, surgeons and barbers were dying for treating the body, priests and monks for treating the soul, grave diggers for giving corpses a burial.' Since it was believed that the only effective prevention against plague was to flee, some 60,000 Neapolitans did just that (which no doubt helped to spread it to the provinces). Controlling the movement of people and goods was bound to be extremely difficult, with such an enormous city and, beyond it, so much coastline. Nor did the situation change much during the following century. The famine—epidemic of 1764 caught the city's renamed Supreme Magistracy of Health as off-guard as its predecessor (figure 2). This despite regulations of 1751 that mention the preparation of a 'weekly report on the state of public health' in Naples and its province especially to control epidemics of this kind. Once again, the expert advice of protophysicians and physicians alike was only sought once the epidemic was well advanced. Greater rigour was shown in carrying out their advice, but the death toll was still some thirty thousand people. The inefficient brutality of the state in dealing with the famine—epidemic and the terrible poverty of the masses compared to the privileges of a very few makes 1764 a watershed in the Neapolitan Enlightenment. One is continually struck by the contrast between proposals for the reform of public health and the paucity of measures actually taken, although more work needs to be done on the Supreme Magistracy of Health to verify this hypothesis. Its reputation abroad remained one of general inactivity. John Howard reported that in 1791 that the city's lazaret was 'very small', with 'little attention' paid to 'passengers and shipping, under quarantine.'

The protophysicians could make a more positive contribution to public health when it came to examining medicines. For example, in the late 1670s, the Collateral Council, at the behest of the viceroy, requested the protophysician to appoint a commission to look into the use of chemical medicines in the wake of several suspicious deaths. This would seem to confirm our impression that Neapolitan protophysicians' raison d'être revolved around the regulation and activities of apothecaries. In fact, the author of the kingdom's first published pharmacopoeia, the protophysician Quinzio Buongiovanni, insisted that apothecaries be prohibited from preparing 'compositions with simples' without having been inspected first by one of the guild officials and the protophysician. Otherwise, he argued, 'they make the compositions in their own way, without fear of God or justice, and to the detriment of human bodies, which for this reason are daily made to suffer.' For this reason, Buongiovanni was present when the head apothecary of the Dominican
monastery of Santa Caterina a Formello in Naples, Fra Donato D’Eremita, prepared his famous ‘elixir vitae.’ But then again, Buonovigni may have been invited by D’Eremita, along with the other dignitaries present (Giovanni Battista Della Porta and Nicola Stigliola), to launch his product as part of a publicity stunt. Was inviting the protophysi- cian a courtesy, a necessity or something that the medicine’s seller could take advantage of? We could ask the same question of Nicola Stigliola, who himself had invited an earlier protophysi- cian, Giovan Antonio Pisano, to attend the preparation of theriac according to renewed classical canons. Most likely, it was a combination of all three factors, in the same way that a char- latan could turn mandatory issuing of a licence to sell his medicine into a stamp of approval to boost sales.

Jurisdictional limitations

Any impact the Neapolitan Protomedicato might have had was limited by several factors, such as the extent of its jurisdiction. The various Italian Protomedicato all competed, or at least overlapped, with trade corporations and other organs of the state. Although the state apparatus grew in size during the early modern period, this did not mean that it replaced or even weakened other centres of power. Local elite groups and traditional institutions maintained their importance in European states. Even the most powerful Protomedicato, that of Spain, had to share its authority with local medical corporations, especially in cities outside Castile. Moreover, the Supreme Council of the Inquisition also assumed the right to license charla- 
tans, inspect apothecary shops and examine and approve foreign physicians in certain circumstances.

Let us begin by considering geographical limitations. The protophysi- cian of the kingdom of Naples had apparent universal authority, reflected in his title ‘royal and universal protophysi- cian.’ But there were the notable exceptions of Salerno and Benevento. Salerno was the only city in the kingdom to have a collegial entity, the College of Doctors, completely autonomous from its Neapolitan counterpart, until it was closed in 1810-11 in the reforms of Joachim Murat. Although Salerno’s medical school ceased to be of any real intellectual importance during the early modern period, its College continued to be an important tool in the city’s local power structure. The Protomedicato tax collectors sought to expand the office’s jurisdiction over Salerno on repeated occasions. Each time the government decided in favour of the Salernitan College’s jurisdiction over local practitioners. In its claims over Salerno, the Protomedicato was not, in fact, seeking to become some sort of modern, overarching public medical authority. Rather, the tax collectors simply wanted to increase their takings. For its part, Benevento was independent not because of a medical college but as a papal enclave, as we have seen.

The position of the Neapolitan protophysi- cian was not in any way exceptional. The consultor protophysi- cian of Sicily, appointed by the viceroy, had jurisdiction over the entire island, but nonetheless had to contend with the presence of municipal protophysi- cians in Palermo, Catania, Messina and Modica. And the extent of the territory under the Roman protophysi- cian general was less than his title of ‘universal protophysi- cian of all the ecclesiastical states’ implied. There was the Bolognese Protomedicato: although Bologna had become part of the Papal States in 1506 it jealously sought to retain remains of local autonomy. The towns of Castro and Ronciglione, Ravenna, Rimini and Urbino were similar exceptions, as were places like Macerata, Fermo and Perugia, with their medical Colleges.

There were also professional exemptions. Unlike the Castilian tribunal, the Italian Protomedicato did not always have jurisdiction over university-educated physicians and surgeons. At the most, newly graduated or foreign physicians would have to undergo an additional examination in front of the protophysi- cian before being able to practise. The protophysi- cian of Naples was typical in having precedence over all other physicians in the kingdom, but he could proceed against them only if they were suspected of preparing medicines. Otherwise, physicians had their own College to deal with whatever criminal and civil disputes might arise involving their practice of medicine.

The protophysi- cians were generally powerless against apothecaries’ shops belonging to Religious Orders, since ecclesiastics were exempt from secular jurisdiction. This was the norm throughout Italy, until eighteenth-century reforms limited the autonomy of the religious orders. The Neapolitan protophysi- cian attempted to insist on this right early on, affirming in 1622 that ecclesiastics may have gained exemption to secular jurisdiction as individuals, but because the protophysi- cian was inspecting their shops, and not them personally, they had no right to refuse. This argument was repeated over one hundred years later. In an edict of 1738 the proto- physician reaffirmed his right to inspect the apothecary’s shops run by members of religious orders, explaining that it is not the people who are inspected, but the goods in their shop. It is impossible to say how effective this argument was; one suspects its impact on ecclesiastical jurisdiction was rather limited. Limitations to clerical power as part of general Enlightenment reforms may be the reason why the 1786 list include monastic shops in Naples and lay apothecaries serving in monastic shops throughout the kingdom.

Further jurisdictional limitations varied from state to state. In the kingdom of Naples the corporate bodies of each of the three branches of medicine – the physicians’ College, and the guilds of the barbers and apothecaries – acted to protect their members’ interests. Where these bodies existed, in Naples and Salerno, they circumscribed the protophysi- cian’s authority. Everywhere in the kingdom barbers were to be approved and licensed by the protophysi- cians, as we have seen; but in the capital barbers were subject only to their own guild, the Quattro dell’Arte. For related reasons, the fine line separating apothecaries and grocers was also a source of dispute, as it was throughout Europe. Grocers traded in many of the same goods as apothecaries and frequently supplied them. Santorelli defined grocers as ‘those who import medications from foreign countries, like agraricium, rubarb, scarmmony, ligustri vitae, sarsaparilla, saxifrage, cloves, cinnamon, nutmeg, and sugar.’ The protophysi- cian Prospero Bove assumed control over the grocers in 1581 after a spate of deaths resulted from poisons they sold. Henceforth they were
to keep records and be inspected like the apothecaries.81 Box's action may have been taken at the behest of the apothecaries, whose statutes stated that only they could sell poisons, and then only to 'discreet people so as to avoid scandak'.82 But it also meant that the protophysician would acquire a whole new source of income from inspection fees. It immediately incurred the wrath of the grocers, who successfully appealed to the viceroy and the Collateral Council in 1604. They argued that poisons like arsenic and verdigris were necessary for the work of artisans and, in any case, could be just as easily obtained from other sources. In addition, it was unnecessary to inspect their shops since the goods they sold were inspected upon their manufacture or importation, and what medical goods were bought by apothecaries would undergo further inspection by the protophysician.83 But the problem did not go away, and by the eighteenth century the protophysician had reacquired inspection rights over them. For the tax farmers awarded the contract to collect the dues of the Protomedicato, the 'right of visitation' of those grocers' shops dealing in compound medicines was an additional source of income which they sought to enforce.84

In addition to geographical and professional limitations to their jurisdiction, the Protomedicato also had to contend with political and legal ones. The issuing of licences was not solely in the hands of the protophysician. Other state tribunals gladly did their share, if for no better reason than the extra income it generated. Neapolitan viceroy could not resist intervening, as when, in 1616, Pedro Girón, the duke of Osuna, personally examined two charlatans, both peddling poison antidotes.85 One wonders what the then protophysician thought of the intrusion. The situation may have resembled that in Sicily, where the viceroy regularly issued patents to non-graduate practitioners. In any case, conflicts of legal jurisdiction were common, as throughout Europe. Each state organism had its own tribunal to investigate cases affecting its interests and employees. This meant that one person could find himself on trial before different tribunals for the same charge.86 The tribunal of the Neapolitan Protomedicato was of an ad hoc nature, meeting as the need arose and without any permanent bureaucratic structure. The protophysician had at his service a legal consultant, 'by means of whose opinion [the protophysician] administers legal matters', an assistant, a notary and a porter. Cases could involve accusations against practitioners for exceeding the limitations imposed by their licences, or for practising without any licence at all. Lawsuits could also be initiated against practitioners for overcharging or causing harm or death, or against the patients for non-payment. When a dispute was presented before the protophysician the matter would be decided by the consultant. However, if a petition or denunciation was presented then the assistant was to be involved, 'as is the custom in the royal tribunals of Naples'. If the court was required by circumstances to imprison people, then 'they are to be incarcerated in the Silk tribunal or the Vicaria'.87 The first was the prison belonging to one of the city's most influential guilds, that of wool and silk workers; the Vicaria was the city's central civil and criminal court.

The protophysician was deprived of the authority to try civil cases in 1752 by Charles III, but it was never very important. In a guide to the city and kingdom of Naples which listed the various royal tribunals, that of the College of Doctors was tenth in order of precedence. The tribunal of the Protomedicato came a mere twenty-first, preceding only the tribunal of the Postmaster General, which had jurisdiction over letter carriers.88 Moreover, other Neapolitan tribunals also dealt with healing offences, further diminishing the role of the fledgling Protomedicato. The Udienza were the principal organs of judicial administration in the provinces, responsible for public order. A physician and surgeon would usually form part of each provincial Udienza, arbitrating disputes and performing forensic examinations. They were not paid much for their services – the tribunal's porter earned almost twice as much – but they could not doubt continue with regular practice as well.89

The other tribunal that frequently intervened in medical matters was the Holy Office of the Inquisition. In Naples the local nobility had opposed the introduction of the Spanish Inquisition, so representatives of the Roman (that is, papal) variety served on episcopal tribunals throughout the kingdom. The episcopal courts were primarily concerned with what they called 'magical and superstitious offences': healing rituals, whatever their content or form, that gained their power through an 'explicit or tacit pact' with the devil. Potentially, this meant most of the rituals used by local cunning folk. According to Santorelli, those who treated wounds with 'meaningless words' were subject to the Protomedicato, 'but those who heal with words and characters must be recognised by ecclesiastics, who are to judge whether to permit such a form of healing or prohibit it as superstitious and containing some tacit pact with the devil'.89 The danger implicit in 'words and characters' had been outlined by St Thomas Aquinas in the thirteenth century. Aquinas, drawing on St Augustine, held that 'cyphers, words or other vain observances' were not 'conducive to any natural effect'; rather, they worked through the power of the demonic. And man had not been given 'power over the demonic to use it for his own purposes'.90 Distinguishing the meaningless from the potentially demonic, especially when the words were muttered quietly by the healer, was, however, far from easy. Jurisdiction in such matters was never clear. Women performing healing rituals could find themselves denounced before either of the two tribunals, regardless of the actual nature of their cures (never easy to determine in any case, given the mixture of sacred and profane). It was a case of which court was notified of such healers first, since a woman using magical remedies to treat the sick was also most likely doing so without any sort of licence. Physicians and surgeons tended to be the ones who made such accusations before the Protomedicato, fearing illicit competition, perhaps, and because they were most familiar with the tribunal's functions. Those outside the medical community might denounce the same women before the episcopal courts, made wary – by preachers, confessors, and missioners – of the 'superstitious' or diabolical element present in such cures.

That said, there was some popular knowledge of the existence of the protophysician's tribunal and its licensing regime, as well as an awareness of potential conflicts of jurisdiction. In 1594 the Neapolitan wise woman Lucrezia Manara sought to boost her respectability before the archbishop's tribunal by declaring: 'I
would obtain a licence to practise if the physicians wished; but so as not to displease this court I did not try to obtain it."^5

The ‘Arrendamento del Protomedicato’

The nature of the Protomedicato as an office closely linked to the state is reflected in still other ways. In pre-bureaucratic Naples the state was a complex network of overlapping and conflicting interests. There was no separation of powers, no formal and absolute value of law, no separation of offices nor a hierarchical delegation of responsibilities."^6 State intervention in the economy was characterised by the consumption of an income derived from the national debt, the contracting-out of taxes and public offices. Whereas in Rome the various fees and fines paid to the Protomedicato funded College salaries and costs, in Naples the income went directly into the coffers of the Chamber of the Sommaria. The picture one gains of it by studying its activities in the early modern period is a far cry from the idealised description made by the Neapolitan physician and historian Salvatore De Renzi in the late 1820s. Instead of being, ‘throughout the past, the safeguard of the regular progress of the healing arts’,^7 the Protomedicato was in fact but one of many arrendamenti or tax farms, a term derived from the Spanish arrendar, to contract. This was a system by which the tax farmer or contractor, the arrendatore, would offer an anticipated sum of money at public auction based on the annual revenues due to that office. The arrendatore, usually by means of a system of sub-contracts, then undertook the collection of the taxes or duties. The arrendamento of the Protomedicato was set up in 1610, for which the first contractor bid 8,310 ducats, keeping for himself the emoluments derived from the granting of licences and diplomas, the inspection of apothecary shops, and the payment of fines. Earnings remained relatively low during the seventeenth century, under 5,000 ducats a year. In the eighteenth century, however, it became a lucrative source of income for the crown, rising from around 9,000 during the years of Austrian occupation (1707–34), and to between 15,000 and 19,000 during the late 1780s. Although the kingdom’s arrendatori stood often made great fortunes, the Arrendamento del Protomedicato was of relatively minor importance. To keep things in perspective, even the gabelle on playing cards brought in more money, whilst the tobacco arrendamento earned the state over ten times as much. By Santorelli’s time, the contractor or his deputy was part of the visitation team. Inevitably, there were pressures on the substitute protophysiocr and proto-apothecary to earn as much as possible for the accompanying contractor, despite 1622 instructions that they must conduct the visitation as judges alone, without any prejudicial interest whatsoever. By 1741, in a climate of reform which saw Charles III’s government attempt to buy back some of the arrendamenti, there was a complaint that the farming-out of the protophysiocr’s procedure seriously harmed the practice of medicine. The arrendatore’s motivation was purely financial, it was alleged, his only object being the collection of dues and the imposition of fines. His capacity turned him into a ‘ruiner of trades’, issuing diplomas and licences without the required examination, which resulted in the mushrooming of practitioners. Inspections of apothecary shops were carried out only after notice had been given, allowing apothecaries to dispose of inferior goods and borrow good quality ones, so that, especially in the provinces, the visitation became a mere formality. When he attempts to intervene and remedy these ills, the protophysiocr ‘finds the way blocked by the pestiferous cause of the arrendamento.’ The office of protophysiocr existed to ‘promote human health by ensuring the quality and perfection of medicaments and the necessary requisites the practitioners of pharmacy must possess.’ But because it was farmed out to the highest bidder, ‘the complete opposite of what the law has resolved is produced, with deplorable disorder.’ The system had to be regulated by ‘a real policing of commerce’, and not by private interest. All the preceding comments were made by the fiscal reformer Carlo Broggia. Admittedly, as a wholesale grocer himself, he did have his axe to grind. After a run-in with protophysiocr Buonocore over the matter in 1738, he was at least able to vent his spleen in his treatise on economic reform. In any case, his complaints came to nothing; a shortage of money brought the government’s policy of buying back arrendamenti to a halt by mid-century.

Calls for reform became more widespread as the century progressed. Physicians in the provinces advocated the appointment of provincial protophysiocrs, to be based throughout the kingdom. By 1780 even the president of the Royal Academy of Sciences and Letters, the influential Prince of Francavilla, was advocating reform. The Prince recommended that the renters be stripped of ‘the authority to dispense licences to treat both in physic as well as in surgery and obstetrics’. Apothecary shops should be inspected directly by physicians of the crown or the protophysiocr, ‘without the intervention of the contractor, who represents the treasurer, leaving to the renter only the authority to demand the visitation fee, which is six carlisi.’ This would have deprived the contractor of most of his earnings. The records of the arrendamento – virtually all that survives with reference to the office’s activities – contain numerous complaints from apothecaries against the contractors. The current system was even said to lie behind the lack of trade in certain provinces, like Capitanata, along with heavy feudal dues and legal fees. However, nothing was done. The protophysiocr himself, Francesco Serao, was opposed to any change, arguing that the tax collector’s participation was required in order to get things done. What he did not state, but what must have been a factor, was that the arrendamento was then at its most profitable.

Needless to say, the collection of these emoluments could lead to abuses whether it was carried out directly by tax contractors or not. Moreover, from the point of view of licensees, at least, there was precious little difference between their assiduity in collecting fees or merely lining their pockets. In 1639 the protophysiocr of Benevento, Pietro Piperno, was accused of excessive zeal in exercising his office by the city’s barbers. They claimed that his earnestness simply masked his desire for the extra income it brought in. The city council agreed, deciding that the barbers should be inspected only once during the protophysiocr’s three-year term. Elsewhere in Italy, where the office of protophysiocr was not infrequently sold to
the highest (medical) bidder, office-holders were keen to make the most of their acquired position. In the Papal States the cost of the various provincial offices varied according to the province's importance. In Sicily, when the viceroy decreed that the office of consultor protophysician in Palermo would become a lifetime appointment (1743), it had already been sold for some time. The viceroy hoped that it would be sold to the most senior and experienced candidate, at a price not inferior to that paid in the past. Of course, venality was typical of early modern office-holding and should not be regarded as synonymous with corruption. But protophysicians had to recoup the costs of their office, their appointees the costs of their tours of inspection and the Protomedicati and Colleges the salaries they paid. Nobody admitted to corruption in any case. The guilty would either hide the fact by pleading innocence or falsifying entries on balance-sheets or cite extenuating circumstances for their actions, removing any moral culpability. Moreover, abuses seem to have been a functional part of the system, each element of which sought to protect its individual position. This was akin to the strategy of bargaining and negotiation which was a normal feature of criminal cases. According to a physician in Reggio, apothecaries knew that they could always reach some sort of compromise with the visitors when their stock was found to be faulty or incomplete. Apothecaries also routinely claimed exemptions from the visitation duty (which in many cases were genuine, but sometimes not). Others shut their doors and fled upon the protophysician’s approach. Still others petitioned that they had been charged too much. It is the nature of complaints by medical practitioners that they are always plausible, at least as far as the historian is concerned. What are we to make of the legions of midwives who had no idea that licences were required for their profession? Or those who petitioned for exemption, claiming to be, like one Neapolitan midwife, ‘unable and foolish?’

The nineteenth century

As offices so closely linked to the workings of the early modern state, most Protomedicati met their end in the wake of Enlightenment reforms. Thus, in Milan, the reforms of the late eighteenth century sought to replace the autonomous jurisdictions of the Colleges and the Protosfiscalato with a single centralised, accountable and much more powerful bureaucracy, dependent on the state. These were the years of increasing state direction of public health, based on the idea of ‘medical police’, as practised in absolutist states like Austria. In Naples, despite a degree of Enlightenment reform during the reigns of Charles III and Ferdinand IV, under the influence of the prime minister Bernardo Tanucci, the Protomedicato was never reformed into a means of organising medicine and public health. Following repeated calls for financial reform, the office was deprived of its authority to try offenders. This was the only significant change to its functions during the course of the whole of the eighteenth century. Later, under the ‘French’ reforms of Joseph Bonaparte and Joachim Murat in the years 1806–15, the Neapolitan Protomedicato’s fee-collecting activities passed from the Ministry of Finance to the Ministry of the Interior. Rather than decline in importance, its authority actually increased, complemented by the closure of the College of Doctors in 1806. The Protomedicato’s registers now become noticeably more detailed, further evidence that we have now entered the kingdom’s ‘statistical age’ (and a temptation luring the intrepid historian beyond the time-honoured chronological boundaries of ‘early modern’).

The office continued to be filled by the kingdom’s most renowned physician. From 1810 the protophysician was Domenico Cotugno, professor of human anatomy (from 1766), founding member (1780) and later president (1809–17) of the Royal Academy of Sciences and Letters, and rector of the University of Naples (from 1811). If protophysician Pignataro represents an important moment in the struggle between medical ‘ancients’ and ‘moderns’, protophysician Cotugno encapsulates an important shift in the development of modern medicine in Naples. In fact, the work of Cotugno and people like him during the latter part of the eighteenth century laid the groundwork for all the reforms of the ‘French decade’. These included the transfer of degree-conferring powers to the University in 1811, the establishment of the Medico-Surgical College at the Incurabili Hospital, as well as the opening of new clinical university rooms there, and the gradual redefinition of disciplines and the founding of new chairs. Rather than face elimination or decline in importance, the office of protophysician seems to find a place in this new order. New statutes governing its activities were approved in 1823 and the whole office was reformed in 1844, becoming a fully-fledged bureaucratic commission. Like its counterpart in Sicily, it came to an end with the unification of Italy.

NOTES

1 Antonio Santorelli, Il protomedicato napoletano, ovvero dell’autorità di esso (Naples, 1612), pp. 25–6.


3 Giuseppe Maria Galanti, Nuova descrizione storia e geografia delle Sicilie (Naples, 1786–90), vol. i, p. 212.


5 Santorelli, Protomedicato napoletano, p. 3.


7 Giovanni Filippo Ingrassia, Constituzioni, capitola, jurisdictiones, ac pandectae regi protomedicato officii (Palermo, 1657), introduction.


9 Alan Ryder, The kingdom of Naples under Alfonso the Magnanimous: the making of a modern state (Oxford, 1976), p. 79; Miguel Muñoz, Recopilación de las leyes, pragmáticas reales,


12 Santorelli, Protomedicato napoletano, p. 98; Galanti, Nuova descrizione, p. 212.


14 Santorelli was author of. Ante praxis medicina, in quibus, ea omnia, quae praevia medicinae agresseri, praeparare et necessarium summa brevissima examinata (Naples, 1622); Post praxis medicina, seu de medicamento defuncto, liber unus; in qua quinquaginta prudenti e. Christiis medicus debet defuncto praestare, explicatores (Naples, 1629); Disquisita della natura, accidenti e pronostico dell'incendio del monte di Somma dell'anno 1641 (Naples, 1632); and De sanitatis natura lib. xxiv in quibus explicatores quascumque ad partum physiologicam, medicinalis, et sanitae tuae (Naples, 1641).


18 Carlo Pignatari, Peccatum in quo constiterint ea, quae quilibet pharmaceutus in sua officina, in hac urbe Neapoli & Regno, in visitationibus faciendi habere & ostendere debat (Naples, 1684), title page.


20 Santorelli does not mention this regulation, though he may take it for granted. Bottini was Neapolitan protophysician until 1626, when he returned to Messina for health reasons. In 1626 he was made corresponding member to the Royal Society in London, to supply information about the 1691 Messina earthquake. His son, Federico (c.1670-c.1745), served throughout the Spanish world: in addition to offices in Naples and Sicily, he was court physician first in Madrid and then in Lima. Cf. Alvar Martínez Vidal, El nuevo sol de la medicina en la Ciudad de los Reyes: Federico Bottini y la Evidencia de la circulación de la sangre (Lima, 1723) (Saragossa, 1992).

21 Marco Antonio Alaimo, Dizionario . . . intorno alla preservatione del morbo contagioso e mortale che regna al presente in Palerme (Palermo, 1625).


51 Santorelli, Protomedeo napolitano, p. 48.
54 In a letter written to Michele Giustiniani in 1616, reprinted in Salvatore De Renzi, Napoli nell’anno 1656 (Naples, 1867), pp. 372-5.
55 Giovanni Filippo Ingrosia, Informazione del pestifero et contagioso morbo, il quale affligge et haue affitito questa città di Palermo (Palermo, 1576); Ludovico Settala, De peste et pestifera afferita (Milan, 1576) et Preservazione dalla peste (Brescia, 1630).
62 Ibid., p. 41.
65 Parrino, Teatro eretto, p. 43.
69 On public health recommendations, see Antonio Borrelli, ‘Medicina et societá a Napoli nel secondo Settecento’, Archivio storico per le province napoletane, cxxii (1994), pp. 147-54.
70 John Howard, An account of the principal lazaretto in Europe (London, 1791), p. 8. So small was it, he decided, that it did not warrant a plate; he depicted the city’s health office instead. The lazaretto he refers to is not that of San Gennaro, intended for Neapolitans and located to the north of the city, but the pesthouse at Nisida. Located on the coast near Pozzuoli, this small facility was built in 1626 by the viceroy, Antonio Alvarez de Toledo, to quarantine incoming infected ships and their personnel.
71 One of the commissioners appointed was the ‘modern’ Leonardo di Capua, who published his findings in 1681: Paree... divisi in otto ragionamenti, ne’ quali parzialmente.


113 V. Parisi, Capitoli e ordinazioni della felice e fedelissima città di Palermo (Palermo, 1768), pp. 96–98; in Pitré, Medici, p. 164.


115 Arcovito a Galanti, in Placanica, Calatoria, 1792, p. 471.

116 A.S.N., Sommario: Protomedicato, series II, 35: 'castello.'


118 The fate of its stronger Spanish cousin was different. Suppressed in 1799 by royal decree, it was re-established and finally abolished in 1822. Grancil, Istoria general, vol. 4, p. 92.


121 Aurelio Musi, 'Medici e istituzioni a Napoli nell’età moderna', in Frascari, Santità e società, pp. 31–2; Borrelli, 'Medicina e società', 126–8.

122 ‘Regolamento del Protomedicato del 3 giugno 1823’ in P Petiti, Repertorio amministrativo ossia collezione di leggi, decreti reali prescritti (Naples, 1851–59), vol. 1; De Renzi, Topografia, p. 388.
No doubt many apothecaries kept annotated registers of this kind for their own use. The use of the vernacular, while disappointing in a trained apothecary, was not expressly forbidden. However, Gizzi’s booklet also contained numerous medical ‘secrets’: tried and tested remedies which worked in hidden, unknown ways. Their inclusion suggested a reliance on practical remedies not in keeping with the training and preparation required of an apothecary. To the court’s dismay, amongst recipes for curing haemorrhoids, ridding the body of worms and renewing the supply of breast milk in nursing mothers, they found instructions on ‘how to bewitch the night guards’ and ‘how not to be injured.’ These were straightforward magical incantations, ‘little becoming a priest.’

Later records make no mention of an apothecary’s shop in Ortona, so Gizzi’s may have been the only one in 1719. This may explain why his activities were largely tolerated by the townsfolk – disgruntled physician and surgeon aside – despite the fact that he never bothered to obtain a licence. When asked if Gizzi handled drugs himself, witnesses replied matter-of-factly that he had. There is no sense of condemnation in their remarks, nor did this fact ever stop them going to him when they needed medicines. When we finally hear from Gizzi himself, a month later, it is something of an anti-climax. Five years earlier, with his own money, Gizzi had bought the contents of an apothecary’s shop run by the local Franciscans. He had hired a succession of apothecaries to run the shop and it was only in the preceding six months that he had been unable to find a replacement. For this reason he turned to dispensing the medicines himself. And he did little enough of that, he says, ‘since there weren’t many illnesses this winter.’ The incriminating recipe book is harder to explain away. Gizzi recounts that he had copied it from a Pietro on kept by his first apothecary, thinking it might be useful to him, given his lack of experience. However, he insists, he has never made use of it. The court is sceptical, referring to Gizzi’s comments and underlinings at various entries. These were copied out exactly as they appeared in the original, he says. As for the ‘superstitious’ entries and their use, Gizzi replies, ‘I don’t know what to say, I don’t know what it is.” The court is more concerned with the other accusations against him. In the end he is absolved, on condition that he not prepare or dispense medicines of any kind, particularly not purgatives, and that his recipe book remain with the trial records (as it has). He is warned to live with all due modesty, not to engage the help of women under forty-five, nor carry out any secular business, or face the penalties of canon law.

Normally, apothecaries caught practising without a licence or exceeding the bounds of their ‘profession’ by dispensing medicines without a physician’s order came under the protoprophysician’s jurisdiction. As a cleric, however, Gizzi could only be tried by an ecclesiastical court. The denunciation made against him by the physician-cum-archpriest is unusual in the variety of accusations made against him. The case against Gizzi can be seen within the context of the ongoing reform of clerical behaviour that followed the Council of Trent. In a wider sense, it also concerns the bounds put on the way in which one earned one’s living. These codes of practice were more than social niceties; they were enshrined in law. It took a physician’s knowledge of the proper medical hierarchy, combined with a sense of professional...
and personal outrage, to initiate the case against him. It was then bolstered with the more customary accusations (against wayward clerics) of drunkenness and debauchery, as well as evidence of tax collecting.

During the seventeenth and eighteenth centuries the medical authorities made unceasing attempts to keep the various branches of the healing arts separate. The ecclesiastical authorities also played their part, whether it was licensing midwives, prosecuting cunning folk or disciplining errant clerics. Both sought to enforce what they saw as a divinely ordained hierarchy and order. The previous chapter explored this from the point of view of the protophysicians responsible for licensing and supervising practitioners. But what about the practitioners themselves? What was it about their activities and the demands of the sick that made licensing necessary? This chapter will explore the practitioners: how they trained, practised and fit into the pluralistic therapeutic network. And it will emphasise that what the medical authorities sought to separate, actual practice and behaviour frequently confused and transgressed.

Physicians and the medical hierarchy

The seventeenth century witnessed a tightening-up of the limits of authority into which the art had divided itself. The intention was to prevent the chaotic number of conflicts between physicians, surgeons and apothecaries. Medical authority defended and developed the specific place of each, whilst respecting a sacrosanct professional hierarchy. Technical capacity was linked to a corresponding politico-moral responsibility. The writers of medical treatises stressed the hierarchical divisions, the boundaries, which separated medicine. The occupational limits and the provinces of each part were regarded as part of a divine order which regulated the Christian community. Medicine was a noble art, because its practice was compatible with nobility, as enshrined in the doctorate. But it depended on two mechanical arts in order to function. At the bedside of the patient, in consultations and prescriptions, physicians wrote in Latin and gave orders, which were carried out by their lesser colleagues, the surgeons and apothecaries. Physicians were specialists of internal medicine, but avoided all manual activities. There was a tendency for physicians to define themselves in terms of what they were not and what they did not do. They were not apothecaries or surgeons, whose art was mechanical and whose knowledge was acquired by apprenticeship or, in the case of some surgeons, training at hospitals. Their titles reinforced this distinction. In Naples, Latin documents referred to physicians, along with lawyers and small landowners, by the honorific magnificus dominus, while surgeons and apothecaries, along with architects, engineers and notaries, were given that of egregius or nobilis (though the latter was by no means an indication of nobility). In Tuscan documents a physician’s name was always preceded by the title ser or messer, whereas surgeons were simply designated as maestri. And physicians were most certainly not empirics, though the public may not always have been aware of the distinction. For the Neapolitan protophysician and professor of practical medicine Antonio Santorelli, the difference was between those who possessed scientia – knowledge acquired at university and recognised in

the doctorate – and those who did not. At the same time Santorelli recognised that physicians did not always comport themselves with the necessary decorum. He singled out one who occupied a ‘good place’ in the profession despite gambling in public, with all the good graces of ‘a thug or blustering soldier.’

The itinerant practitioner, apothecary or barber-surgeon who suggested treatments for internal diseases, despite knowing little or nothing about the body’s composition, its humours and temperaments, was seen not only to violate the technical confines of the medical corporation, but to threaten the order of the whole. As Scipione Mercurio wrote in 1603: ‘therefore, by treating people, they are presumptuous and arrogant, as they are not ashamed to practise so important an art and disregard and do not care that they are losing their souls, since every time they do it they commit a mortal sin.’ Alas, he remarked, ‘every mealy surgeon [cinghietto], every little barber [barbemazzza], every old woman wants to play the doctor.’ His denunciation even included exorcists, who administered powerful purgatives to the possessed. It was an offence even to appear to be a physician, by dressing in the robes which identified his status in society and separated him from the mass of healers. Each occupation had its recognised apparel. The physician’s gown was lined with dark fur, he wore a velvet cap, black gloves and a large gold ring, and his horse had gilded stirrups and was draped with a blanket known as a valdtrappa (figure 3).

Figure 3 Physician on horseback and apothecary, frontispiece to Giulio Cesare Croce’s Secreti di medicina (Bologna, 1635)
outlining its activities and jurisdictions. Much space was devoted to how apothecaries were to be inspected by him, followed by the ‘Petentoro Napolitano’, an official pharmacopoeia which listed the drugs to be stocked by apothecaries. In 1668 he ordered how ‘the Eight’ were to be chosen and the selection of those who were to carry out inspections alongside him was to be carried out. A similar centralisation of power in the hands of the protophysician took place in Palermo.

In Bologna the development was even more pronounced. Here the Protomedicato was a part of the city’s Medical College, itself one-half of the Collegio degli Artisti (the other half being the lawyers). In 1560 the Medical College was awarded powers of inspection, and by the end of the century the apothecaries’ guild had lost its authority to license apothecaries to the College. Furthermore, as noted in chapter two, the Protomedicati of Naples, Rome and Bologna were given the authority over civil cases, that is, disputes between healers and practitioners. Previously this power had belonged to ordinary magistrates. In practice, however, such cases continued to be heard in ordinary courts as well, such as the provincial Udienze of the kingdom of Naples and the governor’s tribunal in Rome.

Indicative of the rise of the Medical Colleges in general was the foundation of the Florentine College in 1560 by the Tuscan grand-duke. It supplemented the old Guild of Physicians and Apothecaries, considered outdated because it united occupations which were considered separate and subject to hierarchical distinctions. The new College consisted of twelve physicians, membership being renewed by co-optation. Membership was the crowning achievement in a physician’s career, bestowing both power and prestige. The College examined new physicians and surgeons, licensing them to practise, and eventually extended its activities to all aspects of the medical profession. Its jurisdiction included the territories of the Fiorentino and the Pisano, even though Pisa had its own College of Physicians, associated with the university there. So the university’s graduates now had to be examined and licensed by the Florentine College, even if they intended to practise in Pisa.

The creation of the Florentine College was in fact reflective of profound social change, as Carlo Cipolla has pointed out. Physicians were assimilated into the upper class, for theirs was a noble, learned calling. Surgeons managed to tag along, where they had a medical doctorate — something possible at Italian universities. Barbers and apothecaries, however, were ranked with the lower orders, for their occupation was mechanical in nature. The latter groups retained their guilds, and sometimes even limited degrees of power over their members. This was true, for instance, of the barber-surgeons’ and apothecaries’ guilds within the limits of the city of Naples. Guilds had the power to fine their members for misdeemansours resulting from ‘weakness, carelessness or negligence’. Most importantly, they saw to the welfare of their members and their families, which included the funding of beds in local hospitals on the members’ behalf. The guilds had an open matricula — whoever had the necessary skills was eligible for guild membership — the intention being to eliminate competition from outside. In the case of apothecaries, this extended even to those who were not Neapolitan citizens, the determining factors being residence
and active practice in the city rather than citizenship per se. Even though there was an internal hierarchy of positions, all members could become masters, and all masters could be elected to the higher positions (consuls or priors), according to the general rules of promotion. The system was competitive, encouraging emulation and promoting members on the basis of merit.25

The Medical Colleges, on the other hand, had a numerus clausus of ordinary and supernumerary positions, and membership depended on criteria of birth and social status. There were essentially two types of Medical College: those associated with the universities, which had a monopoly over the granting of doctorates, and, less powerful, those associated with certain cities, which had jurisdiction over who practised in the city and its immediate territory (contado). In theory, degrees conferred by the university Medical Colleges were valid without territorial limitations, following medieval tradition. However, both types of College seem to have fought against this, claiming at least the authority to license physicians with doctorates from other states. The city or territorial Colleges were the most rigorous in this regard. Some sought to exclude foreign doctors from practising in the area under their jurisdiction. This included doctors from other states and cities, or even from different provinces of the same state, and natives of the surrounding countryside.

However, in large cities the few privileged members of a College could not and did not pretend to achieve a monopoly over the profession. In Milan, for example, where the College was open only to the local patriciate, College members were far outnumbered by the bourgeois physicians they had recognised. What resulted was something of a balancing act. On the one hand, opening up the membership requirements too much, to the point of resembling an open matriculation guild, represented a loss of prestige. On the other hand, keeping the requirements too strict, vis-à-vis the average social status of aspiring practitioners, meant that members were overwhelmed by non-members, with a resulting loss of superiority. By the middle of the thirteenth century the noble physicians of Milan were forced to establish a new College rank of non-nobles attached to the College and allowed to practise alongside them.27 The Bolognese College, for its part, was open only to Bolognese citizens, but the College reserved the right to make honorary exceptions. The number of College members fluctuated (as high as twenty-three), but did not keep pace with the rapidly expanding number of physicians in the city. Whereas at the beginning of the thirteenth century College members represented thirty per cent of physicians, by the century's end they represented only seventeen per cent.28 This inevitably meant a high representation for members of certain families within the College and the creation of family dynasties of physicians, a feature of College life that became even more pronounced during the eighteenth century. The Bologna College is nevertheless striking for its relative openness. Of the eighty-four physicians admitted between 1393 and 1662, sixteen had artisan fathers (including a handful of apothecaries and barber-surgeons), twelve were the sons of gentilhomini, twelve the sons of merchants, ten the sons of physicians who were College members and four the sons of physicians who were not College members.29

The Naples College, rather than close its ranks to non-Napolitans, granted Neapolitan citizenship to its members. More open still was the College in Salerno. Like its counterparts elsewhere in Italy it was typical in its defence of professional privilege, its adoption of the mechanism of co-optation, the disputes with the city and in the localistic criterion employed in the awarding of positions. But it was exceptional on two counts. First, it accepted all local graduate physicians as eventual members, as the limited places (ten in all) became available. Second, the positions within the College hierarchy were distributed on the basis of seniority, making it a gerontocracy.30 Despite the decline of the School of Salerno during the early modern period and the claims of the Neapolitan Proto medicato, the Salernitans College of Doctors maintained the right to license local apothecaries, as well as authority over its medical degrees, until its closure in 1810–11. Even towards the end of its existence the College was still issuing large numbers of medical degrees every year, to students from all over the kingdom. Doctoral registers for the eighteenth century suggest that close to a third of students came from the two Principato provinces - no surprise, given their proximity. The rest came from other provinces throughout the kingdom, more or less in keeping with their respective populations.

A few even came from Sicily.31 The fact that Salerno did not require matriculation no doubt helps account for its continued numerical success. It had long been common practice for students to take their degree at Salerno after having initiated their studies at Naples, saving themselves a few years in the process. One who did so was Marco Aurelio Severino.32

The power of the Colleges in early modern Italy had a number of important effects on the practice of medicine. The territorial Colleges of smaller cities, like Pavia, sought to deny the right to practise to any but its own members. These limitations eventually extended to those lacking the noble or 'civil' requisites introduced into the College statutes. The Colleges sought to enforce the perceived nobility of the medical profession. Several denied access to physicians from merchant and artisan families. The Milanese College, for example, was open only to the local patriciate, as we have seen. The Pavia College went so far as to obtain a privilege from the emperor in 1607, by which all College physicians became 'Counts Palatine' upon their co-optation.33 In effect, the Colleges codified social inequality. They reserved for their own members control over examinations and licensing, as well as positions of prestige in the state bureaucracy. Most College members did not even practise medicine, in keeping with their patriciate status; they left that to those physicians ineligible for College membership. The dominance of the Colleges affected the nature of examinations and the awarding of degrees, which shifted from being a check of merit to proceedings aimed at ascertaining the requisites of birth. For those ineligible for College membership, the degree declined in value because it could not pave the way to collegiate access.34 And because the Colleges often shared their hierarchies with those of university medical faculties, this effectively disqualified many physicians from university careers. The closed nature of the Colleges and their degree-granting authority often led to medical dynasties, as mentioned above. In Naples the very successful might look to
an even more prestigious profession for their sons: the law. Occasionally, they bought their way into the nobility.38

‘Ancients’ and ‘moderns’

The power of the Colleges also affected the way new ideas and theories were received. Most notably, the Colleges were the focus of battles between the medical ‘ancients’ (dedicated to upholding the classical medical corpus) and the ‘moderns.’ As physicians, the latter group wanted to be defined, not by birth or seniority, but by their studies, knowledge and publications. Symptomatic of this hidebound system was the reliance of professors of medicine on substitutes for the menial task of giving lectures.

Throughout Italy academic salaries declined during the seventeenth century and were often paid in arrears. As a result, many of the best lecturers accepted well-paying positions outside the university or offered private lessons to paying students, entrusting their university lectures to substitutes.39 Moreover, the dominance of Medical Colleges meant that students would choose to study under a College member in order to increase their chances of eventually gaining access. In Naples this also meant serving as an assistant, or pratice, for a number of years. The clear separation between the Colleges, with their degree-granting and licensing authority, and the university, meant that students could obtain their doctorates by merely matriculating, without attending lectures at the university. Indeed the Neapolitan College only lost its degree-granting power to the university in 1811. The publicly granted doctorate, based on mnemonic formulas of medieval origin, became a mere preparation or prerequisite for enrolment and further training within a Medical College, for those who were eligible, or with a recognised professor for those who were not.37

In Naples, the university had been founded by royal will and lecturers were still appointed by the sovereign. The head of the university, the chaplain mayor, was not a scholar, but a state functionary, and university affairs were controlled by the government.39 The chaplain mayor, in fact, set the curriculum for the teaching of medicine, traditional in nature. The Spanish authorities had sought to turn the Studio into the true academy of the kingdom, by means of legislation and by increasing the number of chairs. But private instruction continued to expand despite this, in addition to the ever-present alternative of the School at Salerno, which did not require attendance. The 1616 pragmatic resulting from the viceregal university reforms defined ‘substitutes’ as those who filled in for lecturers when the latter were ill or otherwise unable to come; they were not to be used as replacements. Except during vacations, no lecturers were to give lectures ‘in their own private houses, nor in any other place ... so that all [students] attend the university, where, in public, they will hear sound and healthy learning.’ A fine of one hundred ducats was imposed for a first offence; for a second offence, the lecturer was to be fined two hundred ducats ‘and relegated for three years to the Island of Capri.’39

Such was the widespread nature of the custom that private houses were no longer spacious enough. In 1621 the government ordered that private lectures were not to be given in churches, chapels or other religious institutions, or in the cloisters of these buildings.40 In 1663 strict orders against both teachers and students were posted by the chaplain major. Some arrests resulted, occasionally involving lecturers and their students sitting at regular rows of desks, taking notes. Thus in 1669 Giovan Battista Coraggio, lecturing on medicine, while caught in flagrante jumped from a window and hid in a nearby church, while the guards arrested the students and sequestered the desks.41 But the few arrests could not stem the practice. In 1680 the chaplain major complained that more than half the university attended private lectures, some of which had as many as two hundred students, with the lecturers earning as much as three hundred ducats a month.42 If this was true, the highest paid lecturer could earn as much in two months as he could earn in one year from his university chair.43

The plague of private lessons continued well into the nineteenth century, when it was denounced by Domenico Pignatari.44 It was a symptom of the precarious state of the university, moved from its own edifice (the Palazzo degli Studi) to the monastery of San Domenico Maggiore in the seventeenth century, and back again in 1736, and thence to the Jesuit mother house in 1777, following the expulsion of the Society of Jesus from the kingdom. By this time the reformed medical faculty was kept separate, housed at the Incurabili Hospital. Meanwhile, the Palazzo degli Studi was used for the newly founded Royal Academy of Sciences and Letters. The Academy itself was merely the latest in a long line of such institutions which sought to fill the gaps left by an impoverished university structure. Its immediate predecessor had been Celestino Ghali’s Academy of Sciences, set up in 1732. Ghali was chaplain major at the time, and rather than directing his energies to reforming the university, he nominated two famous university physicians to important posts: Niccolò Cirillo as president and Francesco Serao as secretary of the Academy.

In the mid-seventeenth century the new academies had offered a challenge to the stagnant university-college system, offering scope for scientific and experimental investigation. Then the medical ancients had the advantage: they occupied all the important chairs and could make use of mechanisms like censorship and the Inquisition to defend their cause. The moderns were dependent on private means or the chance support of a liberal patron. Organising themselves into academies was one solution, but this required even more powerful patronage in order to withstand attack.45 In Naples the moderns Tommaso Cornelio and Leonardo di Capua founded the Accademia degli Investiganti in 1663. It was under the patronage of Andrea Concublet, the Marquis of Arena, at whose palace they met. They advocated the teaching of chemistry, which was not then part of the university medical curriculum, and so they gave private lectures. The old plague of private lectures now assumed a new urgency, and Carlo Pignatari forbade them. As royal proto-physician and holder of the primary chair in medicine, he was already a force to be reckoned with. And he was a traditionalist. He had copies of Sebastiano Bartoli’s Astronomiae microcosmicae systema novum destroyed, after one of the city’s ecclesiastical authorities had declared Bartoli’s medical system blasphemous – despite the fact
that the book had received the Neapolitan civil and ecclesiastical imprimatur.\textsuperscript{46} That same year, 1665, an epidemic of 'malign' fevers, accompanied by skin eruptions and high mortality, had broken out around Lake Agnano, near Naples. Following the protophysician's lead, the ancients had ascribed the epidemic to heavy rains, which had prevented the removal of the hemp and flax reeded in the lake. The resulting corruption of the air had caused the epidemic. The moderns wanted further studies made, but Pignataro simply forbade the reeding of flax in the lake for one year.

It may be, however, that this hasty decision and Pignataro's subsequent tenacity were motivated more by a desire to inconvenience the Jesuits, who owned the land surrounding the lake, collecting a thousand ducats every year from it. The Jesuits of Naples had been wont to call for Pignataro whenever they needed treatment. But after the death of the previous viceroy's younger son under Pignataro's care, and the viceroy's request to have worthy physicians sent in from the provinces, the Jesuits now called in the physician who had been sent up from Calabria, Diego Ragusa. To make matters worse, Ragusa sided with the moderns in the Lake Agnano dispute. In the pamphlet that ensued, Pignataro's party identified the Investiganti as a stronghold of opposition and a source of satire against the protophysician, who was nicknamed 'Jew-beard', referring to the beards, old-fashioned costumes and affected dignity of the orthodox physicians.\textsuperscript{47} The heat seemed to symbolise all that the moderns disliked about the ancients. In one passage Bartoli remarked that the Galenic physicians, 'with long beards and religious hypocrisy ingrate themselves with princes, gentlewomen, masters of ceremonies, prelates and similar important people, to whom they give medical service gratis, with the hope of later multiplying their gain.'\textsuperscript{48}

The moderns did manage some successes before their ultimate 'defeat' of the ancients by the mid-eighteenth century. In 1665, two years after the suppression of his Systema novum, Sebastiano Bartoli became physician to the new viceroy, Pedro Antonio d'Aragona. Bartoli had just saved the life of the head of one of the kingdom's most powerful aristocratic clans, Domenico Caracciolo, the Marquis of Brienza; after orthodox treatment had failed. Three years later Bartoli was appointed to the chair of anatomy and surgery at the university, one of the first moderns to gain a university position. He may also have contributed to an interruption in Pignataro's career as royal protophysician. In 1665, in fact, d'Aragona appointed Pignataro's rival Diego Ragusa to the post, which he held until 1673.

However, though Pignataro was no longer protophysician, he retained enough influence to have Bartoli's second version of his book—a 'examination of the commonly received dogmas of the art of medicine'\textsuperscript{49}—put on the Index and burned. Pignataro also set up the Accademia dei Discordanti to rival that of the Investiganti. Luca Tozzi was its head. Tozzi became a respected champion of the ancients, dying in 1717, after having been appointed to the chair of medical theory in 1695, and protophysician for three years in 1696. He was a thorn in the side of university reformers because he had his lectures read by an unpaid substitute whilst he went 'daily about the city, doing his rounds and other business.'\textsuperscript{50} The sessions
A large number of physicians would have been concentrated in the capital, as was true in all the Italian states at this time. The presence of power structures, from the university to the court, meant that state capitals attracted disproportionate numbers of physicians. The fame of Bologna as a centre of learning meant that there were sixty-three licensed physicians in 1659, for a population of just over sixty thousand.\(^3\) And Rome, as both a religious and secular capital, had 140 physicians for its one hundred and twenty thousand inhabitants in 1656.\(^4\) Exact numbers for Naples are lacking, since the Promedicato had no authority over graduate practitioners until the Napoleonic reforms. But during the plague of 1656 the city’s health officials, the Deputati della Salute, rounded up fifty-three physicians to serve the city’s twenty-nine districts (attini), a figure that probably represents only a small fraction of the physicians then resident in the city. It also appointed one physician-surgeon, fifty-four surgeons and sixty-seven barbers.\(^5\) Appointed practitioners were assigned to specific areas in their attina. They were not to refuse treatment to any sick person, especially when requested by the deputies of the attine, and they were to wear a cross of red cloth of at least palm’s length pinned to their chests so they could be recognised. In the same year, by way of comparison, the Roman Congregazione della Sanità appointed sixteen physicians – out of the 140 theoretically available – for its fourteen rioni.\(^6\) In the years following the plague Camillo Tufini’s unpublished ‘anatomical description’ of Naples numbered the practitioners at only sixty-six. And this figure included physicians, surgeons and apothecaries. In addition to this there were 261 barbers and 106 grocers (many of the latter sold medicinal ingredients).\(^7\) Physicians were fairly evenly spread throughout the city, though new arrivals tended to settle in northern areas, where the noble palaces and religious institutions were concentrated. Barbers, on the other hand, in accordance with their status as tradesmen, tended to gravitate southwards to the commercial heart of the city, which included the port and the main market.\(^8\)

As for the kingdom as a whole, there were between two thousand and three thousand physicians, spread more or less according to relative population densities, as we saw in chapter one. The vast majority of graduate doctors would have returned to their places of origin, with the exception of those who sought to make a life for themselves in the capital. We may take with a pinch of salt the polemical comments of Domenico Pignataro, for whom the best of the kingdom’s physicians remained in the capital (‘where they are able to pursue with greater convenience a glorious career in the natural sciences’), while the worst (‘the layabouts, the sluggards, the medical charlatans’) returned to the provinces.\(^9\) After all, the kingdom’s typical physician was not the College doctor in Naples, but the practitioner based in a small provincial town. He would have obtained his doctorate at either Salerno or Naples. Physic would have made up only a portion of his overall income – perhaps as well, since a provincial practice would have provided a meagre income. Other sources included land ownership, financial investments and commerce. He would have considered himself a member of the town’s elite and might have harboured a desire to join the local aristocracy (or at least enable his children to do so). We are a long way from the modern full-time professional.

Whatever Pignataro might say about competence (impossible to ascertain in any case), there was certainly no lack of physicians outside the capital – whether this is based on anecdotal references, culled from a variety of accounts, for earlier centuries, or based on the Promedicato lists for later ones. Indeed, if the Promedicato numbers hold any surprises, it is the relatively small number of physicians who chose to remain in the capital, despite its undoubted attractions, professional and otherwise. While Naples could claim ten per cent of the kingdom’s population, it could only attract 5.7 per cent of its physicians. Put another way, Naples had four physicians for every ten thousand people. Although this was higher than ratios for either Paris or London, cities of comparable size, the rest of the kingdom fared much better. Towns one-hundredth Naples’ size could expect a ratio of at least eight for every ten thousand. In fact towns of under two thousand inhabitants were, proportionately, the best served, averaging in the region of ten physicians for every ten thousand people.

By way of comparison, in the part of the Tuscan Grand Duchy studied by Cipolla, twenty-three physicians – out of the fifty-two whose birthplaces could be determined – practised in the small centres where they were born. Another fourteen practised in communities within thirty kilometres of their birthplace. Of those practising in the larger towns of Pisa, Pistoia and Arezzo, nineteen of the twenty physicians whose birthplaces could be determined practised in their native city.\(^5\) Given the forms of clientelism then available upon which a physician might build a career, this model probably holds throughout the peninsula. Where possible, graduate physicians took up some sort of permanent engagement (obbligo fermo) as a basis for private practice. This consisted of a contract to serve a person or community of people – a household, hospital or religious community – in return for steady remuneration. Many served the last group: it was not unusual for one-third to one-half of physicians to be retained by convents and monasteries.\(^6\) Salaries varied according to experience, reputation and, occasionally, time spent serving the institution. The sums involved were not large, but then practitioners could pursue private practice at the same time (just as individual friars might elect to be treated by outside practitioners). In what seems to have been a typical case, the salary of physician Domenico Pisciotta was raised from twelve ducats to fifteen in 1735 by the friars of San Domenico Maggiore in Naples. In 1743 he received a bonus of three ducats ‘for his extraordinary efforts’ and in 1746 his salary was increased to twenty ducats. At Easter, Christmas and on the feast of St Dominic physicians and surgeons at the monastery would be offered gifts. Those with long service might even receive a small pension when they retired.\(^7\) The example is Neapolitan, but similar possibilities existed throughout the kingdom.

Aspiring physicians could also seek to develop links with local noble families as a way of ensuring future employment on their return. Whether they chose the law or medicine often depended on circumstances. Patricians with a medical doctorate might, however, view actual practice with distaste, especially if that meant depending on the income derived from it. All of these aspects are reflected in the words of Nicola Gallo, a patrician physician in Bisignano (Calabria Citeriore), about his own
experiences. He began by studying law, before turning to medicine, obtaining his doctorate in 1708 from the School of Salerno.

I have practised this profession since then, more to assist in the illnesses of their lordships the prince and princess [Sanseverino of Buignano] and their children when necessary, than to derive income from the profession, given that I have only gone to [treat] other sick people for the sake of convenience or charity.68

In addition to being the household’s physician – Gallo made clear – he was also the prince’s private secretary, lieutenant-general, vicar-general and procurator-general, as well as vice-prince. Many other graduate doctors from well-off families returned from university to a life of relative ease in the provinces, with no intention of practising. Some came from the professional ranks of the civil, families which tended to invest in land. When the last medical graduate of the School of Salerno, Oronero Croce, returned to the small Abruzzese town of Montenerodomo, he turned his hand to administering the family’s lands, and later became the town’s mayor.69 Whether they followed outside interests in order to boost their status or because of financial need, it left them open to the criticism that they were putting the sick in jeopardy through lack of experience. In 1811 Giuseppe Giosi wrote in response to the kingdom’s statistical survey that ‘the meagreness of their fees and the need to involve themselves in other business in order to survive, the responsibilities they take on, especially that of mayor, and other similar reasons, mean that they neglect their studies’.70

Rather than too few provincial physicians, there were too many. There were not enough well-heeled patients to go around. Some, especially young physicians, turned to the public sector for a steady income, small though it undoubtedly was. They served as a community physician (medico condotto). The arrangement whereby a community hired a doctor to look after its medical needs had its roots in ancient Rome and was revived during the thirteenth century.71 Towns and villages took the decision to hire a community physician very seriously. Though it represented an expensive undertaking for the town budget, it was deemed necessary in order to ensure medical provision. Mercurio remarked that smaller communities (castelli e terre) were so rigorous in ensuring their selection of a proper and upstanding physician as their condotto that it was ‘as if he was being promoted to an episcopate’.72 Nevertheless this arrangement ensured a high medical provision throughout Italy, rural areas included. The model for this has been Cipolla’s study of parts of Tuscany, where just over half of the physicians in rural areas were found to be on the public payroll as condotti in 1630.73 But it was as true for the Sicilian countryside, where small towns hoped that physicians would build up a sufficient clientele to be able to remain after their contracts expired, as it was for the Pisan countryside, where eleven community physicians practised in an area with a population of forty thousand.74

In the kingdom of Naples towns were free to offer special conditions, such as tax exemption, to attract physicians and surgeons. In 1602 the town of Bari offered a ‘most worthy’ Milanese physician-surgeon twenty ducats towards his rent, raised by another twelve the following year.75 Furthermore, the Bari situation suggests that for some towns at least the salarising of public physicians was a matter of administrative routine. Bari had a physician on the public payroll from at least the early sixteenth century, and four or five serving concurrently throughout the seventeenth century. But it remained a contentious issue. The Bari town council narrowly approved the salarising of five public physicians in 1605. Salaries were to range from 300 to 120 ducats a year, based on the physician’s age and experience. This amounted to a total annual expenditure of 1,770 ducats. The decision was rushed through, the matter having been deemed most urgent, ‘since the city is large and needs not only the said medics, but others too’.76 The town authorities also encouraged physicians to remain on the public payroll by giving them occasional raises, one-off payments in recognition of extra labours and a small pension when they retired from service. Occasionally, physicians were able to negotiate a pay-rise by threatening to quit unless they were paid more. But the town’s annual expenditure remained more or less the same, in the 900–1,200 range. This meant that when one physician retired during the course of the year his salary would be divided up amongst the remaining physicians. Besides making for straightforward accounts, it may have been a recognition that there would be more work for the remaining physicians to do.

Much research remains to be done for Naples before a even a tentative picture can emerge, since the Protomedicati lists for the 1780s and 1809–10 do not distinguish condotti. During the seventeenth and eighteenth centuries there was no national policy in this regard and the decision, as well as the cost, was left up to the individual towns. Only in 1816 was an attempt made to ensure more systematic provision. In that year a law was passed requiring every town in the kingdom to have both a community physician and surgeon, who would have the status of civil servants.77 This is not to say that towns had not been doing their best to attract and employ such people; but information is patchy. For example, we know that small, hilltop towns like Atena and Brienza (Principato Citeriore) were, according to baronial assessments of the time, able to attract physicians to serve their communities.78 And in the 1590s the municipal officials of the town of Trani (Terra di Bari), despite a deficit, salaried two community physicians and one community surgeon.79

The 1811 statistical survey of the kingdom does offer some precise, though selective, information about the presence of town physicians and surgeons. Of the eighty-one communities listed in the Basilicata report, twenty-four are listed as having a town physician or surgeon. In Molise, 28 communities out of 140 hired a medical practitioner, while in Capitanata and Abruzzo Ulteriore we are only told that ‘most communities’ did so. Finally, in Calabria Citeriore, out of 272 physicians, 38 were condotti.80 The figures are only partial and are presented in a variety of ways, which only seems to reinforce the haphazard nature of the service. Towns could have several condotti one year and none the next. On the plus side, many towns are recorded in the survey as paying doctors’ fees on behalf of the poor on a case-by-case basis, without going to the trouble of offering a physician a regular contract. The impression the reader derives from these provincial reports is of an institution
on the wane. The compiler for Calabria Ulteriore, the physician Giuseppe Grio, remarked that 'very few towns have maintained the longstanding custom of keeping community physicians', despite recent attempts made to revive the arrangement. Instead, individual families resorted to the practice of agreeing a price with a local physician for a year's treatment, when they could afford to. Even with the best will in the world, small, isolated communities found it difficult to attract outsiders, when there were no locals to meet the demand. They could not afford to be too fussy. The lack of surviving Protomedicati trial records for the kingdom of Naples necessitates a brief trip north, to the Papal States (although the practitioner involved is Calabrian). Disputes between communities and their physician brought before the Rome Protomedicato show that the local elites could be unsatisfied. The presence for the disputes is often the fact that the physician was unchristened or lacked similar recognition from the collegiate authorities. Many condotti were taken on without the requisite collegiate recognition and documentation, for it meant a trip to Rome and the payment of a fee. It was only if and when things started to go wrong that this lack of College matriculation became a useful tool for redress. The complaint was generally made in the name or on behalf of 'the poor of the community'. An unsigned petition from the town of Castel Bellino (near Jesi in the Marches of the Papal States) noted that its physician 'makes use of secrets in treating people, and not prescriptions, since he cannot speak Latin.' In this way 'the poor of the town' discovered that he had no matriculation. They wanted him removed, since 'it is better to live without any physician at all, then under one who knows not how to read or write.' The accused physician, Giuseppe Umili of Paola (Calabria Citeriore), wrote to the Roman protoprophysician in his defence that he had a 'doctoral privilege' from Duke Sforza; so that he did not think he needed to matriculate. He added that 'this sort of rigour is not applied in the kingdom of Naples.' Was this true, or simply an attempt at self-justification? In any case, the town's governor came to Umili's defence. He advised the protophysician, the anatomist Giovanni Maria Lancisi, that he felt unable to suspend Umili, 'so as not to give the poor man this humiliation, and even more so as not to deprive him of his income, of which he has great need; moreover, regarding him and his way of treating people, I have had no complaint, but, rather, I have heard some praise given.' The protophysician ordered Umili to come to Rome to be examined and matriculated. Umili made various excuses, citing the foul air in the town which was causing many people to fall sick. The protophysician then ordered the governor to suspend Umili and fine him twenty-five ducats, only to be informed by the governor that Umili had fled and no one knew anything of his whereabouts.

The hiring of community physicians was not restricted to small towns, as we have seen with regard to Bari. In Naples the urban territory was divided into twenty-nine districts, or osine, each of which had a physician salaried by the city. Their duties were to treat the poor and distribute medicines free of charge. In order to qualify, paupers were issued with a certificate by the Maestri della Carità. The authority for each decision belonged ultimately to the Tribunal of San Lorenzo.

MEDICAL PRACTITIONERS AND MEDICAL PRACTICE

Even if there was a golden age when a majority of the kingdom's communities had their own salaried practitioners, we must ask whom the condotti served. Contracts varied from place to place and through time, but they usually stipulated that the physician (or surgeon) was to reside in the community and treat the poor gratis. In the case of Bari, physicians had to obtain permission from the syndics before absenting themselves from town. The community's size and wealth would also affect the conditions and salary. In Basilicata some contracts bound the town physicians 'to treat every class of person', others referred only to 'the poor', still others 'the indigent.' In Sicily, by way of comparison, condotti might receive 150 soldi a year for their services, and were sometimes permitted to charge well-off patients additional fees by the day. In the Pisan countryside, the larger centres might offer the physician a higher, all-inclusive salary, obliging him to treat everyone gratis, while the smaller centres might offer a lower salary, which the physician could then top up by charging the rich for his services.

The decision to salary a community physician was justified with reference to necessary charity for the community's needy poor. Yet it is unlikely that the condotti had much to do with the poor. First of all, in cultural terms, the physician was attached to the local well-to-do. They would have been the ones to request his services most often. They shared the same general outlook regarding medical practice, based around the divine ordering of society. A conservative, corporate solidarity was at work. As for the rest of society, there were cultural barriers, however permeable, which favoured the choice of a traditional, popular, easily available form of treatment over a merely accessible learned one. If the elites might have recourse to irregular or improvised practitioners only out of dire necessity or as a last resort, the rest of the population had no such qualms. As late as 1811 it was said that 'the people in [the province of] Molise, as elsewhere, are more prone to believe and obey the herbalist than the physician; they throw themselves into the arms of the charlatan, the cunning man and the astrologer-shepherd for diseases that they believe incurable, and which then become so in fact.' And there was another factor at work. Most people would have been unable to afford the remedies the physician prescribed, even if the visit itself came free of charge and even if 'inferior' remedies were recommended for the more rustic constitutions of the poor. A constant refrain of the 1811 survey was that the poor may have had the 'assistance' of a physician but they were on their own when it came to medicines. Testimony to this, and one possible solution, comes from an unexpected source: the canonisation processes. To counter the problem of expensive remedies, the bishop of Bovino (Capitanata), Antonio Lucci, set up a mone for the sick poor of the town in 1730. According to devotees, the bishop gave a sum of money in trust to a local merchant. This was made available to the sick on the basis of ciths signed by the town's physicians, corresponding to the cost of the medicines required. Such was the exceptional nature of this charity that the bishop,
amongst other factors, was regarded as saintly. Many forms of treatment advocated and practised at the time were simply the reach of the vast majority of the population. One of the treatments of which Bishop Lucci willingly bore the expense was that judged necessary for a peasant ‘tormented by acute fever with inflammation of the viscera.’ The disease was ‘very dangerous and almost incurable’, in the words of one of the town’s physicians. The treatment was a luxury; it consisted of slaughtering a series of goats, the steaming entrails of which were to be applied to the sufferer’s stomach. As the entrails of the first goat cooled, they were to be replaced by the entrails of a freshly slaughtered goat, and so on. ‘Ten or twelve goats were killed’, according to the physician, and ‘within the space of three days the sick man got better.’

Surgical divisions

Towns that could not afford both a community physician and a community barber-surgeon might request that the physician practise surgery too, offering him a slightly higher salary. But physicians were rarely willing to lower themselves. It was generally easier to hire a community barber-surgeon. They were paid substantially less than their physician counterparts, as beffited their inferior status. The community physician’s salary could be as much as four to five times higher than that of the barber-surgeon’s. His contractual arrangement was similar to that of the physician, though there are cases of the role being passed from father to son, with the town’s approval (something that does not seem to have happened with community physicians). The barber, bloodletter or phlebotomist was the most common sort of medical practitioner. He really came into his own in towns of fewer than 1,000 inhabitants. Towns of 1,000 people or more would usually have at least one of each type of medical practitioner, from physician to midwife, as outlined in chapter one. But the kingdom’s very numerous smaller communities would often have only their barber to turn to. He played an important role in the everyday management of health, such as seasonal bloodletting (figure 4). Moreover, his administrations accompanied all forms of physic. Finally, the barber’s services were much more accessible, financially and culturally, than those of the physician. The role of the barber in treating the mass of sick people thus represented something of a link between learned and popular medical practice.

For this reason there were pressures on barber-surgeons to practise physic on occasion. In this way he was like the parish priest, who, as a mediator with the sacred, was often cajoled into performing illicit exorcisms by his parishioners. The exorcisms, used as a remedy to ‘liberate’ the sick from disease, were illicit because the parish priest was neither trained or licensed to carry out what was a specialised activity. To practise their profession canonically, barber-surgeons could only intervene on a physician’s orders, not at the sick person’s behest. Much of their daily practice, however, would have been based on interventions requested directly by the sick themselves, on the basis of self-diagnosis. Indeed, a not infrequent statement made against a barber-surgeon when incriminated for a variety of reasons is that ‘he goes about treating all those who call him.’ Worse than practising surgery without the physician’s instructions was the actual practice of physic, primarily the administering of ‘oral’ or internal remedies. The barber-surgeon was placed between two stools: on the one hand, he had to respond to his clientele, upon whom his livelihood depended, and, on the other hand, there was pressure from the medical elite to follow the rules and respect the boundaries of his profession. This reality is summed up in Cintio d’Amato’s twice-reprinted treatise on barbering. Of course, the barber was the physician’s servant: ‘that which the learned physician with judgement proposes, the diligent barber with his hands carries out.’ Elsewhere, however, for example in France, there were barbers who practised physic. Besides, the ‘diligent barber’ was often forced by local realities to practise without a physician present, going beyond the bounds of his licence, whether obtained from the protophysiocr or the College of Salerno. In such cases, d’Amato concludes, he was equal in importance to the physician.

The sick themselves did not make the clear distinctions between the different ranks of the healing arts that the Medical Colleges were seeking to impose. We have already mentioned Mercurio’s assertion that licensed barber-surgeons were called ‘Signor Dottore’ by the populace. Apparently, this was especially the case
with community barber-surgeons. The problem, and the resulting temptation for surgeons, was exacerbated by the fact that, in Padua for example, 'a few doctors of medicine treat surgical cases', as well as practising physic. These were the medici chirurgi, or graduate surgeons. Because of them, according to Mercurio, 'the barber-surgeon assumes that he too may practice both arts.' Tiberio Malfi, a native of Montesarchio (Principato Ultraiore) and counsel of the barbers' guild in Naples, noted in his 1626 treatise on barbering the increasing number of physicians who also practised surgery. Though this was not so prevalent in the kingdom as in 'foreign parts (I mean amongst the Spanish, French and others)', there were some noteworthy Neapolitan exemplars. Yet one has the feeling that this point is being made to justify the barbers' practice of physic when the situation required it. Barbers should know more about physic and internal remedies, Malfi asserted.

I am not saying at all, however, that the barber must become a physician, since if that were the case he would be a physician and not a barber. But since he is a barber and will have to treat people medically, he should have a knowledge of and familiarity with the remedies he would have to use. This knowledge would protect him from charges of 'inexperience' if he applied a remedy and was later charged with damages by a disgruntled patient. The 1656 plague epidemic exacerbated these tendencies by increasing the demand for medical practitioners and simultaneously decreasing the supply. As the chronicler Parrinio wrote: 'The vilest barber passed himself off as a distinguished surgeon, an excellent physician, and one had to beg him and pay him very well in order for him to come.' Indeed, the plague brought with it a generalised sense that the natural order of society had been overturned, given the opportunities available to those surviving in a depopulated city. Giambattista Valentino, a clerk, expressed the sentiments thus in his 1665 poem, written in Neapolitan:

Lasciamo alla gente mestier
o guarno voce la mutazione
è fatto gentilissimo lo stafiero
no pedecchino è fatto mercantone.

The barber illicitly practising physic became a real concern of the Medical Colleges during the seventeenth century and the early part of the eighteenth. Of the twenty-four denunciations concerning illicit medical practice made to the Roman protophysician-general Giovanni Maria Lancia in just one year (1711), four were against barber-surgeons for practising physic. Denunciations (nociati) were made either directly by disgruntled physicians of the concerned or anonymously by 'the people of the town.' These interprofessional conflicts crop up only sporadically in Bologna during the seventeenth century, but increase during the eighteenth century. This is due in part to the increased frequency of practitioners going beyond the limits of their own professions. But an ever-increasing vigilance on the part of the medical authorities throughout Italy to affirm the hierarchical and professional divisions of the healing arts is also a crucial element of the story.

Once again, there was no question of the subordination of surgery to physic:

Every doctor of medicine is also a doctor of surgery, and no simple surgeon can be a doctor. And if one sees, as if very often the case, that, of physicians, not all practise surgery, this is due either to respect for the Colleges or to the fact that not everyone has the stomach to practise it. And for this reason a few manual labourers (manuali), called licensed surgeons, are permitted to treat sores and abscesses, clean pus, take the pulse and put on plasters, all however with the permission of physicians. Nor must they persuade themselves that, because of this office, they are doctors, but simple labourers, which is precisely what the name surgeon [chirurgo] means, derived from the Greek word (chirio) for hand.

To confuse matters still further, the Colleges divided the surgical profession into two, even three categories. Each was permitted only certain surgical operations. In Naples, the Protomedicato distinguished between non-graduate surgeons, who were to be examined on 'head wounds, nerve punctures and other things necessary for the setting of bones,' and barber-surgeons, who were to be examined on the location of veins and the techniques of blood-letting. They paid different licence fees as well: the surgeon paid three ducats for his approval by the protophysician, almost three times more than the barber-surgeon's twelve cantini for his licence. In Bologna, however, surgeons were subdivided into three categories of competence. These varied from those licensed only to let blood, those who could let blood and treat simple wounds, and those who practised all surgical acts. In both cases, licensing combined restriction and recognition. It sought to limit practice to a corresponding level of skill and experience, while at the same time granting a specific, officially sanctioned status to the practitioner. This was important in a world where individuals without identity were suspect.

In order to be licensed, barber-surgeons were to undergo examinations, according to their category of expertise. Some trials resulted when barbers practised with just the recognition of their guild, without the now (as of the seventeenth century) necessary supplementary licensing by the Medical College or Protomedicato. In some cases the guilty barbers pleaded ignorance of the need for a dual licence. Many more refused to undergo this trial, either because they sought to evade the licence fee, or because they lacked the training or experience necessary to be approved. And for those lacking even guild recognition it meant swelling the ranks of illicit itinerant practitioners. Many of those classified as charlatans and mountebanks by the medical authorities were in fact practitioners of rudimentary forms of surgery, in addition to those who peddled various medicinal remedies.

As far as the elites were concerned, there was a world of difference between the barber-surgeon grudgingly licensed to perform the simplest surgical acts and the hospital-trained, sometimes even university-educated, surgeon. Of barber-surgeons Garzoni wrote: 'they generally prattle like magpies...[T]o tell a barber a secret is like telling it to a Levantine Jew, because the example of King Midas' barber, who
revealed that the king had cars like an ass, tells us everything. 105 Garzoni makes no such remarks at the surgeons’ expense. Indeed, their office was of great importance: to separate what, in bodies, is united, to unite what is divided, to draw out the superfluous, to preserve without pain and to prevent putrefaction. 106 While the lowest barber-surgeon overlapped with the charlatan in terms of preparation, practice and status, the graduate surgeon, or medico chirurgio, overlapped with the physician. There were chairs in anatomy and surgery at most Italian universities. At Naples it was quite prestigious: one of those who held it, Marco Aurelio Severino, surgeon at the city’s Incaboles Hospital, numbered the founders of the Accademia degli Investiganti amongst his disciples. 107 As noted in the previous chapter, he was a victim of the very 1656 plague he was assigned to study, as head of a group of physicians appointed to the task. 108 Venice even had its own College of Surgeons, distinct from the barbers’ guild (and from the College of Physicians, it must be said). In 1547 the Surgeons’ College was made up of fifteen doctors of surgery, three doctors of medicine and seven without doctorates who had been specially examined. One surgeon was even appointed medico per la terra, concerned with identifying cases of plague in the city. 109 During the eighteenth century surgeons throughout the peninsula would press for their guilds to be awarded the status of colleges.

There is no doubt that the status of the surgeon changed over the early modern period, though not to the same extent as elsewhere in Europe. This was due in part to the conservative nature of the medical authorities — university, college, protophysi- cian — and their attempts to maintain the separateness of the ‘professions’, making up the art of medicine. But surgeons did eventually increase their presence at the kingdom’s larger hospitals. What seventeenth-century treatise-writers had encouraged as a useful, if somewhat informal, part of a surgeon’s training now became increasingly structured. Hospital experience was linked to formal instruction, as university courses were moved to the Incaboles Hospital, with its two chairs in surgery and one in anatomy. However, Neapolitan surgeons were far away from usurping the role of physicians or becoming general practitioners. For their part the barbers, increasingly known as phlebotomists or merely bloodletters (sag- natori), continued to occupy the lowest rung, though they did have the consolation of knowing that their services would still be the most accessible to the sick.

The ‘good apothecary’

The same can be said of apothecaries. A rare apothecary-surgeon, in the small Abruzzese town of Montenerodomo was, the town’s physician grudgingly admitted, ‘if not very able, at least of great use to the people’. 110 Despite the usefulness and accessibility of apothecaries the transformation into general practitioners that took place in England never occurred in Naples. Towards the end of the period a handful of practitioners are identified in the Protomedicato registers as ‘surgeon- apothecaries’, but they are clearly exceptional. Apothecaries practising in the capital, whose numbers fluctuated around a hundred throughout the period, were kept in check by both the protophysician and their own guild. The various branches of the healing arts were to be kept separate:

When you find an apothecary practising physic with our licence [the protophysician ordered], you will take it away, because if this had been clear to us we should not have granted it, given that it is not appropriate to be both an apothecary and a physician at the same time. And if the apothecary be a doctor in physic, you will order him to choose one or the other of the said practices, prohibiting the apothecary to meddle in physic in the future, if he should elect to be an apothecary. 111

This is not to say that apothecaries did not practise physic or surgery on occasion. If the temptation for barber-surgeons to practise physic was great, especially in extenuating circumstances, it was only slightly less so for apothecaries. Given the first-hand knowledge of drugs they acquired both through apprenticeship and the filling-out of prescriptions for physicians, it is no wonder they dispensed drugs themselves on occasion, without a doctor’s intervention. As far as the sick were concerned, this form of illicit practice was unlikely to present a problem. Indeed, apothecaries were probably responding to the requests of the sick when they turned to physic, just as barber-surgeons did. The Neapolitan Dominican and apothecary Fra Donato D’Eremita was perhaps writing from personal experience acquired at his shop in the monastery of Santa Caterina a Formello when he remarked: ‘It seems to us that the common people hold an apothecary in higher regard than a physician. And we see that a sick person, not believing in the ten most important physicians, will not mistrust in the least the work of a single apothecary, be he poor, vile, corrupt and ignorant.’ 112 Not that Fra Donato was advising apothecaries to exceed the limits of their profession; far from it. He reminded apothecaries not to dispense any medicine not prescribed by a physician, nor substitute or otherwise alter their ingredients. 113 But these were widespread practices nevertheless, as the Gigzi case reminds us. However, if a death resulted and criminal accusations were made against the apothecary, it was the sort of evidence that would be brought out to incriminate the accused still further. In any case, it was usually the physician of the town who made any accusation before the medical authorities. If the moral order was threatened by the apothecary’s actions, it was only the physician who seemed really concerned, to the extent of making false accusations to bolster the case against his rival. As has been found elsewhere, the Protomedi- cati do not seem to favour their own cases involving physicians in some way. 114

For the eminent French physician and writer Laurent Joubert, the ‘ruin of physicians’ and ‘calamity for patients’ lives’ was the apothecary, who, with but a little knowledge of medicines, presumed to treat people. But the grass was always greener on the other side of the hill (or the mountains, in this case):

In Italy and Spain (as I understand it), patients are much better off, for the apothecary does not visit the patient except out of courtesy and friendship, not as an apothecary. And the physicians do not write at the bottom of their prescriptions what the medicine is for, so that the apothecary knows as little about the physician’s intent as if he
had seen nothing at all. In this way he is unable to abuse the physician’s prescriptions or does so far less than our own apothecaries, to whom everything is too plainly divulged.\textsuperscript{115}

Far from stressing their relative ignorance, however, several Italian writers praised the apothecaries’ knowledge. Garzoni praised the apothecaries for their medicinal expertise. They ‘sometimes amaze the physicians themselves, even though [physicians] are generally contrary and opposed to this type of practitioner’.\textsuperscript{116} Their knowledge of the pharmacopoeia, and their role in introducing new drugs, often gained them positions of prestige, far beyond the status of tradesman. To say nothing of money: some apothecaries, like some surgeons, could earn far more than physicians. In the mid-sixteenth century Ferrante Imperato achieved great renown in Naples as a botanist and keeper of a private natural history museum. Two centuries later Nicola Meola boasted of similar successes, causing amazement amongst the city’s College physicians with his preparation of antimony (though we have only his words to go by).\textsuperscript{117} Meola — who lived and worked in the small town of Greci (Principato Ulcierio), after having trained and served his apprenticeship in Naples — is interesting because of a lengthy and rather personalised collection of remedies he compiled. In it he suggests, amongst other things, that he was prescribing remedies, trying them out on patients, as well as dispensing.\textsuperscript{118} Moreover, he had the daring to advise physicians on what drugs they should use, advice that came with more than a hint of bitterness. With regard to theria, he comments, in his typically discursive prose:

Here I am at last under the pressure of truth for the sole [purpose of the] unmasking of malice, oh graduate professors of the medical art, Galenics, Hippocrates and Spurgyric, it rests on you, oh practicioner, for both the decorum of such a proud profession and for the true recognition of simple medicaments, to put into use (without, however, revealing it to the state) a so celebrated antidote, so prodigious, so universal, without faiths, without caprices, without danger. Put it under your eye’s, for it is in this especially that consists its power and human benefit.\textsuperscript{119}

An experienced and well-informed apothecary like Meola was no doubt quite welcome in a small town (aside from the unwitting victims of his drug trials, perhaps). This was especially so where there were no physicians or surgeons, as in Greci. Scipione Mercurio, a physician like the above-quoted Joubert, remarked in his book devoted to ‘popular errors’ that a ‘good apothecary’ was more important for a community than a ‘good physician.’ ‘This is the case’, he wrote, ‘because the experienced apothecary can often correct the error of the ignorant physician, due to the great experience he has both of the nature of the medicines and their doses.’ But there is an important qualification to Mercurio’s praise. A bad apothecary, ‘miserly and negligent’, may ruin the medicines ordered by a learned physician. In the cities the good apothecaries will make up for the one bad one; but in a small town one is in the hands of the only apothecary. From this follows Mercurio’s fervent support of the Protomedicati, especially that of Bologna, because they inspect the apothecaries on an annual basis. While community physician in the town of Lonato, near Brescia, Mercurio instituted a similar procedure. ‘Although it cost me much effort and made me hateful to the apothecaries’, he remarked, ‘nevertheless I wanted to do it to ease my conscience and because I saw how useful and necessary it was for my patients.’\textsuperscript{120}

Apothecaries, however much they were appreciated and needed, were reminded to keep their place. Francesco Sirenà, in his 1678 guide to the profession, pointed out the need to know how to measure time into minutes or half- and quarter-minutes for the preparation of medicines; more reliable and better known to him would be the recollection of the doses of medicines, more reliable and better known to him would be the preparation of medicines. He had the daring to advise physicians on what drugs they should use, advice that came with more than a hint of bitterness. With regard to theria, he comments, in his typically discursive prose:

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straightforward for the Protomedicato and Medical Colleges to exercise authority over both midwives and itinerant ‘charlatans’, since they had no other bodies to represent them. Actual practice proved otherwise.

Midwives were not a real concern of the medical authorities until the latter half of the seventeenth century. This was left up to community sanction and the parish priest. Midwives were generally illiterate, without any formal training. They usually assumed their role late in life, after having children themselves and gaining experience accompanying an already recognised midwife. Their recognition came as the result of community consensus and some form of episcopal licensing. The Counter-Reformation Church sought to ensure that midwives were pious and of honourable behaviour because they had the responsibility to baptise infants in danger of death and were the only women permitted at the baptism. At first, any concern the protophysician may have had was cursory: the bare minimum needed to justify payment of the licence or visitation fee to the Protomedicato. The Neapolitan protophysician Santorelli, writing in 1652, commented that a midwife need not be examined on what the pregnant woman should do before and after birth; she need only know what to do during birth.125 This attitude changed little over the next 150 years. When rudimentary training was introduced by the medical elites it was not energetically enforced. Licensing continued to reflect the traditional means of choosing a midwife – community sanction – rather than challenge it. Figures for licensed midwives may seem low in comparison to, say, barbers: around nine per ten thousand of population in smaller towns and four per ten thousand in larger towns. But then a large proportion never bothered to obtain a licence, as we shall see below.

The midwife existed in the overlap between learned, ecclesiastical and popular forms of healing, as suggested in chapter one. However, this did not mean that midwives were of irregular or unrecognised status. On the contrary, the state granted them a degree of official recognition by calling on them to act as expert witnesses in cases of rape and infanticide. In Naples, however, they do not seem to have achieved the status of salaried municipal midwife as it existed in some areas of Europe. But, as with the condotti, more research needs to be done at the local level to ascertain the practices of the municipal authorities. In everyday reality midwives frequently found themselves between two different levels of society, two different notions of what was expected of them. On the one hand, there was the link between the midwife and popular culture, where she was associated with the wise woman, because of her ability to treat disease, and where her childbirth experience was complemented by a knowledge of spells and ritual healing techniques. On the other hand, she was connected with power structures, ecclesiastical and medical, on a par with society’s artisan classes. A 1615 case involving the Neapolitan midwife Fiorella Testa illustrates this tension.126 Testa was accused by Antonio Vinaccia, a carpenter, of having caused the deaths of his two children by magic. While on his way to the apothecary’s to get a syrup for his ailing baby daughter, he met Testa, who had delivered and baptised both of his children. He mentioned his daughter’s illness and Testa returned with him to have a look. She concluded that the infant had been ‘touched’ by witches (janares) at night. According to Vinaccia she took the infant in her arms and ‘secretly said words into her ears and then licked her forehead and spit on the ground.’ But the real shock came when Testa remarked to an unsuspecting Vinaccia what a shame it was that his son was also ill.

As a first precaution she ordered bunches of herbs hung by the window and door. The only real solution, however, was a magical rite, and there was no time to lose. Testa ordered Vinaccia to bring her a certain coin, go to the crossroads as the Ave Maria bell was tolling and pick up a handful of earth. He was to divide this into two pouches, one for each child, which they were to wear. Despite this, the infant girl died, followed by his son, three days later.

Was Vinaccia’s denunciation of the midwife Testa motivated by the search for vengeance at the untimely death of both his children? Did she really make use of the magical remedies described? Midwives were frequently suspected of including such rituals in their repertoire; but they were just as likely to turn to more orthodox religious responses if their store of natural remedies proved insufficient. The episcopal court asked Testa if she did any healing, in addition to delivering babies. She admitted to treating babies ‘who were crying because they had a stomach ache or because of other illness.’ But the treatment she admitted to practising was totally acceptable, consisting as it did of placing her hand on the child’s forehead, making the sign of the cross and saying ‘slowly and softly’ three Paternosters and three Ave Marias ‘for a devotion I have to Saints Cosmas and Damian’. This was appropriate, since they are the patron saints of medical practitioners. As for the signing ritual, it was one of the most common remedies, used throughout Italy, to the point that in some areas the verb ‘to sign’ was the equivalent of ‘to treat’. Testa can only conclude that Vinaccia must have mistaken her prayers for magical utterances. She never said the girl was ‘touched’. Certainly, this was a very real form of disease causation as far as most people were concerned. It was a possibility that worried parents, since young children were considered especially vulnerable. However, Testa denied knowing ‘how to recognise babies touched by witches, and I don’t know any remedies for it.’ Nor was any magic involved in identifying his son’s illness. It was clear he was suffering from a hernia. She instructed the parents to prepare a rosewater infusion for the boy. It was Vinaccia who insisted on the magic, though she warned against it. Later, when Testa noticed the two pouches, she asked him what they were for. Vinaccia told her what they contained and said ‘they served to keep the witches away from this house.’ The coin she asked for was in payment for her services, nothing more. Testa ended her defence by remarking that Vinaccia blamed her for the death of his two children, especially that of his son, that he had threatened her and called her daughters whores.

The Vinaccia house was searched by court officials, where they found the two pouches and various bunches of herbs. At this point there was no obvious way of reconciling the two contrasting versions of events. A month later the court received a petition signed by six men describing her honourable and pious behaviour as a midwife. In form and content it is strikingly similar to testimonials written on behalf of young apothecaries wishing to open their own shops and sent to the
openly illicit nature of her activities, the Protomedicato could be lenient if certain conditions were met: (i) if she was a licensed midwife, or prepared to undergo licensing; (ii) if she treated the sick gratis, in good faith and at their behoof; (iii) if there were no other licensed practitioners in the vicinity; and (iv) she had caused no one any harm.

Medical attention to the standards of midwifery practice began in the eighteenth century. A school of midwifery was first set up in Turin, following the French lead, in 1732. Such schools, generally linked to hospitals, university courses or the rising medico-surgical Colleges, were soon founded elsewhere: 1757 in Bologna, 1769 in Milan, 1774 in Padua. In Naples this happened in 1777, when Domenico Ferranti was awarded the newly established chair in obstetrics at the university and taught 'the art of delivering births' at the Incurables Hospital, Salerno followed in 1791. As far as actual practice was concerned, the Incurables was the only Neapolitan institution to take in women in labour. It admitted 167 in 1759. By 1787 the Hospital had its own maternity ward, under the direction of the Frenchwoman Thérèse Ployant, author of a treatise on midwifery.

With Ployant we are clearly entering into a new phase in the history of midwifery, though one that was not without obstacles. Her role as 'chief obstetrician' at the hospital presented some difficulties, as both an outsider and a woman, in a new academic discipline dominated by men. In her book Ployant relates that on one occasion, while she was removing the placenta from a woman 'in a gentle way, as is required', a young hospital doctor pushed her aside, and took it out 'in a frenzy.' The woman survived the ordeal, but the conflict between Ployant and the doctor wound up before the protophysiocrate, with the doctor attempting to discredit her and have her dismissed. Though the attempt failed, it does remind us of the tensions that existed.

In Italy – as in Spain – the rise of obstetrics did not see the replacement of midwives by men-midwives or accoucheurs. The schools aimed to increase standards of childbirth through the education of women, rather than seeking to edge them out. Moreover, the Catholic Church felt that only women were appropriate to the task, except in emergencies. If formal training did not mean the end of the midwife in the Italian peninsula, it did spell the beginning of the end for the traditional midwife. Nowhere did this take place overnight, of course. Courses may have been offered, but traditional midwives were reluctant to take them, often for very practical reasons. As late as 1816, of an estimated 600 midwives practising in Naples, only six turned up for the course at the Incurables, though it was obligatory for all midwives under fifty. One wonders at the success rate of the impromptu courses that physicians were supposed to hold for aspiring midwives outside the capital. If the comments made as a result of the 1811 government survey are anything to go by, the situation changed little. Most provincial midwives continued 'to learn through practice'. Only the expectations seem to have changed. By now it was becoming a conflict between two different levels of society: between the taught courses, examination and licensing that the central medical authorities were increasingly insisting on and the traditional local way of choosing local midwives,
based on acquired experience, skills frequently passed from mother to daughter. But, even then, there persisted a tacit acknowledgement that, in the absence of taught courses, the only way a woman could gain the knowledge of midwifery necessary in order to be approved and licensed was through previous, unlicensed, experience. The protophysician was also fairly lenient when it came to payment of inspection fees, given that many midwives were poor and requested exemptions. Local administrators judged the fee too high. The intendent of Abruzzo Ulteriore wrote to the Interior Minister requesting a reduction in the fee for the ’wretched midwives who, in the small towns of this province practise out of humanity, helping each other, without any payment.’ Finally, in 1824 the intendant of Naples complained to the protophysician that so many practitioners, especially midwives, were evading licence fees and proposed harsh police measures against them. The protophysician took a more realistic, mediating position, asking how unlicensed midwives could be prevented from practising ‘if they are the totality?’ It would be unwise, not to say harmful, to leave the populations without any assistance. Moreover, the protophysician acknowledged, even if many midwives were unlicensed, they were invariably ‘women experienced in the occupation and grown old in their practice.’ Community sanction continued to be the most important factor behind a midwife’s local practice well into the nineteenth century.

Itinerant practitioners

One group that makes only the briefest of appearances in the 1786 and 1809–10 Protomedicato lists – but is frequently referred to in the 1811 survey – are the itinerant practitioners. Known by the terms charlatano or moutombâno at the beginning of our period, by the end of it the terms empirico and segretista have taken over. In practice, charlatans tended to be evasive by their very nature, and often escaped licensing. If itinerant practitioners stuck to the licensed selling of drugs or minor surgery, they were tolerated by the authorities, despite the harsh and satirical medical rhetoric of the time. The Medical Colleges and Protomedicato took a realistic stance regarding charlatany: they never sought to eliminate it, merely to contain it within what they considered proper limits. And as we have seen with regard to barber-surgeons, licensing should not be seen merely as a restrictive phenomenon. It also bestowed a form of official recognition of the charlatan which he could use to his advantage.

Charlatany was simply a response to a demand for accessible medicines, presented in a theatrical and entertaining manner. Some of Europe’s most famous empirics were Neapolitan, like the self-styled Orvietan, the focus of chapter four. Yet we know very little about charlatans within the kingdom. An edict issued in 1581 prohibited unlicensed practitioners from practising medicine or dispensing medicaments. In 1652 the protophysician Antonio Santorelli noted that previously those people who practised without undergoing an examination and without being licensed by the protophysician were ‘deprived of all their moveable goods.’ Whereas by his time the prosecution of a charlatan was dependent on a disgruntled patient’s accusation, which rarely took place since the patient was usually satisfied with his money back. Charlatans ranged from family dynasties organised into theatrical companies, selling their own patented medicines, through to impoverished peddlars making do with a few jars of some herbal remedy bought wholesale. They toured the markets and fairs of the kingdom, concentrating their activities in Naples itself. Here they operated in the Piazza del Mercato, where the 1647 revolt began, or in the nearby Largo del Castello, the ample open space by the harbour in front of the Castel Nuovo. Little can be said about numbers, though there must have been thousands throughout the kingdom. It is impossible to verify the extent to which licensing was a municipal matter because of the destruction of the city archives in 1943. By way of information, the Paris police kept a register of empirics that contained 1,746 names when it was turned over to the Société Royale de Médecine in 1778. If they were all active and present in the city at that time this would mean that charlatans outnumbered physicians and surgeons by three-to-one.

Charlatans were potentially an even greater threat to medicine’s moral order than apothecaries or barber-surgeons because of the sheer numbers who boasted of practising physic better than the physicians themselves. The public was easily taken in. Santorelli claimed, Medicine was not like the other professions where ‘we are immediately aware if the author is ignorant, whether by the tailor ruining his garment or the shoemaker his leather.’ Moreover, the charlatans may have been short on university learning, but they were not short of audacity, and ‘because he who knows less prates and raises his voice more, and the populace recognises he who shouts the loudest, so it is that the [person] ignorant in medicine is at times more esteemed than the learned and modest.’ For Mercuro it was not simply the remedies they used, but the way they used them. Charlatans wanted ‘to heal their patients right away and acquire quick profits from them.’ Conversely, physicians awaited ‘the motions of nature’, attempting to bring about a purgation by means of reasonable remedies in a suitable time. Charlatans met with much revulsion from learned physicians precisely because they straddled the boundaries which separated the medical community. Their use of spectacle and performance to sell their remedies was a sign of their liminality. The medical elites struggled, in vain, to keep the theatrical and commercial side of the selling of drugs separate from the medical aspects of diagnosis and treatment. Charlatans called their remedies ‘secrets’, because they worked through unknown means, seeking to distinguish them from ordinary simple and compound remedies then available. But, in fact, their ‘secrets’ did not differ substantially from the drugs listed in the official pharmacopoeias, and the medical authorities knew this.

The ‘professions’

Given the increasing attempts by the medical elites to exert some sort of control over these various sorts of healers, in particular with regard to enforcing the moral structuring of the medical world, can we speak of an ongoing process of professionalisation? To begin with, it would be wrong to regard all the medical arts as
forming one profession. Indeed, in the terminology of the time, each was a 'profession', in the sense of being an occupation. Of course, a clear hierarchical distinction was made between the manual or mechanical and the learned, but this was not implied by the use of the word 'profession', which was not then restricted to prestigious occupations alone.

Professionalism and professional functions were present throughout early modern societies. Healers mediated between a social demand for the prevention and treatment of illness and a more or less esoteric corpus of knowledge. The healer possessed the general knowledge necessary to treat the client's specific case. The healer's social role, derived from his or her social knowledge, is thus a defining characteristic, unaffected by issues of therapeutic efficacy or science-based authority. Practitioners, taken as individuals or groups, may have been of a low or precarious economic status, but their social and even political role remained strong.145 This applies as much to physicians as to midwives. What distinguishes the two groups, however, was the existence of formal occupational associations for the physicians, but not for the midwives. It is, in fact, what most distinguishes the medical 'regulars' — physicians, surgeons and apothecaries — from the outside, officially at least, like charlatans and midwives. Like the physicians, barber-surgeons and apothecaries were organised occupational groups, with a broad demand for their services.

It is not difficult to conceive of early modern Italian physicians as a professional group, regardless of the ability to heal the sick in any effective way. They possessed a body of knowledge taught at institutions of higher learning and a means of qualification and official recognition. Through their own exclusive corporations they sought to impose a monopoly on the practice of physic. Their status ensured them of contacts with the wealthy and the powerful, even though most practitioners were not themselves able to attain these attributes. Professionals in early modern Europe need not have been amongst the top levels of the social hierarchy. Physicians, in fact, were considered inferior to the lawyers, to say nothing of the wide variance in status between a protophysician, holder of a university chair and prior of the local Medical College, and physician serving out a contract in some isolated mountain town as its condotto. But it has been more difficult for historians to grant professional status to the manual practitioners of early modern Europe: the barber-surgeons and apothecaries. Their professional structure — the guild — was different from that of the physicians, in that it was socially inclusive and comprehensive, rather than elitist and exclusive, but it did provide them with both legal status and group identity. These are two features of a model of the profession that Toby Gelfand has constructed for 'ordinary' early modern European practitioners. Another defining characteristic was substantial numerical strength, with levels of provision approaching one practitioner per thousand inhabitants, and wide geographical distribution, extending into rural areas. Finally, despite nominal subordination to the medical authorities, there is a degree of de facto autonomy, as well as independent training structures.146

That said, it would be inaccurate to characterise the increasing supervisory role of the Medical Colleges and Protomedicati as professionalisation. The increasing regulation by the medical elites and attempts to enforce the hierarchical and occupational divisions of the healing arts was not an attempt to control the whole medical field. It was not going to pave the way for the unity of medical practice in its various forms. Nor was it in any way striving to constitute and control the medical market for the expertise of a reorganised and unified profession.147 As this chapter has attempted to show, it was directed at enforcing boundaries and bolstering the distinction, prestige and power of physicians as reflected in their own professional organisations. It reflected the outlook and of the medical elites more than that of the thousands of lesser practitioners throughout the kingdom, to say nothing of the sick themselves. Local reality often meant a mixing of 'professions'. The 'disorder' so dreaded by the elites was always bubbling away just beneath the surface. As late as 1792 one disgruntled Calabrian physician saw in a renewed Protomedicato the hope that it 'would help put an end to other abuses where some apothecaries take the liberty to practise now as physicians, now as surgeons, especially in syphilitic maladies; surgeons practise as physicians and apothecaries; not to mention several physicians who take advantage of the situation to dispense certain of their own remedies'.148

His words reflect a breakdown in the corporative divisions that was a feature of late eighteenth-century medicine. But, as we have seen, these transgressions were a fact of life throughout the period. His words would have struck a familiar chord with the elites at any time over the previous two centuries.

NOTES

2 Ibid., fol. 18v.
3 Ibid., fol. 3.
4 Ibid., fol. 7.
5 Ibid., fols 20v., 27v.
7 Giovanni Cossi, Il notaio e la pandetta: microstoria salentina attraverso gli atti notarili (sec. XVI-XVII) (Galatina, 1992), p. 11.
8 Carlo Cipolla, 'The medical profession in Galileo's Tuscany' in idem, Public health and the medical profession in the Renaissance (Cambridge, 1976), p. 76.
9 Antonio Santorelli, Il protomedico napolitano, ovvero dell'autorità di esso (Naples, 1652), p. 44.
10 Scipione Mercurio, De gli errori popolari d'Italia (Verona, 1645), pp. 207, 214.
11 Ibid., p. 114.
13 Tommaso Garzoni, La piazza universale di tutte le professioni del mondo (Venice, 1616), p. 70v.

A. S.B., Studio, 214, no. 2.

Mercecurso, Erroi popolari, p. 208.

Given that the tripartite division was in fact the norm in Italy, it would appear to have more in common with the French system than Laurence Brockett and Colin Jones allow, in The medical world of early modern France (Oxford, 1997), pp. 12-13.


The 'Petitorium' was revised in 1684, though in a Latin version: Carlo Pignatari, Petitorium in quo continetur ea quae quilibet pharmacus suis officina, in hac Urbis Napoletanae et Regno, in visitationibus faciendi habere et ostendere debat (Naples, 1684).


Cipolla, 'Medical profession', pp. 72-3.

Statuti del nobil collegio degli speziali dell’alta città di Roma (Rome, 1607), p. 34.

Brambilla, '‘Sistema letterario’', p. 84.

Ibid., p. 121.

A.S.B., Studio, 197 and 235 for lists.

From a survey of the civilitates probationes by Pernati, Promessa, p. 16.


Ibid., p. 201.

Cipolla, 'The profession', p. 51.

Brambilla, ‘‘Sistema letterario’’, p. 86.


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41 A.S.B., Cappellania Maggiore: Processi archivi, 1570, fol. 29; in Cortes, ‘Studio di Napoli’, p. 49.

41 A.S.B., Cappellania Maggiore: Varietà, 43; in Cortes, ‘Studio di Napoli’, p. 50.

41 Salaries varied from 600 ducats a year for the permanent chair in practical medicine, 400 ducats for medical theory, and 300 for anatomy and surgery, to anywhere from 50 to 50 ducats for the quadrennial chairs. Filippo Caravita, ‘Relazione’ in G. de Blasis (ed.), ‘L’Università di Napoli nel 1714’, Archivio storico per le province napoletane, i (1787), pp. 153-5.


44 We have only Bartoli’s word to go by, as related in the dedication and preface to the second version, Ars medicæ dogmatæ communiter receptionem examen in decem exercitationes paradoxicas distinctum (Venice, 1660); in Fisch, ‘Academy’, pp. 524-5. The Systema was officially banned in 1666.


47 Bartoli’s Examen cited above. It was officially banned in 1669.

48 Caravita, ‘Relazione’, p. 151. Earlier in his career he had substituted for others, such as the protophysician Andrés de Ganzé. Tozzi went on to serve as physician to Pope Innocent XII and was on his way to Madrid to serve as physician to Charles II in 1700 when the latter died.

49 The Marquis of Arena, having been appointed secretary to the treasury (scriverio di ragione), was assassinated in April 1675, Fisch, ‘Academy’, p. 537.


51 Musi, ‘Medici e istituzioni’, p. 28.


54 Gelfand, ‘Medical profession’, p. 1131.


56 Cipolla, ‘Medical profession’, p. 82.


The Franciscan Antonio Lucci was bishop of Bovino from 1729 until his death in 1752. From the testimony of Dr Tommaso Rossomandi, in A.S.R., Ritu, 270, fol. 89.

Cipolla, ‘Medical profession’, 91; Pesciati, ‘Maestri’, 127.


From a 1722 accusation against the unlicensed surgeon Francesco Antonini, A.S.R., Università, 2, XVI bis.


Ibid., p. 56.

Domenico Antonio Parrino, Teatro civico e politico de’ governi de’ vicere del governo di Napoli (Naples, 1654), vol. 3, p. 42.

They totally abandon their former trade/everyone wants to change/the footman has become a gentleman/a lousy beggar has become a big merchant. Gianbattista Valentino, Napolino storaggiaro dopo la prezze (Naples, 1775 edn), p. 34. Footmen, in fact, were now earning fifteen ducats a month, three times their pre-plague stipend. Giulia Calvi, ‘L’oro, il fuoco, le forche: la peste napoletana del 1656’, Archivio storico italiano, cxxxix (1981), p. 457.

A.S.R., Università, 62, c.g. fols 84–9, 901.

Pomata, Promessa, p. 148.

The pun on ‘hand’ (manuali e chiusa) is lost in translation. Mercurio, Errori popolari, p. 209.


Garzoni, Piazza universale, pp. 3699–3702.

Ibid., p. 509.


Croce, ‘Due patelli’, p. 405.

Lorenzo Giustiani, Nuova collezione delle stampe mediche del Regno di Napoli (Naples, 1685), vol. 12, p. 216.


Ibid., p. 6.

Pomata, Promessa, p. 215.


Garzoni, Piazza universale, p. 84.
HEALERS AND HEALING IN EARLY MODERN ITALY


118 Meola, 'Capaccio', fol. 204–5; in Corrain, 'Prontuario manoscritto', p. 49.

119 Meola, 'Capaccio', fol. 47; in Corrain, 'Prontuario manoscritto', p. 73.


123 Statuti ... delli spieiali, pp. 21, 31.


125 Santorelli, *Protomedico napolitano*, p. 56.

126 A.S.D.N., *Sant'Ufficio*, *Contra Floreale Testa obstetriciorum*, 468, no foliation.

127 For a 1688 example sent to the prior of the Salernitan College, see Andrea Sioni, 'Diplomi di laurea dell'Almo Collegio salernitano', *Archivo storico della provincia di Salerno*, i (1927), p. 227.


138 A.S.N., *Consiglio d'Istruzione Pubblica*, 3102; in Guidi, 'Levatteri', p. 115. The estimate of 600 possible midwives may have been somewhat high, since there are 200 licensed midwives in the 1809 Protomedico list.


142 Ramsey, *Professional and popular medicine*, p. 205. He suggests (pp. 211–13) that in most areas the numbers of unlicensed practitioners (empirics, people dabbling in surgery, part-time healers) would most likely be roughly the same as for licensed practitioners (physicians and surgeons).


In 1641 Secondo Lancellotti, an abbot of the Olivetan Benedictines of Perugia, published a curious little book in Paris, which he dedicated to Cardinal Richelieu. Entitled L’Orvietano per gli hoggidiani, it was intended to combat hoggidismo. From the word hoggidi, meaning ‘nowadays’, hoggidismo was ‘the believing, and so always bemoaning, that the world is worse NOWADAYS, and more calamitous than in the past’ (according to the title page). The amusing work consists of quotations from a whole range of areas, where authors have expressed this sentiment, with Lancellotti’s linking remarks. Despising this negative philosophy, Lancellotti proposed his book as an antidote to the disease, ‘an instantaneous and most useful medicament.’ It was to be an ‘orvietan’ for sufferers. In his dedication, the author explains that orvietan was ‘an elecytary and medicament which has become famous in our time, not only in Italy but also beyond.’ What was it about orvietan that made it so successful, to the point of being used as a synonym for ‘antidote’? And, more generally, what can remedies like orvietan and the charlatans who peddled them tell us about early modern medicine?

To begin to answer this question we must go back a further fifty years. According to some accounts it was at this time, the end of the sixteenth century, that orvietan was invented, by a certain Lupi of the town of Orvieto, in central Italy. This assertion has proved impossible to document. The earliest records of the remedy concern the Neapolitan charlatan Girolamo Ferranti, who called himself l’Orvietano, the Orvietan, and bestowed this name on the remedy he sold. He may, in fact, have been orvietan’s originator, though the fact that a Neapolitan living in Rome should call himself ‘the Orvietan’ suggests that he was capitalising on something. The commercialisation of medicine, evident in the profusion of proprietary remedies, was well under way in Italy a century or more before its heyday in England. Although the success of charlatans has often been explored in such commercial terms, this chapter will seek to broaden the analysis. While it does say something about their appeal, a purely economic model does not explain why charlatans were so repeatedly denounced. Nor does it shed much light on the place of charlatans in the period’s therapeutic network. This chapter will explore just what this might have been, by looking at these often misunderstood practitioners, the drugs they sold and the way they sold them. The focus remains the kingdom of Naples, but...
Ferranti’s earliest documented appearance would seem to be in Florence in 1609, when he petitioned the Orto di Balia, the chief criminal court, to be permitted to set up a platform and personally sell his antidote throughout the Grand Duchy. The correspondence mentions a similar petition made – successfully – in 1607. The resulting licence of May 1609 granted Ferranti the privilege ‘to mount a stage with his company throughout all the states of the aforesaid Most Serene Grand Duke, and particularly in the city and state of Siena, to dispense the said secret.’ No one else was to be permitted to make and sell orvietan, with the exception of Jacopo Talavino, ‘il Tedeschino’ (the Little German). Talavino, from Udine, was well known to the Florentine Medical College. In 1599 he had been granted a licence to sell ‘philosophers’ oil, hyena and turpentine oil’, and, in the same year as Ferranti, was licensed to sell two other oils, ‘with his company and women’.

But Ferranti did not limit his activities to Florence. Indeed, his appearance there followed in the wake of a more successful stay in Paris, of several years’ duration. The physician Thomas Sonnet, in his Satyr contre les charlatans, published in 1610, wrote of having seen a ‘notorious and shameless charlatan who was called il signore Hyeronimo’ eight years earlier in Paris. The description he gives makes it likely that this was the same Hieronimo, or Girolamo, Ferranti (also Fioranti) who operated around that time in the vicinity of the Pont-Neuf. Back in Italy, in 1611 Ferranti and his son Gregorio were licensed to sell orvietan in Siena. In 1613 Gregorio petitioned the Rome Protomedicato to be allowed to hang a sign outside his house, where he also dispensed the elixir. It was to read: ‘Here lives the Orvietan, who sells the elixir against poison and other infirmities; those obtaining it from others under my name will be deceived.’ But while keeping up the shop, where they manufactured the antidote, members of the family were also on the move in search of other markets. Around this time Gregorio was licensed by the Venetian Medical College to sell orvietan there. In 1616 the Orvietan was reported in Florence with his company. According to the city’s Avisi, what drew attention most was ‘the alluring Vettoria’. The young woman was paid fifteen scudi a month ‘to sing, dance and skip every day in the square’. Every evening entertainments were performed by the company, varying in length according to how much money had been taken in.

The amiable Vettoria, cleanly and neatly dressed as a young boy, has large numbers of people running to her, with the somersaults she does, her divine dancing and singing, such a sweet and beautiful sight, that the enchantment touches and hills everyone, so that, sighing, they cry: alas, alas my heart, what is this? And most of all certain old men, who look at her with mouths agape, because they would like to flirt with her and partake of that tasty morsel.

It may be that around this time Girolamo Ferranti returned to Paris, where he died, leaving his Roman wife, Clarissa. All we know for certain is that Clarissa, widow of Girolamo Ferranti, inherited the French patent for orvietan. She passed it on to her second husband, Jean Verrier. Verrier changed his name to the Italian-sounding Vetrario, taking advantage of the Italian origin of orvietan and of many of the charlatans operating in Paris. But it was Clarissa’s third husband who would have most success with the antidote. He was Cristoforo Contugi, a genuine Italian this time, native of Rome, who was identified as being married to Clarissa when they took out French citizenship together in October of 1646. The next year he was granted royal letters patent to sell and distribute orvietan throughout the kingdom. Try as he might, Contugi was unable to obtain the recognition of the Paris Medical Faculty. It is unlikely that he needed the prestige that their approval would bring to boost his sales, to judge by the number of imitators that sprang up in Paris and throughout France. In fact, it might have been to thwart the competition that Contugi repeatedly sought the Faculty’s recognition. Contugi was forced to defend his royal privilege on various occasions within the space of a few years. In May 1666 he obtained a royal injunction against three different charlatans who had been making and selling orvietan in different parts of France over the previous ten years. One claimed to be the son of Jean Vetrario, thus Contugi’s stepson, whilst another claimed to be Contugi’s brother-in-law. They were charged with having attempted to sell their medicaments under the same name of Orvietan and under the sign of the Sun which has always allowed the supplicant to establish the difference between his antidote and the others’, ‘recognising the great reputation which the suppliant has acquired for the manufacture and distribution of his antidote’.

Orvietan became a real sensation in Paris during the middle years of the century. Its acclaim was such that orvietan also made it into popular medical collections and books of secrets. Its success outlived Contugi himself, who died in 1681. Contugi left his widow – not Clarissa, who had died in 1659, but a second wife – and nine children a small fortune, consisting primarily of property in the villages of Vaugirard and Issy, as well as the secret of orvietan. His descendants continued to do well out of the remedy: the patent for the remedy stayed in the Contugi family until 1764, when it was sold to a charlatan named Nicolas Portier. By this time French orvietan-sellers had more security and legal protection than ever before, and their numbers soared.

Orvietan also achieved some notoriety in England. The Italian Johannes Puntaeus (Ponzio), with a licence in surgery from the University of Oxford (1649), achieved renown through his sale of it. To demonstrate its efficacy, Puntaeus had his servant poisoned with a draught of aqua fortis (the solvent nitric acid) before the Oxford physicians. The servant seemed to get the worst of the poison, only to recover the following day. Licensing and patenting was also a lucrative source of income for the Crown. Cornelius à Tilborg (often spelt 'Tilbourne'), with other variants, was appointed a physician in ordinary and awarded a gold medal and chain by King Charles II, after he performed a similar trial in the king’s presence. But his success brought him into dispute with Pier Maria Mazzantini, who claimed to have cured a groomsman of the king’s bedchamber with the antidote. Mazzantini asserted that he was the first practitioner to bring orvietan into the British Isles in 1660, having obtained the recipe in Orvieto in 1646. He had then passed the recipe on to Tilborg, who had promised to use it only overseas. In various handbills from the 1690s Tilborg claimed that he alone could sell orvietan and gave notice that he would dispense it from accommodation in Covent Garden or Bishopsgate.
Orvietan was by no means the only antidote sold by charlatans. Another Neapolitan, Martino Grimaldi, dispensed his own elixiry against poison. It was still being sold by his heirs in 1736. Charlatans were often forced to compete for custom in the same square. It went on to become something of a literary topic, of which the square described by Tommaso Garzoni, with charlatans emerging from all corners, is the most elaborate example. A quarrel between the Orvietan and another charlatan selling another antidote in Naples was mediated by the viceroy himself in December 1616. He ordered them to appear before him and test their respective antidotes out on themselves. Only the Orvietan survived the test, and was awarded a collar of gold and privileges.

But the most serious competition for the Orvietan came from other charlatans selling the same remedy. A sign of orvietan’s popularity was the number of imitations. One is tempted to call them ‘illicit’, as they were so often manufactured by those outside the original family. But most of these charlatans were able to obtain a licence or ‘privilege’ from one body or another, due to the overlapping in jurisdictions which characterised the early modern state. The surest way for a charlatan to gain prestige and a patent was to tout himself as the successor of the remedy’s originator. The physician Thomas Riollet wrote in 1665 that over two hundred charlatans claimed to be the ‘true possessors’ of the orvietan patent. The figure may cause some doubt, but not the real situation behind it. As late as April 1714 the Neapolitan Paolo Toscano petitioned the lieutenant-general of police in Troyes to be licensed to sell his orvietan. Toscano claimed that he was the ‘successor of Hierome Ferrand’ and that the authorities of Troyes had licensed him twice before, in 1693 and 1707. No mention was made of the actual French patent-holders, the Contagi family, but Toscano was granted a licence none the less.

A similar situation prevailed in orvietan’s country of origin. In Naples and Rome the authorities issued edicts against the illicit selling of the elixiry by people calling themselves ‘relations’ or ‘companions’ of the Orvietan, but to no avail. Issued by the Roman cardinal chamberlain, no doubt at the behest of the patent-holder, a 1645 edict warned ‘mont’m in banchi et chiomatori’ (mountebanks and charmers) not to dispense elixiries imitating orvietan in ‘smell, colour or taste’, under penalty of a five hundred-ducat fine. It is hard to believe that these edicts had any effect in discouraging competition. From 1632 to 1652 the Siena Protomedicato licensed half a dozen different Orvietans from places like Pisa, Ravenna and Bergamo, all claiming to be relations or heirs of the originator. The edicts did, however, have the effect of heightening the seller’s prestige and offering him a means of recourse should he want to prosecute those infringing on his patent. For this reason Paolo Angelini went to the trouble—and, no doubt, expense—of having himself recognised as the ‘true heir’ to the secret by the Tuscan grand duke in 1665. Nine years later he petitioned the Rome Protomedicato to be recognised as its ‘true fabricator’ with the right to pass it on to his descendants, which was duly done in an edict published the following year. This official recognition suggests that the antidote had achieved a certain status in Italy.

The Bologna Protomedicato adopted the most cautious stance. In 1642 it denied Giovanni Cei a licence to sell orvietan on the grounds that the ‘public service’ did not warrant it. The physicians did not give any reason. In 1630, after appearing on several occasions before the College without success, Francesco Nava was finally issued a licence to sell it. The physicians had had two dogs bitten on the testicles by a viper and administered orvietan both internally and on the wounds. The dogs emerged unharmed and the physicians approved the elixiry. Not all Colleges were equally severe, however. In 1665 the above-mentioned Angelini was asked by the Sienese Protomedicato to put his orvietan to a similar test. Armed with a large bundle of attestations and licences from other Colleges, Angelini refused. The College protophysitian and counsellors wrote to Grand Duke Ferdinando II: ‘He is ready to try it out on himself, which makes us worry that he could or might want to protect himself with other drugs before the experiment, which we would have been more satisfied to see [performed] on an animal.’ But Angelini so impressed them with his answers on ingredients and doses that they recommended the grand duke to approve his petition anyway. The apparent duplicity of the medical élites in their treatment of charlatans is something to which I shall return below.

Competition did not come just from other charlatans, however. The apothecaries were eager for a share of orvietan’s riches. As early as 1624 an apothecary named Giovanni Battista Passino published a treatise in Latin on orvietan, describing when it could be used and in what doses. This was a sign of things to come. It was not long before it would appear in official pharmacopoeias throughout Europe for the benefit of apothecaries: by 1674 it had appeared in the pharmacopoeias of Lyon and Toulouse. By the eighteenth century the apothecaries of Paris were preparing their own ‘superior’ version of the antidote, in the presence of magistrates from the Faculty of Medicine. In Italy, Religious Orders such as the Dominican manufactured and sold it at their own pharmacies, which were exempt from secular jurisdiction until the end of the eighteenth century. Orvietan, like other remedies peddled or marketed by charlatans, was not some sort of alternative medicine. Rather, it was based on traditional medical knowledge, as we shall see. For this reason remedies sold by unlicensed charlatans, when confiscated, were often not destroyed but sent to local hospitals.

In any case, admirers of the orvietan antidote may have felt that all this competition only served to lower its quality. As early as 1665 Thomas Riollet wrote: ‘The orvietan that is displayed in public nowadays is not the same: it has many more simples and drugs. But it has more or less the same taste, the same smell and the same consistency.’ The ‘nowadays’ in Riollet’s remark brings us back to our point of departure: not even orvietan was spared the negative appraisal of the closet hoggidiari.

The fear of poison

To call orvietan simply an antidote is to do it a grave injustice. Handbills distributed by the various Orvietans testify to its numerous virtues (figure 6). In addition to countering poison, ‘both living and dead, cold and hot’, it was effective against
Poison was one of the great fears of the age. Its threat lay in the fact that its mode of operation was considered similar to that of magical spells and sorcery. For Leonardo Vairo, bishop of Pozzuoli, near Naples, veneficia were the same as maleficia: not poisons so much as bewitchments, the horrible effects of which could be ascribed to demons. The belief was shared by physicians too. The community physician at Imola, Battista Codronchi, writing six years after Vairo (in 1595), expressed similar views, arguing that demons could come to possess the human body through veneficia. The belief in the occult or hidden nature of poisons persisted throughout the following century, despite the beginnings of more experimental notions towards the secret arcana of nature. ‘We call poisons’, wrote the Frenchman Jean Baptiste Du Hamel, ‘what in some occult way are wont to attack us or suddenly take away our life’. Antidotes worked because their corpuscles joined up with the poisonous particles, which were then expelled from the body together.

And poisons had a wide range of effects, according to the Swiss Jean Prévost, professor at Padua: some madden, some induce sleep, some inflame, others extinguish the natural heat and sufocate by flatulent humidity, others kill by dryness, erode and exacerbate, some irritate parts of the body by excessive morosity and dryness, and some by lethal attrition.

A whole genre of scholarly writing dealt with poisons and how they could be countered. For the Sicilian protophysiocrich Inggrassia the first defence against poison was to lead a Christian life, praying and doing good works. This advice was contained in an essay dedicated to the viceroy, Juan de la Cerda, Duke of Medina. Perhaps it was requested by the viceroy himself; he certainly must have felt the need for it, given the in-fighting and intrigue at his court. Inggrassia proposed swallowing a decoction of his own invention before meals, describing how this was to be done. It is worth noting that the advice for taking orvietan, quoted from above, was laid out in much the same way and made use of the same sort of language. Inggrassia could not have known of orvietan, but he did recommend analogous elucubrations like theriac and terra lemmia. He also included some practical cautions, such as:...
as eating one's food slowly and carefully, checking its smell, taste and colour. Given the intricacies of baroque culinary concoctions, this would not have been easy to follow. Harder still, for a vicerey, was Ingrassia's advice that the foods themselves should be simple, as poisons could easily be hidden in complex and elaborate dishes.

To combat the fear of being poisoned at table, the elites had official food-tasters. In 1584 Girolamo Mercuriale, physician at Padua, wrote favourably of three means of detecting poison at table: serpent's horn, which was said to sweat in the presence of poison; dishes made of auricular salt, which would change colour; and emerald worn in a ring, which would lose its green colour. There were other alleged methods, such as the gem actites, which would actually prevent the intended victim from swallowing poisoned food, and, most remarkably of all, vulture's foot. If this were used as a lamp, the flame would go out in the presence of poison. Not all methods described met with equal favour. Andrea Bacci, who lectured on poisons in Rome—a city with some empirical evidence on the matter—advised anyone who thought himself to be the victim of poison to vomit it, even if this occurred at his own table.

Whilst physicians may have been tending away from a specifically demonic force in poisons, the link between sorcery and poison continued to be widespread. The records of Italian ecclesiastical tribunals bear witness to this in the number of cases that mixed the two: bewitchment and poisoning were both methods by which one person might inflict harm on another. Witnesses themselves did not generally distinguish between the two: known cunning folk who gave people food and drink to harm them might be accused of 'poisoning' them. They were both part of the same magical ritual, worked in the same way against the body and, most importantly, could both result in diabolical possession.

Those in power lived in constant fear of bewitchment and poisoning. In some senses it was the same fear. Magical spells and charms could be used to bring about the prince's death. Magistrates took accusations of such activity very seriously, even when it was undertaken by those in quite inferior social positions. Both could be used to bring about the ruler's death. But a magical spell could be more insidious, since it could surreptitiously result in the ruler's loss of self-control and opened the way to manipulation by others. It was not unusual for confidants or favourites at court to be suspected of having used magical means to gain the prince's ear. It could explain the ruler's attraction to an otherwise unremarkable person. But the accusation could also be employed by opposing factions to incriminate and remove that person from court. Needless to say, it was also a fear that preoccupied, even obsessed, the rulers themselves. The Duke of Osuna, viceroy of Naples, was frequently disturbed by such worries, if contemporary chroniclers are anything to go by. He was the same viceroy who challenged the two rival charlatans, honouring the victor. In autumn 1616 a rumour reached him that he had been bewitched by one of his mistresses, Donna Vittoria Mendoza. The spell had led him to favour Donna Vittoria with some potentially lucrative business information and appoint her son-in-law, Don Antonio Manriquez, to the regency of the Vicaría, the kingdom's central civil and criminal court. She was eventually exiled, and her jewels sequestered, while her son-in-law was deprived of his offices and imprisoned in the castle of Gaeta.  

It is also possible that the viceroy only used the charge of sorcery in order to justify his own actions against the pair. Such accusations were all part of the intrigue at court. This penchant for intrigue and conspiracy gave Italians a dubious primacy. The Englishman Fynes Moryson, who had travelled extensively in Italy at the end of the sixteenth century, noted that 'By this nature, or practise growing to a second nature, the Italians above all other nations, most practise revenge by treasons, and especially are skilful in making and giving poisonings... For poisons the Italians skill in making them and putting them to use hath been long since tried.' Divided into factions as they were, Italians could not trust one another, and were forced to employ Swiss or German guards. It also explained the fact that 'the bakers of bread in most parts of Lombard, as having means to betray men by poision, are not Italians, but commonly Germans.'  

Poison was regarded as being part and parcel of Italian political life. The behaviour of Italian rulers and elites would seem to bear this out. When Alfonso the Magnanimous of Naples was sent a copy of Livy (once owned by Petrarch) by Cosimo de' Medici, his physicians advised him not to touch it as the pages might have been poisoned. Both the Sforzas of Milan and the Aragonese of Naples were suspected of having recourse to poison in order to achieve power. But more than anything else, it was the Borgias who gave their name to poison as a form of government and crisis management. Their preferred poison, according to contemporaries, was a whitish sugary powder, probably based on arsenic. It could be dissolved in a liquid or mixed with food without its own taste being noticed. The reputation of Pope Alexander IV and his son Cesare was such that their poison was said to work at any distance of space or time. This is not completely surprising, given beliefs about the nature of poison and the way it worked. What is somewhat surprising is that Cesare should have inherited the reputation of an arch-poisoner since, as Duke of Romagna, he usually favoured more direct methods of assassination, like the dagger and the rope.

The prominent reputation of Italians as poisoners did not mean that poison was a tool of government and social relations in Italy alone. As this chapter began with the success of orvietan in France as well as Italy, it might be worth noting that poison was not an unheard-of method of assassination in the former country. But even in France there is no getting away from the unsavoury reputation Italians had at the time. After the Italian Catherine de' Medici married Henri II in 1531 presumed deaths from poisoning in Paris increased so considerably that a scare ensued. Italians were occasionally employed as hired assassins during the wars of religion. In 1568 the Cardinal of Lorraine's plots against Huguenot leaders included paying some fifty Italians one thousand crowns each to 'empoison wine, wells and other victuals.' The prominence of some Italians merely increased suspicions of their general craftiness and 'Machiavellian' tendencies (a term always used in the superficial sense of political perversion). According to the mental logic of the time, it is perhaps no surprise to find that if Italians should be considered master poisoners, then an Italian could market the most successful poison antidote in France. Fear of poison—and
The archpriest’s surname, Ciarallo (given in Latin as Ciaullus), referred to his role in just such a dynasty. The snake-charmers even achieved the kind of official sanction that came with attempts to regulate them. In his 1564 gloss upon the 1429 Constitutions of the Sicilian Protomedicato, Giovanni Filippo Ingrassia listed the snake-charmers as those who would come under the jurisdiction of the medical authorities. In addition to physicians, barber-surgeons and apothecaries, Ingrassia refers to ‘the pylli, who are called chinalli in the vernacular (because they operate without medications by the powers of St Paul the Apostle, to whom they are given from birth).’ In the kingdom of Naples they are occasionally listed in the records of the Protomedicato, as in the case of the ‘cirale’ licensed in the town of Sanarica (Terra d’Otranto) in 1785.

Ingrassia thus introduces another element: the saintly patronage that snake-handlers acquired for themselves. The involvement of St Paul was part of the Christianisation of their ancient ritual. The Acts of the Apostles (28:8–10) recount how St Paul, on the island of Malta, shook off a viper which had fastened on his hand without coming to any harm. Snake-handlers capitalised on this association, referring to themselves as members of the ‘house of St Paul.’ They thus became known as paulliani or sanpaulliani. The first published description we have of them in this guise is in Ferdinando Ponsettii’s 1521 treatise on poison, which devotes a chapter to them. Ponsettii, a former physician and bishop of Molfetta (Terra di Bari), concentrated on the tricks and deceits they employed to carry out their various feats. Later authors would take up this same approach. Ponsettii noted that when they caught snakes, they held them by their tails and spit on their heads, since human saliva was reputed to have a property against snakes. Before ingesting the snakes’ venom, they were plenty of tripes. This retained the venom temporarily. They then swallowed plenty of hot water mixed with oil and butter, causing them to vomit the tripes and poison together. Their cure for a snakebite was to make the sign of the cross over the bite and have the victim drink some water tempered with terra sigillata, whilst they pronounced the following incantation: ‘Curo caruent, reparat sanum et emanuel paracudium. The ritual was even supposed to work at a distance, when performed on the messenger who brought news of someone having been bitten.

Terra sigillata owed its existence to the same Pauline incident on Malta. Literally meaning ‘sealed earth’, these small cakes were originally made from earth of the island of Lemnos, as described by Dioscorides. To certify their authenticity, they were stamped with a seal. Lemnian earth was believed to have absorbent, astringent and sudorific properties, and was used as an antidote and general remedy against infection. By the period under consideration here Maltese earth was in the ascendency. It was known under a wide variety of names: Terra di Malta, Gratia Pauli, Pietra di San Paolo. Such was its reputation that it was even worn around the neck as an amulet, to protect the wearer from the bites of vipers and poisonous snakes. But not everyone was convinced of its efficacy. In his 1544 commentary on Dioscorides, Pier Andrea Mattioli wrote that although terra sigillata ‘has not a few properties against serpent’s venom . . . In truth, where someone has been bitten by a devil’s head or a viper, little or nothing will help.’

In this region of ours [Abruzzo Ulteriore], in the town of Bisigna, Father Paolo Ciarallo, then archpriest, and the males of his family, who maintain that they descend from the ancient Marsians, pick up serpents with their hands without harm, heal serpent bites with their saliva and from birth bear the image of a serpent on their right arm.
Terra sigillata’s reputation was none the less better than that of the sanpaolor who often sold it. Tommaso Garzoni’s 1583 description of one such operator is worth quoting at length:

Master Paolo of Arezzo appears in the square with his banner where on one side you see a St Paul, sword in his hand, and on the other a bed of snakes which, hissing, they almost bite everyone who looks at them, painted as they are. Now he starts to recount the false origin of his house, the fictitious descent that he draws from St Paul; he tells of the story when he was bitten on the island of Malta, he untruthfully declares how he is the present in all those of his family, he describes the trials undergone, the competition experienced, the victories received, the banners, the snake which, unfolded to show to the people, he picks up his box, and takes out a charcoal-black serpent, two yards long and thick as a pole, and then a madonna, and then a viper, and he frightens the people with the horrible appearance of these beasts. Here he weaves a tale around how he caught them in the forest, while the harvesters harvested the wheat, and saved the estate from the certain death which threatened everyone because of the damage those damned serpents. The plebeian curb in fear, the peasant trembles at the news, which is told with such ability that no one feels safe putting a foot out of the city if they have not first drunk a glass of powder given them by Master Paolo.70

The reputation of the sanpaolori was brought further into disrepute thanks to the rivalry they had with another similar group of snake-charmers, the sandomenicari. Originating in the Abruzzi, they took their name from their saintly patron, St Dominic of Sora. The two competing operators fought pitched battles for customers whenever they encountered one another. Or, no less harmful, they would interfere with one another’s performances. To thwart their rivals, they were said to substitute secretly wild vipers for the tame ones their competitors were using, with often fatal results.71 As early as 1451, a snake-charmer (ciurmatore) known as Master Ferrante from Lecce was found guilty of using his serpents to cause the death of another snake-charmer, Master Alessandro, in Florence.72 The sandemenicati boasted of an advantage over the sanpaolori: they had St Dominic’s tooth as a relic. In one miracle narrative dating from the eighteenth century the holy tooth was charitably employed to save the life of a rival sanpaolori. The snake-charmer was performing in the town of Cocullo (Abruzzi Ulteriore) on the vigil of the feast of St Dominic, bearing of being of the house of St Paul and recounting how he feared no poisons. Whilst playing with his vipers, he was bitten on the tongue. The sanpaolori would have died had the priest not brought him into the church and signed him with the tooth.73

The groups of snake-charmers I have been describing were part of a wide range of itinerants described as swindlers and cheats by the literature of roguary, going back to Teseo Pini’s Speculum cerimonie of around 1484–86.74 They were the first charlatans, and the direct ancestors of the Orvietan and his competitors. The most obvious semantic link between snake-charmers and charlatans is in the Tuscan word used for charlatan, ciurmatore, which means ‘charmer’ or ‘bewitcher’. It was employed with reference to the two 1451 snake-charmers cited above. Vernacular terms used elsewhere in Italy referred to their on-stage performance. Thus montinbanca, or mountebank, which refers to their mounting a platform to perform their wares. The term charlatan itself derives from chiarlano, a result of the diminution of the verb chiarlare (to chatter or prate) into the word ceretano. The latter term designated someone from the Umbrian town of Cerreto, whose inhabitants had the ill fame of wandering about dressed as pilgrims, collecting alms under false pretences. In the tradition that begins with Pini, they gave their name to all sorts of false mendicants and traders: pilgrims, indulgence sellers, friars, alms collectors for hospitals, relic bearers, disease sufferers, all fake. And, of course, snake-charmers. As the most successful of the lot, combining healing skills with show, they are a crucial link in the transformation, real and semantic, from ceretano to charlatan. The Orvietan, a charlatan par excellence, may himself have been a snake-charmer. He certainly capitalised on the tradition: his stage name and alleged place of origin in the central Apennines, his antidote which contained vipers’ tongues and terra sigillata. The Orvietan was a true entrepreneur, making use of traditional beliefs and rituals, whilst at the same time taking advantage of new economic opportunities. His patented medical ‘secret’, one of medicine’s earliest brand-names, was grafted on to the older world of the sacred healer exemplified by the snake-charmer. At a time when most charlatans were peddling ‘distilled waters and divers ointments for burning aches and stitches and the like, but especially for the itch and scabs’,75 charlatans marketing their own exotic electuaries were the first of a new breed.

Medical secrets

What else did the orvietan antidote contain? This is not merely a pedantic exercise. The contents of the remedy will help explain its popularity and tell us something about the seventeenth-century medicine besides. Charlatans stressed the mystery and exotic nature of what they sold. A medical ‘secret’ would not have been much good to a charlatan if the public at large knew its ingredients. According to proto-

[108] physician Santorelli, charlatans call the remedies they use secrets, and as such unknown to physicians, to whom they do not want to reveal them, in case learned by [the physicians], they would take their earnings away. [These people] are commonly called empirics, both because they cannot explain what they do and because they have learned that that medicament is effective, either by means of an experiment done on themselves, or on a friend or relation.76

The ‘secrets’ they marketed were justified as having been ‘tried’ or ‘tested.’ Some charlatans even published booklets of secrets, containing recipes for the treatment of common ailments, a genre of how-to writing that went back to the Middle Ages. These were collections of supposedly proven medical recipes and other ‘how-to’ instructions. They were ‘secret’ because they worked by hidden or artificial (as opposed to natural)
means. During the Middle Ages the best known had been the pseudo-Aristotelian Secretum secretum, an Arabic work translated into Latin in the twelfth century, and the Liber aurum et secretorum aurea, attributed to Alberuni Magnus. The advent of printing brought with it an expansion of such works, directed to wider readerships. Such was Girolamo Ruscelli’s Secretum secretum of 1567. It contains an astonishing 1,245 different recipes: over one thousand were various medical remedies, the rest a miscellany of cosmetic and technical recipes. The book’s author had moved to Naples in the early 1540s, where he entered the service of the marquis of Vasto, Alfonso d’Avalos. Ruscelli apparently founded the Accademia Segreta during this time, where the recipes later published in the book were collected and tried out. The Academy was ‘secret’ in the literal sense of being a secret society and in its investigation of the workings of nature. With the support of a local nobleman, the Academy built a three-storey building, complete with herb garden and laboratory. Its twenty-four members made use of the services of various apothecaries, goldsmiths, perfumers, herbalists and gardeners to assist them in their trials. We only have Ruscelli’s word on all this, but its existence is quite plausible. The patron Ruscelli refers to was probably the Prince of Salerno, Ferrante Sanseverino, who was, amongst other things, supporter of the university there.

If the Academy had a direct descendant it was the Neapolitan Giovani Battista Della Porta. While still young he may have been one of the Academy’s privileged observers. He went on to found his own Accademia dei Segreti in the 1560s. Moreover, his Magia naturale of 1558, consisting of recipes and experiments in medicine, crafts, optics and other secrets of nature, is similar to Ruscelli’s work in both content and methodology (despite the fact that Della Porta’s approach is sometimes quite obviously tongue-in-cheek). Throughout his life Della Porta remained interested in natural magic – calling it ‘the science of the extraordinary’ – and was acknowledged as Europe’s foremost authority. It was something he was not afraid to take advantage of. Towards the end of his life he was even said that he had received more than one hundred thousand ducats from his patrons for his work, ten times the viceroy’s annual salary.

Despite the eventual impact of the new science, an esoteric tradition survived in the kingdom, as elsewhere. Nor did printed recipe collections entirely supplant the manuscript tradition. For example, the familiar mixture of medicine, magic and religion is present in an eighteenth-century manuscript recipe-book that has come to light. It is unusual in that we know its author: he was Jacopo Fraiise, from the town of Capaccio, south of Salerno. The title he gave to his collection suggests his reason for compiling it: ‘Idleness avoided in prison. A collection of very good secrets and proven [tried out] medicaments.’ I cannot say why he was in prison or what his profession might have been. But I can say that his collection consists of nearly three hundred recipes, which follow one another without apparent order. The recipes are a mixture of: (i) Latin verses taken from the ever-popular Regimen Sanitatis Salernitanum, with Italian commentary; (ii) remedies in Italian for a whole range of maladies; and (iii) a series of verses from various psalms. The latter, when uttered ‘devoutly’, had the power ‘to find hidden things’, spare those in danger of drowning, provide divine help for the sick, or counter the bites of dogs and serpents, to mention just a few. Certainly there is nothing surprising in using the recitation of psalms to beseech divine intercession. What might surprise, however, is the way each psalm was used to target a specific malady or misfortune, in the same way that popular invocations addressed the particular saint most relevant to that malady. Biblical verses are scattered throughout the collection, such as the remedy for falling sickness (that is, epilepsy). This was to have a priest say the verse ‘Memento, Domine creature tuae’ three times into the sick person’s left ear. A remedy for kidney-stone consisted of a powder made from rosemary which had been planted on the feast of the Annunciation (25 March) and picked on the feast of St John (24 June), similar to remedies found in popular healing rituals. Many of the secrets listed by Fraiise are not medical at all: ‘to destroy any maleficence’, ‘to find out whether the husband or the wife dies first’, ‘to find out if a woman is pregnant’, and even laundry advice on how ‘to remove any stain’ (brandy and starch). It is impossible to say whether the collection was ever consulted, and if so in what way. Was it ever used in a household setting? All we can say is that it was managed to find its way into the archive of the Del Mercato family, where it still rests.

Were such collections ‘popular’? The answer depends upon our definition. Fraiise certainly drew upon oral herbal traditions, the property of every housewife, and the incantations and conjurations of cunning folk. But he also took his secrets from the published works ‘of the finest ancient and modern authors’, as he says in his preface. These include Della Porta and a certain Madama Fochetta. The latter turns out to be the Frenchwoman Madame Fouquet, author of a successful charitable handbook, first published in 1675. But unlike Fouquet, Fraiise was not writing for the uplift of the poor, but for his own delectation and that of his class. The vegetable ingredients like ambergris, saffron, ‘dragon’s blood’ (a resinsubstance given off by the Indian palm), myrrh, and the mineral ingredients like rock alum, litharge (protoxide of lead) and minium (red lead), which fill his secrets, were accessible only to the well-off. The same can be said of the recipes found in Ruscelli’s Secretum secretum, which reflect upper-class tastes, especially evident in the secrets of a cosmetic, alchemical and technological nature. The Italian manuscript recipe collections I have come across range from the very detailed and technical, compiled and used by apothecaries, to the more approachable, descriptive and practical, for use in upper-class households. The Gizi ricettario, described in the previous chapter, has elements of both. The collections are all very eclectic and varied; and they are clearly intended for an at least semi-educated, literate audience. It is, of course, quite possible that some of these medical secrets would have found their way down to the oral tradition. For this reason it may be helpful to see these collections as mediators between oral and literate cultures, much like the charlatans.

In 1585 Tommaso Garzoni included a description of ‘professors of secrets’ in his Piazza universale, referring to them as tireless searchers into obscure, veiled and occult things. Some of their secrets were ‘great’ (such as for healing plague), others ‘mediocre’ (healing quartan fever) and others ‘light’ (healing scabies). Some were ‘perfect’, in having the desired effect all the time, others worked most of the time.
the rest rarely. The link between them and charlatans was the increasing commercialisation of the economy as a whole and of drugs in particular. As far as Santorelli was concerned, it was axiomatic that charlatans sold ‘secrets.’ The Neapolitan Protomedicato continued to label ‘secrets’ certain of the charlatans it licensed, eight of whom were included in the 1784–85 list for the capital. Charlatans became synonymous with the secrets they marketed, like orvietan. Referring to orvietan, the Palermitan naturalist Paolo Boccone bemoaned that ‘the secret passes from father to son by inheritance and usually these charlatans or mountebanks do not reveal the entire description of orvietan to the authorities for fear of losing their daily income.’ Boccone could only repeat the description of it made by Madame Fouquet in her book of remedies, adding the version revealed to him by a Palermitan charlatan operating in Genoa in 1688. Fortunately, we have the records of the Italian Medical Colleges and Protomedia to help us. As part of their petitions for licences and patents, charlatans had to list the ingredients of their ‘secrets’ and the quantities used. Whatever Boccone thought of the deceptions of charlatans in withholding details from the authorities, by comparing the submissions of various (competing) charlatans for licences over a period of some one hundred and fifty years, we should be able to get at the actual contents of the antidote.

Riollet gives two versions of orvietan. The first, which he states was dictated to him by the charlatan Desiderio Combes, contained eight ingredients. The second contained fifteen ingredients. Although the two versions had only three ingredients in common, their contents were entirely herbal, with the addition of theriac and mithridatum (about which, more below). Other versions circulated, according to Riollet. But, whatever their differences, they all share ‘a horrible bitterness, that can only come from the roots I have listed.’ Anyone who considered the people selling orvietan, the price at which they sold it and the short time and minimal fuss required to make it, could only come to the conclusion that the orvietan was made of plants, without any rare or precious ingredients. Orvietan’s low price and the ‘prodigious quantity’ sold indicates that the simples were abundant and readily obtained.

In fact, there were many more ingredients than those included in Riollet – as many as forty-five. The sheer number of simples suggests that orvietan was being offered as an accessible, if not poor man’s, theriac. This was the conclusion reached early on by the German physician, resident in Rome, Johannes Faber. Referring to a 1603 case, he noted that orvietan was ‘very common amongst the people, much less effective than theriac and therefore much cheaper.’ The theriac of Andromachus still came out on top, with sixty-four ingredients, but orvietan was a close second. The most detail comes from two petitions made in the second half of the seventeenth century, when the Protomedia and Medical Colleges were at the strictest when it came to examining and approving charlatans. Of these two recipes for orvietan, the first has forty-five ingredients and the second forty-two. At first glance they seem quite at odds with one another, since only just over half the ingredients are found in both orvietans. This is especially curious since both recipes come from submissions made by the same charlatan, Paolo Angelini, heir to Gregorio Ferranti. The first is contained in a petition made to the Siena

Protomedicato (1665), the second in a petition made to the Rome Protomedicato (1674). It would seem to bear out the words of Boccone. However, a closer look at the seemingly disparate list of ingredients reveals some noteworthy similarities. Both recipes depend overwhelmingly on traditional herbal simples, with three or four spices (cinnamon, cloves, cassia, pepper) added for good measure. Both share a core group of the same thirteen simples reputed to be effective against poison: angelica, snakeroot, blessed thistle, white dittany, vipers’ bugloss, gentian, juniper berries, St John’s wort, bay berries, tormentil, valerian, vervain, swallow-wort. In addition, they contain a few simples – though not necessarily the same ones – used to treat wounds and sores (such as speedwell, germander, agrimony). Finally, they each contained at least ten simples used to cleanse, purge and open obstructions of certain organs. How could it fail? Orvietan took advantage of accepted wisdom on herbal antidotes, putting them all together for added effect. And it included powerful simples known for their perceptible purgative effects on the body. No poison would dare to remain in the victim’s body with all that working against it.

If the simples did fail, then theriac was there to back them up. Riollet was prepared to admit that orvietan did have its ‘good effects, sanctioned by long and happy experience.’ But it could not fulfil the extravagant claims made for it by swarms of charlatans. Herbs alone could not possibly perform miracles. Though orvietan may have been prepared with ‘good things’, one had no way of knowing whether the roots were well chosen, gathered when their balsamic virtues were strong and prepared in such a way as to maintain these virtues. ‘Orvietan is nothing but a confused and badly compounded mixture of powders and roots’, Riollet concluded. Therefore any efficacy it had must be due to the theriac contained in it. Orvietan’s success was just a flash in the pan, whereas theriac had been an approved remedy for over eighteen centuries. Moreover, unlike orvietan, it was methodically prepared and dispensed with ‘marvellous order.’

The antidote of antidotes

Theriac, always popular, had been enjoying something of a new vogue when orvietan came on to the scene. In 1572 the physician and professor at Salerno, Bartolomeo Maranta, wrote that theriac had two principle virtues, ‘one that . . . it preserves the healthy, the other that it cures the sick.’ Its sixty-four ingredients formed a miniature pharmacopoeia. Indeed it owed its success to its very complexity, for a medicine’s therapeutic value was proportional to its compositional intricacy. Theriac was a standard feature of medical practice, especially for the rich, who could afford its costly and exotic ingredients. The poor were stuck with more standard herbal remedies, especially garlic, which was proposed as the ‘theriac of the rustic’ and considered better suited to their rougher constitutions.

The origins of theriac went back to the ancient world, when a physician of Alexandria prepared a remedy against poisons for King Mithridate VI. To his antidote, called mithridatum, Andromachus the Elder, physician to Emperor Nero, added vipers’ flesh. It was believed that vipers were resistant to their own as well as
other poisons, because their flesh contained something active against them. Disease itself was thought to be a kind of poisoning, through the corruption of vital humours. Therefore, when ingested by humans, viper's flesh would be effective not only against viper's venom, but against disease in general. For this reason Galen recommended theriaca for all sorts of ailments, in addition to poison. It gained a reputation as a universal remedy, with an important role in preventative medicine. During the early modern period every Italian city with a university or Medical College prepared its own theriaca, in elaborate public ceremonies involving medical, civic and ecclesiastical dignitaries. It was being manufactured in Venice as early as the twelfth century. In fact, Venetian theriaca achieved the most renown throughout Europe. This success was ‘an expression of Venice’s commercial power and the wealth of the great Venetian emporiums, well-stocked in all kinds of spices and drugs.’

For the Bolognese naturalist and protophysiologist Ulisse Aldrovandi, the theriaca of Andromachus was the ‘regal antidote of antidotes’, ‘the most powerful and invincible, and Ishall say predestined arm that physicians can use against every lethal, soporific, wasting, incurable, incurable, pestiferous poison.’ During the latter decades of the sixteenth century botanists and apothecaries like Aldrovandi felt they were getting closer to the theriaca of Antiquity, locating the precise simples that made up the ‘true’ theriaca of Andromachus. The Neapolitan apothecary, botanist and museum-keeper Ferrante Imperato spent years tracking down the true ingredients, some of which he obtained from contacts in Venice. Between 1557 and 1571 he was able to reduce the number of substitute simples used in its preparation from ten to six, according to Maranta, who collaborated with him. Such was the momentous nature of developments towards perfecting theriaca according to classical canons that the Neapolitan physician Nicola Stiglioli invited the kingdom’s protophysiologist to attend its preparation.

For his part, Imperato had gone about as far as it was possible for an apothecary to go in the kingdom. His museum of curiosities allowed him to dabble in natural history, the sort of thing that would normally have been off limits to an apothecary. His interests propelled him forward and opened up new worlds. He was a member of the council governing the guild of apothecaries, the Speziali degli Otto, author of a treatise on natural history, had close ties with the Spanish viceroy, and would go on to hold various political positions. He was able to help a fellow apothecary when Aldrovandi, as protophysiologist, got into difficulty over his attempted reform of Bologna’s official theriaca. The dispute centred around the quality of the vipers that the Bolognese apothecaries were using and the troches made of them. Imperato wrote in Aldrovandi’s defence, as did other prominent physicians, including the Neapolitan protophysiologist, Giovanni Antonio Pisano:

You will hear from Ferrante Imperato, from whom I received one of your most learned letters, that I have procured the opinions of our College so that it would be more authoritative, confirming the correctness of your judgement of the time to collect vipers and that those troches were badly made. I wrote it myself, showed it to everyone and had it confirmed by the Prior of our College.

As it did not help Aldrovandi’s position in Bologna much. The city’s apothecaries allied themselves with the Medical College to have him ousted as protophysiologist, though he was eventually reinstated.

The popularity of theriaca in Bologna does not seem to have suffered as a result, appearing in the city’s Antidotari from 1574 through to 1783. This longevity was in no way remarkable. In the nearby city of Reggio Emilia the last official preparation of theriaca was around 1850, while Venice had only abandoned its public ceremony in 1842. Theriaca was one of the few compound medicines which went on being recommended during the eighteenth century, including the French writers of the Encyclopédie. Its decline in some areas – it was left out of the Edinburgh pharmacopoeia as early as 1756 – seems to have had little effect on the kingdom of Naples. At mid-century the experienced apothecary Nicola Meola referred to theriaca as ‘a miracle continued here on earth for the benefit of man.’ He thought it should be more widely used, though this should be kept secret from the state, presumably because of the latter’s attempts to enforce a monopoly on its production and sale. King Ferdinand IV was determined to reinforce this monopoly. His pragmatic of 1779 was meant to ensure that all the kingdom’s theriaca came from the same source and was of the same standard. Previous attempts to control it had been through the inspection of apothecaries’ shops. The kingdom’s apothecaries were required to stock only jars of theriaca bearing the signatures of two of the Speziali degli Otto, responsible for its preparation. Needless to say, apothecaries were occasionally tempted to prepare their own. For instance, in 1697 two Salerrian apothecaries were accused of making twenty litres. Worse still, they had done so in secret, at the villa belonging to one of them – in contrast to the official theriaca, prepared very much in public. The penalty for the offence was an amazing 1,000 ducats, an indication of how seriously the authorities regarded their monopoly. Nor could it prevent its clandestine importation from dubious sources, including cheaper theriaca manufactured illicitly in Trieste and resold as far afield as Constantinople. The 1779 law stated that all the kingdom’s theriaca was to be prepared in the chemical laboratory of the newly founded Royal Academy of Sciences and Letters. It obliged all apothecaries to buy a certain amount annually, all from one apothecary’s shop in the capital designated to dispense it. Profits from the sale of theriaca were to go to finance the activities of the Royal Academy. The Abbé Ferdinando Galanti was prompted to remark sarcastically: ‘in order to make an excellent theriaca, superior to Venice’s, and in order to oblige apothecaries to buy it by force’ an Academy was founded, ‘much more as an object of finance than for the progress of human knowledge.’ Rather than ease difficulties surrounding the distribution and control of the sale of theriaca, this policy led only to further irregularities, which persisted until all pretence to the monopoly and the income generated by it was finally abandoned in 1866.

Charlatans and theatre

Given the official nature of theriaca, it is easy to see how orvietan could undercut the market. It was touted as something new. It responded to the attraction for
novelty, according to Riollet, despite the fact its contents were entirely traditional, simples known and sold by apothecaries. What for Riollet was a weakness, a sign of deception, could also be seen as a point in orvietan's favor, helping to account for its success. But there was something new about orvietan. Riollet realised this, when he observed that 'there is also the high-flown display of dancing and pantomime, which strongly attracts the people, and which compels those who see them to give them money, more with the intention of obliging the sellers to put on their faces than with the purpose of buying their remedies for their health'.106 The Italian charlatans in general, and the Orvietans in particular, brought entertainment with them. And not just any tricks, but theatre, in the form of the commedia dell'arte. The more orvietan they sold, the longer their performance would be. Though not all commedia dell'arte troupes sold patented remedies, and not all remedy-sellers performed extemporised comedies, there was a significant overlap between the two groups.

At the end of the sixteenth century these overlapping groups were new on the French scene and soon caught the public's imagination. Italian troupes had been coming to France since the 1570s, and by the early decades of the seventeenth century they were staying longer - as long as ten years - and becoming a familiar part of the French cultural scene.111 The years when Italian charlatans like Contugi decided to reside permanently in Paris were also the years when Italian actors did the same, eventually leading to the formation of the Comédie Italienne in Paris.112 The fact that both groups came from Italy helps to explain why French opérateurs like Verrier and Descombes should change their names to Vetrario and Combi, respectively. To quote Riollet once again, Frenchmen 'have not missed the opportunity of calling themselves foreigners in order to sell their drugs with as much fuss as the others'.113

In Italy the commedia dell'arte and charlatanry derived from the same medieval traditions of farce, trickery and clowning.114 Both began to flourish at the same time. Just when snake-charmers were developing into charlatans, the commedia dell'arte players in Naples and elsewhere were drawing up contracts for professional performances.115 Their histories are in fact intimately interwoven, a fact which has been hidden by the divergent approaches of scholars over the years. Historians of theatre have, naturally enough, been interested in the performance-related elements, whilst historians of medicine have focused on the remedies sold. But the distinction is, often as not, an artificial one. Certainly, in the strict climate following the Council of Trent the religious and secular authorities tarred them all with the same brush. They were all itinerants, lacking a secure legal status. Moreover, any kind of acting was suspect, since their fictions were considered akin to lying and deceit. After having excluded troupes for a time, Naples opened its gates to them again in 1589. By way of penance, however, the income derived from the licence fees for each performance was awarded to the Incorruptibles Hospital.116 In Milan the governor forbade all 'masters and players of comedies, herb-sellers, charlatans, buffoons, zanes and mountebanks... who are wont to mount their platforms and to draw a crowd around them' from performing on Church feast days or during Lent and from erecting their platforms near the church.117 Neapolitan archiepiscopal decrees were more concerned with their activities inside churches, especially disruptive while mass was being said.118 Contemporary descriptions also relate how troupes would choose a place in the public square, where, having set up a stage, they get up on to it, to be first the charlatan and then the actor. They would gather the attention of passers-by with tricks and clowning. Once a crowd had formed, the head charlatan would discourse on 'the great and incomparable credit of his marvellous medicament.' It would then be offered for sale. Once the selling had come to an end, 'the platform becomes a stage and every charlatan an actor.' The grand finale was 'a theatrical performance which, in the comic tradition, entertains the people for about two hours with reverence, laughter and amusement.'119 The overlap between player and charlatan is also reflected in the licensing records. Actors and charlatans were frequently the same people, as their stage-names reveal. The tooth-drawer and seller of a 'refreshing ointment' for burns and sores and an oil to help hair grow, Tommaso Maiorini of Capua (near Naples), went by the name 'Policinella', one of the characters in the commedia dell'arte, and particularly linked to the city of Naples.120

The charlatans' use of theatre was one of the aspects that most infuriated the medical elites. The Italian Medical Colleges and Protomedicati were increasingly concerned with trying to impose some kind of order on the wide range of healers. As explored in chapter three, physicians, surgeons, apothecaries and midwives all had their recognised roles. They were not to exceed their professional boundaries. Charlatans, however, broke all the rules. They had pretensions to knowledge and experience which, the elites believed, should have been the monopoly of university-educated physicians and surgeons. By selling medicines, they competed with apothecaries, a fact that was especially insidious because they often insisted on calling them medical 'secrets'. Their use of performance and entertainment was the most apparent indication of their ambiguous status. It was thought to bring medicine into disrepute. Critics like Scipione Mercurio quoted St Thomas Aquinas on the sinful nature of stage-plays, based as they were on dishonesty and deceit. Watching their 'performances acted out by zanies, Gratans, puppets or other sorts of buffoons' was not just sinful; trusting in their ineffectual remedies prevented people from employing other remedies, of help to the sick.121 In their treatment of charlatans, we see the medical elite's 'fear of crowds, of novelty, of strangers and, perhaps, of laughter itself.'122

It was not just the charlatans who were accused of being 'theatrical' during this period. The same criticism was made of Fra Antonio da Camerota, who would announce miracle cures to all and sundry in the church of Santa Maria della Sanità, in search of donations, as we saw in chapter one. Whereas the investigating physicians may have seen cause for reserve and caution, the friar certainly did not. Indeed charlatans frequently had to share the same square with equally histrionic monks and priests. In Naples one well-known preacher shouted to the crowd to ignore the Policinella performing opposite. 'The true Policinella,' he said, pointing to his crucifix, 'the really great Policinella, here he is.'123 Camillo de Lellis, the Abruzzese
founder of the Ministers of the Sick, also made the connection. On one occasion, in his native town of Buccianico, he climbed on to a platform and told the people gathered outside church on Sunday that he had ‘resolved to come into the square to find you and be a spiritual mountebank for your salvation.’ After preaching on the abhorrence of sin, he said: ‘Just as the other mountebanks always sell something useless to the people at the end of their patter, so at the end of my talk I would like, not to sell, but to give you a pious and blessed thing.’ And he took from a bag, not the usual patent medicines, but religious medals, which he handed out to the crowd.124

Preachers and charlatans alike – sacred and secular orators – held their audiences spellbound by their emotionally charged performances. While charlatans were being reviled and ridiculed by the medical elites, they were also exceedingly popular with audiences everywhere, as the example of Girolamo Ferranti shows. They mixed care for the body with an understanding of popular culture and sensibilities. The combination of spectacle and treatment became a kind of social ritual, the charlatan – with his patented ‘secret’ – a ‘commercialised shaman.’125 In a very public space charlatans offered entertainment, escape, laughter, play, fear and surprise, along with medical treatment and the easing of suffering. Of course, not all charlatans managed to reach the heights of prestige in the Ferranti. In fact, most charlatans led a rather wretched, wandering existence. They would take advantage of whatever opportunities to buy and sell presented themselves, often selling simple remedies for everyday ailments purchased from apothecary shops.

Many itinerant peddlers were not born into the trade, but adopted it as part of a personal strategy of survival. It was often just a stage in a person’s life, giving way to other activities according to need and opportunity.

The only reason so much can be said about the Orvietan and other charlatans is because of the medical licensing records. Fortunately for the historian, the medical elites were inconsistent in their revulsion for charlatans. The physicians may have despised them in their learned treatises, but they licensed them to sell their remedies throughout Italy and France. Though so often perceived as the ‘other’,126 the charlatan was in fact a crucial part of the medical network of early modern Europe. A remedy like orvietan was within firmly established medical traditions. The assumptions behind it were entirely humoral. Its contents were repeatedly examined and approved by the medical authorities. The petitions made by generations of Orvietans to the authorities were written by literate men. And the handbills they used to sell orvietan were written in Tuscan Italian, the language of a small elite, employed to impress. They had as much faith in their patented antidote as the elites had in theria. For this reason at least one Orvietan dispensed his ‘secret’ from his Roman home. That is, he had a permanent address, which, far from keeping hidden from the public, he actually sought to capitalise on.127 When it came to marketing secrets, regular practitioners soon learned how to play the charlatans’ game. The only difference was that they hid their own rare secrets in learned treatises. The physician-surgeon Federico Zerenghi concluded his 1603 work on surgery with a teasing reference to his own sure-fire cure to the French disease. It purported to cure within a few days, without suffering or inconvenience. Anxious – or merely curious – readers were referred to his next book, soon to appear.128 (But like the academic monograph announced as ‘forthcoming’ for years on end, it never did.) More in keeping with this chapter’s subject was protophysiologist Piperno’s proposed antidote included in his treatise on magical afflictions. It was proclaimed to be effective against ‘all magical and inveterate diseases’, poisons and animal bites, acting as both a preservative and a curative. Piperno compared his remedy favourably to orvietan, though his version had a paltry twenty-five ingredients. But, the author boasted, unlike the mass of greedy charlatans, he was motivated to reveal his antidote by charity alone: ‘for, in the words of St Augustine, to hide the truth is to tell a lie’129 This public-spirited motivation was one way in which physicians attempted to differentiate themselves from charlatans. The charlatans themselves, when caught selling without a licence, or when accused of harming someone, also played the charity card. They insisted that they had been distributing their wares gratis, for the benefit of the poor sick, not for financial gain. It is to the role of charity in health care that we now turn.

NOTES

1 Secondo Lancellotti, L’Orvietano per gli hoghediani (Paris, 1641).
4 The point is made by Mark Jenner in his article ‘Quackery and enthusiasm, or why drinking water cured the plague’ in O.P. Grell and A. Cunningham (eds), Religion, medicine and religion in seventeenth-century England (Aldershot, 1999), p. 327.
6 Ibid., p. 40.
8 A.S.S., Studio, 60, fol. 28v.
9 A.S.R., Università, 58, xxxi, fol. 175.
10 From a document contained in a petition to the Rome Protommedico, A.S.R., Università, 58, no. xxxi.
11 Archivio di Stato, Florence, Carteggio di Don Giovanni, 5140, fols 452v, 466; in Alessandro D’Ancona, Viaggiatori e avventurieri (Florence, 1974 edn), p. 109. The Annali (advises, notices) was a sort of early newspaper, containing items of local news.
71 Riollet, Remanes, 31, citing Mattioli.
74 Reprinted in Campanari, Vagabondi, pp. 3-77.
75 Moryson's, Itinerary, p. 424. His observation is borne out by the detailed records of the Siena Protomedicato. In the period from 1592, when records begin, to 1611, the first appearance of Ferranti in the records, most charlatans sold a variety of unglaubliche medicines designed to treat general ailments. A.S.S., Studio, pp. 45-6.
76 Antonio Santorelli, Il protomedico napoletano, ovvero dell'autorità di esso (Naples, 1652), pp. 222.
77 Girolamo Ruscelli, Segreti nuovi di maneggiatura virtù (Venice, 1567).
79 Ibid., p. 222.
81 Madame Fouquet, Recueil de recettes choisies, experimentées et approuvées (Villefranche, 1675).
82 Garzoni, Piazza universale, pp. 80v-81r.
83 A.S.S., Sommaria: Protomedicato, series II, 34.
84 Paolo Boccone, Museo di fisica e di esperienze (Venice, 1697); in Alberico Benedicenti, Modesti, medici, farmacisti: storia dei rimedi attraverso i secoli e delle teorie che ne spiegano l'azione sull'organismo (Milan, 1951 edn), vol. 2, p. 992.
85 Combes, or Descombes, went by the name of Combi, claiming to be an Italian; Le Poulmier, L'Orvietano, p. 16.
86 Riollet, Remanes, pp. 17-18.
87 Johannes Faber, Renum medicarum Nove Hispaniae thesaurus, seu plantarum animalium mineralium mexicanorum historia (Romae, 1651), p. 778. Faber was physician at the Rome hospital of Santo Spirito at the time. He recounts that a peasant came to him, at death's door following a viper bite and having taken some orvietan. Faber immediately administered some theriac, amongst other things, and cured the man. My thanks to Silvia De Renzi for bringing this to my attention.
88 A.S.S., Studio, 48, fol. 181-3; A.S.R., Università, 58, no. xxxi. A third recipe is contained in Francesco Navas, 1649 petition to the Bologna Protomedicato. It contains thirty-four ingredients, two-thirds of which are shared with the Angelini recipe. A.S.B., Studio, 144, fol. 55.
89 Riollet, Remanes, pp. 5, 21-3.
90 Bartolomeo Maranta, Della teriaca et del mistriado lieti in (Venice, 1572), pp. 8, 163.
93 Galen, De teriaca, xv, xvi.

95 Mongelli, 'Diffusione', p. 314.
98 Paula Findlen, Possessing nature: museums, collecting and scientific culture in early modern Italy (Berkeley, 1994), p. 217. Giugliola was a member of the Accademia dei Lincei and author of a treatise on theriac, Teriaca et mistriado Nicolai Stelliiiae Noriani bellius (Naples, 1577).
99 Ferrante Imperato, Dell’historia naturale (Naples, 1599). It was dedicated to the viceroy's son-in-law and governor of Milan, Juan de Velasco. Imperato's son Francesco would follow in his footsteps, both as author and as man of politics, eventually becoming the Marquis of Spinetto.
100 Biblioteca Universitaria, Bologna, Aldovrandi, MS 21, vol. iv, fol. 318r (Naples, 10 December 1575); in Findlen, Possessing nature, p. 283.
101 Olmi, 'Farmacopea', pp. 213-14; Corsini, Medici ciataliani, p. 36.
103 In a short treatise entitled Antiteriaca, essay on mistriado and theriac (London, 1745), the English physician William Heberden denied theriac had any antidotal virtues at all. None the less, theriaca did find its way into the London pharmacopoeia of 1746; it disappeared from the following one, issued in 1798. Watson, Theriac, pp. 116-47.
107 According to a 1777 Venetian trial discussed in Mariano Brugnera, Frammenti di un processo per la falsificazione della teriaca veneta', Atti e memorie dell’Accademia italiana di storia della farmacia, viii (1941), p. 87-93.
110 Riollet, Remanes, pp. 6, 26.
111 Dubost, France italienne, p. 101.
113 Riollet, Remanes, 15.
116 Archivio degli Incurabili, Piatta (1859), fol. 349; in Croce, Teatri, p. 50.
118 Constitutiones et decreta provincialis synodi neapolitanae (Naples, 1580), p. 73; Constitutiones diocesanae synodi neapolitanae (Rome, 1608), p. 6.
CHAPTER FIVE

HOSPITALS, POOR RELIEF
AND HEALTH CARE

As one of Europe’s most populous cities throughout the early modern period, Naples had hospitals to match. The Casa Santa dell’Annunziata, for example, was Europe’s richest. Built ‘like a spacious castle’, according to a seventeenth-century guide-book, ‘it maintained as their condition, age and health require, two thousand souls’. It took in many hundreds of children, ‘between orphans and exposed infants as well as males as females’, instructing them ‘in letters and art, according to their inclination till they become great. It treated the sick of all kinds, dividing them up into wards. Each patient had, much to the amazement of an anonymous seventeenth-century English visitor, ‘a clean bed, with all necessaries and attendance, as if he were at home in his own house, until he recovers, all gratis.’ What was more, ‘every bed stood as in an alcove, and had a wall on both sides separating it from beds on both hands, and as much void space on both sides of the bed that the bed itself took up but half the room.’

The Annunziata was but one of the city’s many hospitals. Enrico Bacco’s guide to the city, first published in 1616, lists eleven hospitals in operation, ten conservatories for women, eleven for girls, five for boys and one for the aged. Together, they assisted some six thousand people every year. The Annunziata and the Incurabiles hospitals were by far the largest and most endowed. Together, they were referred to as ‘the two eyes of Naples, the two columns’ supporting the city. However, despite their imposing presence and the impression they made on visitors from abroad, their contributions to poor relief in Naples were but drops in the ocean. Throughout the early modern period the kingdom lacked a co-ordinated programme of poor relief, depending instead on forms of charity that had their roots in the Middle Ages. The study of poor relief and health care in Italy has tended to focus on the development of hospitals for beggars. In Naples, this took place relatively late and was never very effective. This does not mean that poor relief was lacking, but that it was decentralised. The unification of smaller hospitals into one large ‘ospedale maggiore’ that took place in some other Italian cities during the second half of the fifteenth and first half of the sixteenth centuries did not occur in Naples. As in other Italian states, forms of charity were extremely varied. And although the Counter-Reformation inspired a flowering in works of charity and devotion, most of this was ad hoc and sectorial, arising out of particular situations
or in specific places and targeted at special groups. The Catholic Church, in the form of a strengthened episcopacy, did seek to exercise increased control over hospitals, as it did over confraternities and other 'pious works.' Yet this went in the face of ever increasing politicisation of hospitals, more closely linked to civic and state authorities. These are the features of health care and poor relief during this period.

A Naples hospital for the mal de Naples

Some of Naples’ charitable structures were in place by the fourteenth century. The earliest hospital was San’Eligio, founded in 1270 by the French who came with Charles of Anjou, and followed by the Annunziata in 1336.7 The hospitals were assisted by confraternities like that of San Cristoforo, already flourishing by the mid-fourteenth century.8 The same could be said of the kingdom’s other cities, for example Lecce’s Spirito Santo Hospital, founded in 1392 and still that city’s largest hospital in the seventeenth century, or the hospital of the Benedictine monastery at Cava, in the mountains above Salerno, already exercising a specifically medical function in the early twelfth century.9 But it was the sixteenth century that witnessed the greatest expansion in the kingdom’s hospital structure, beginning with the Santa Casa degli Incurabili, the Incurables Hospital, in 1519. Hospitals for ‘incurables’ were a response to a new plague which had been spreading through Europe since the closing years of the previous century: the ‘French disease’ (the name given to syphilis and related complaints). It first appeared on the European scene in Naples, explaining why the French preferred to call it the mal de Naples.

The first hospital to be set up was San Giacomo di Augusta in Rome, which received Pope Leo X’s approval in 1515. The response to the disease is best seen in a devotional context, in the religious renewal that was taking place throughout Europe and would lead to both the Protestant and Catholic Reformations. The Incurables Hospital in Naples was founded by the Catalan noblewoman Maria Laurenzia Lonc, through the assistance and inspiration of the Genoese Ettore Vernazza. The latter had set up the pious association known as the Oratory of the Divine Love, first in Genoa and then in Rome. He even attempted to found one in Naples, but it floundered on the rocks of rivalry between the local nobility and the Genoese merchant nobility.10 The Oratory had a close relationship with hospitals for incurables: in Genoa it would run Santa Maria del Ridotto, and it founded other hospitals elsewhere.

The project to build such a hospital in Naples attracted substantial donations and bequests, and within three years it had moved to new larger quarters at Santa Maria del Popolo. Lonc was indefatigable and chose to live in the hospital. By 1525 it was taking in ‘almost innumerable poor people . . . oppressed by the misery of sores and diverse illnesses.’ A short ten years later the number of inmates was put at six hundred.11 It is difficult to say how strict the criteria for entry into the hospital were, and just what conditions were included under the rubric of illnesses ordinarily ‘incurable’ at home. In fact, like many of its counterparts elsewhere on the peninsula, initial specialisation in the care of syphilis did not exclude other illnesses, nor did it mean a shift to an exclusively therapeutic function.12 By this time the hospital was also the base of the pious brotherhood known as the Compagnia dei Bianchi, taking the place of the Oratory of the Divine Love in Naples. Similar to the Oratory in most respects, the Bianchi had the important distinction in that they provided assistance to people condemned to death. Many early members were important religious figures, like Gaetano da Thiene, founder of the Theatines. Some were followers of the Spanish reformat Juan de Valdés during his stay in the city. One such was Sigismondo Miñoz, who was also one of several Bianchi who served on the hospital’s governing body.13 In 1523, soon after its inception, the Bianchi moved to the Incurables from their original base, at the ancient church of San Pietro ad Aram, in order to bring benefit to the said hospital and increase its devotion.14 In its charitable activities, the hospital was to be given priority, a weekly alms collection being destined for it. As the brotherhood’s 1525 statutes explained: ‘given that we are as a limb to it, it is right, indeed natural, that one member feel compassion for the other.’15

The Incurables was unusual in being founded and run by a woman. In 1533 Lonc retired to a strict, enclosed Capuchin convent, which she herself had founded. She was succeeded by her assistant and confidante, Maria Ayerbe d’Aragona, the duchess of Termoli. Ayerbe was likewise a pious noblewoman, a source of inspiration to the hospital staff. At the same time, the hospital was acquiring a more regular bureaucratic structure. The viceroy Pedro de Toledo sought some sort of control over the institution. As of 1539 the appointment of governors had to meet with the approval of the civil authorities, according to the hospital’s statutes of that year, recognised by the viceroy. The statutes suggest that Ayerbe’s role was reduced to the spiritual and hint at possible tensions between her and the governors. They concluded with a reminder to all members of the governing body ‘to show all possible reverence and respect, as befits her Ladyship’s services, and involve her in all the affairs of the hospital.’16

Ayerbe rewarded the hospital by leaving it all her worldly goods. Indeed, bequests of money and land were soon pouring in from all over the kingdom and beyond (principally Spaniards and Sicilians). Most of the wills did not stipulate how the money was to be used. A few testators, however, donated to the hospital on the condition that they be cared for there until they died; others, for the maintenance of a specific number of beds within the hospital.17 One benefactor even specified that special consideration be given to other natives of his own town of San Marco in Lamis (Capitanata). This included giving them three ducats for their return home after hospitalisation.18 Two other features of the legacies are worth noting. First, the fact that most concern income derived from the collection of the kingdom’s numerous taxes and duties (the arratameniti and gabelle): an indication of just how common this form of investment was. Second, benefactors were quite happy to give to the Annunziata Hospital as well, splitting their money evenly between the city’s two main charitable institutions.

The hospital belonged not just to the city but to the entire kingdom. Links between the Incurables Hospital and the viceregal administration expanded over
the course of its first century. The formation of its governing body went far beyond purely municipal dynamics. One of its governors had to be designated from amongst the ranks of the kingdom’s Collateral Council, another had to be a titled nobleman, another a knight from one of the city’s five noble assemblies (Seggi nobili), another a Spanish member of the great central tribunals, two were to come from the popular assembly (the Seggio del popolo) and one was from the representatives of the foreigners in the kingdom. This did not mean that the hospital was somehow secularised, but it did ensure that serving on its governing body became a mark of prestige for those holding important administrative offices. Moreover, benefactors living throughout the kingdom left substantial sums to the hospital, especially in its first seventy years. In practice, the hospital did not exist for citizens of the capital alone, as has been suggested. The same could be said of the Annunziata. Indeed it was not unusual for well-placed functionaries to serve on the governing bodies of both institutions. One early example was Giovanni Battista Manso, jurist, baron and president of the Chamber of the Sommaria, who was a governor at both hospitals in 1539.

Hospitals and the Counter-Reformation

If there is no real dividing line separating hospitals founded before Trent and those founded after it, there is no doubting the great impulse that the Counter-Reformation gave to hospital charity. It is worth emphasising in this context that we must resist the temptation to see hospitals as existing in a medical or welfare sphere that is outside the religious. This is especially true after Trent when, with their increased powers, bishops seek to exercise jurisdiction over them. For contemporaries, hospitals were ‘pious works’, sacred places, in the same category as churches, monasteries, convents and chapels. Communities of religious lived in the hospitals, along with other pious individuals who dedicated themselves to serving them. This is why they are so often the theatre of religious devotions, the nature of which changes as the religious climate at large changes. At the same time, and not always harmoniously, they were also sources of political power, as we have seen. Finally, it is only towards the end of our period that hospitals become the focus, first, of medical learning, usurping the role of the universities, and, later, treatment, competing with home visits by practitioners. It is worth bearing in mind that even in the 1780s the Incurabili hospital had more ecclesiastics than medical practitioners and nursing staff combined.

One of the many clerics who lived at the Incurabili in the 1580s was the Piecantine Alessandro Borla, assistant to the bishop of Naples. Borla’s presence there allowed him to have needy girls and women admitted, who had been refused entry by the Casa dello Spirito Santo. The latter was itself founded in 1564 as a conservatory for vulnerable women or pericolanti – the fear being that they had already or might turn to prostitution. In 1583, in response to what was felt to be an obvious need, the princess of Sulmona, Costanza Doria del Carretto, spent twelve thousand ducats to have some ground-floor rooms renovated, to house the poor women. It was one of the spheres in which women, especially noblewomen, could undertake initiatives. At the same time, del Carretto was continuing in the female tradition of the Incurabili Hospital. Two years later, through Borla’s ongoing influence, she was able to found the Casa Santa del Rifiuto, purchasing the former Orsini palace for the purpose. Like many other Tridentine structures of its type up and down the peninsula, it was intended for the reform of prostitutes, the hope being that they would eventually marry or become nuns. In the meantime, they were to be isolated from the world: living a cloistered life, centred on work and prayer. The fact that the girls processed into the refuge wearing the habits of Capuchin nuns was a sign of what was in store for them. It also points to a paradox typical of the Counter-Reformation: while women were encouraged to undertake important charitable activities, their effect was to exclude groups of women from the public sphere. Despite del Carretto’s substantial means, the refuge relied on public support for its continued survival. Amongst the contributions was a fixed donation every year from the bank of the Annunziata Hospital – as incongruous as it may seem to have one hospital contributing to another.

The Annunziata had the ability to adapt to the changing climate. Even before the Council of Trent had ended in 1563 the hospital had become a renewed focus of spirituality and charity. In 1556 its governor, the nobleman Alfonso Piccicelli, downplayed its activities in an attempt to involve the nascent Society of Jesus. He told St Ignatius that the hospital was only working to half its capacity: caring for bodies most splendidly, but ignoring people’s souls. This opinion was not shared by other Jesuits in the city. In the same year Cristoforo Mendoza informed Ignatius that ‘if there is devotion in Naples, it is all in the Annunziata.’

The hospital’s liturgical and spiritual activities continued to be performed by a well-prepared clergy, resident at the hospital. The clerical body consisted of sixty priests and thirty deacons. In 1575, after the Jesuits had declined to become directly involved, it established its own seminary, training twenty-five priests. The hospital’s superior, the sagrista, was usually a bishop, and was an important figure in the life of the city. The hospital’s church became a centre for preaching the Tridentine message, including such preachers as the Jesuit Alfonso Salmerón. The splendour of its ceremonies was well known: one thousand ducats a year was spent on music alone. In fact, its wealth was the result of centuries of bequests. Luigi d’Aragona, bishop of Avessa, put it on a firm footing in 1515 when he left it the fief of Montevergine. As of 1587 it had its own bank, or Monte. By the time Francesco Imperato wrote his treatise on the hospital in 1629, the Annunziata possessed landed estates throughout the kingdom and owned numerous buildings in Naples, as well as earning interest from investments in the collection of various taxes and arrendamenti. The latter earned the hospital around two hundred thousand ducats a year.

The physicians it employed earned a salary of two hundred ducats a year, fifty more than that of a university professor of medicine and ten times more than the physician serving the city’s main Dominican monastery.

But the fate of the Annunziata also rested on the fact that the money was spent, and spent charitably. It maintained some eight thousand foundlings a year, many of
whom were sent out to its 2,500 wet nurses. Whatever the infants’ places of origin — and many foundlings were sent in from provincial towns — they were considered Neapolitan-born, acquiring the right to Neapolitan citizenship (assuming they survived).\textsuperscript{27} At the age of eight, boys were entered into a trade, via the city guilds, or into a family. Occasionally, they became clerics. Girls could remain in the hospital until the age of eighteen, where they were taught ‘feminine activities and skills’ by the hospital’s several hundred teachers.\textsuperscript{28} Each year seventy girls were awarded dowries of ninety ducats.

Although the abandonment of infants was a regular practice, the Tridentine Church did not attempt to eliminate it. Rather it insisted that infants only be abandoned out of dire necessity, and only once they had been properly baptised. Infants were to be left with a note around their neck bearing their name. And they were to be left only at hospitals and other places prepared to take them. The phenomenon seems to become worse during the second half of the seventeenth century with the decline in living standards. In some areas parents temporarily left children at foundlings’ homes, as part of an economic strategy to cope with lean times — like admitting oneself to the workhouse during periods of the year when work was slack outside.\textsuperscript{29} The effects were particularly acute for those living from day to day on temporary work. It may explain the constant increase in the number of foundlings taken in by the Annunziata. Despite an only gradually increasing population throughout the kingdom, the annual average intake of the hospital climbed from around 600 foundlings in the 1680s to around 1,100 in the 1730s.\textsuperscript{30} According to Giuseppe Maria Galanti, writing in the mid-1780s, of the kingdom’s twenty-five thousand foundlings, two thousand were sent to the Annunziata from outside Naples every year. This was despite the existence of a network of Annunziata foundlings’ homes, linked to the Neapolitan parent home, throughout the kingdom, but especially in the province of Terra di Lavoro. In addition, it received another seven hundred from within the city. Of the total, over half were dead on arrival or died within their first year while out at a wet nurse (numbers that are comparable for other European cities).\textsuperscript{31} The situation was worse in the provinces. In most areas there was not a single institution able to take in and care for foundlings, with the result that ‘they are exposed at the gates of monasteries far from inhabited areas, or at the doors of [the houses of] parish priests, confessors or public midwives. Eight out of ten perished.’\textsuperscript{32} An attempt to reform the situation was only made in 1801 under Ferdinand IV. Each municipality, overseen by a local commission, was to be equipped with a nota to receive foundlings, who were to be visited by community physicians and surgeons. But differences between Naples and the rest of the kingdom remained, as did the low payment awarded to wet nurses.\textsuperscript{33}

The Annunziata was also a hospital for the sick, divided into several separate wards: an infirmary, and wards for fever sufferers, those with curable sores and convalescents. The English Catholic priest John Eustace even noted that ‘when a patient has recovered his health and strength and is about to return to his usual occupations, he receives from the establishment a sum of money sufficient to compensate for the loss of time and labour unavoidable during his illness.’\textsuperscript{34} Can this have been standard policy? The Annunziata also supported charitable activities outside its walls. Its five maestri had a list compiled of deserving or shamefaced poor, to whom was destined a total of 100 ducats a month. This was not a great amount: roughly enough to pay the monthly wage of seventeen labourers. For the more common poor the hospital could spend up to thirty ducats a day, plus one thousand ducats every Saturday. The latter was a substantial amount, enough to buy around a thousand tonoli of wheat (forty thousand kilograms), though less than half that amount in times of dearth. In addition to dowries for its own foundlings, the hospital poor girls from the city and surrounding countryside with dowries of sixty ducats (equal to what a labourer might earn in ten months) and contributed to the dowries of the less poor to the tune of twelve ducats each. Every year it made two thousand ducats available for priests and religious institutions fallen on hard times, as well as providing some convents and monasteries with medicines.

It supported the city’s smaller hospitals (as we have seen) and contributed one complete meal to the inmates of each of the city’s ten prisons once a week.\textsuperscript{35} It even responded to private requests for assistance, providing help to take up a trade or pay the rent.\textsuperscript{36} Such was the Annunziata’s place in the heart of Neapolitans that when a fire destroyed part of it in 1574 donations poured in from all sides, including two thousand ducats from the Incurabili’s hospital.

As with the Incurabili Hospital, the governing body of the Annunziata was made up of highly placed individuals, though they were more closely connected with city politics than the governors of the Incurabili. Of its five top governors, one — the mastro nobile — was to be appointed from the noble Saggio of Capua, and four — the mastri cittadini — from the Saggio del Popolo, so that non-noblemen tended to hold sway. Indeed the hospital was one of the strongholds of the popular assembly, and many of its governors went on to become representatives (eletti) of the Saggio.\textsuperscript{37} In this sense, it was used as a power base or a stepping-stone to greater things. Because of the Annunziata’s multiplicity of interests and activities it had to govern itself shrewdly and seek to maintain links with the civil authorities. The demands of influence and integration into local elites explain why its four ‘popular’ governors are specifically referred to as citizens of the city. But this was the only sense in which the Annunziata privileged city residents over outsiders. Other offices, such as that of physician, often went to practitioners from outside the capital.\textsuperscript{38} And, as we have seen, the foundlings and patients themselves came from all over the place. Once again, there does not seem to have been the same discrimination against non-citizens for poor relief as experienced in other Italian capitals, such as Turin.\textsuperscript{39}

Although private charity in Naples continued to revolve around the Incurabili and the Annunziata, individuals did establish their own, smaller hospitals. This was a continuation of traditional models of charity, where institutions were set up to meet a specific need. Such was the conservatory and hospital of Sant’Onofrio, for the aged, founded by Ottavio Cassano in 1607, the conservatory ‘for blind youths’, founded by Aniello de Mano the following year, and the hospital ‘for poor cripples’ founded by the surgeon Tiberio Melfi in 1655.\textsuperscript{40} The inspiration behind such
foundations was primarily devotional and charitable, but practical considerations had an important role in governing them, dependent as they were on private funds for their continued survival. The founding charter of the hospital for poor cripples advises caution, and a dose of scepticism, in awarding home relief: 'Do not pay heed to the lamentations that with much show they are well able to demonstrate and exaggerate their needs, giving to believe that they alone suffer more than everyone else; therefore let experience be your teacher.'

Lay confraternities

In 1608 Sanzio Cicatelli described the large numbers of Neapolitan noblemen, divided into various religious brotherhoods, who 'without any kind of disgust look after the sick.' Born in Naples, Cicatelli could not help remarking that 'to tell the truth I do not remember ever having read or heard that in any other city of Christendom such a large number of noblemen go to serve in hospitals as in Naples.'

The statutes of one such noble congregation, the Oratorio del Santissimo Crocifisso, founded in 1553, identified in such charity the reason why 'Naples is exulted as the garden of Italy, not just for its pleasant hills, but also because [it is] a land ever rich in talented people and lively intellects, and cradle of saints and useful institutions.'

The obligation for confrères to perform acts of charity was not new by any means, but the Tridentine emphasis on the performing of good works as a means to salvation was formally written in to the statutes of the many confraternities founded or renewed after Trent. The 1562 statutes of the Santa Croce confraternity asserted that since visiting the sick is so important, the Lord himself having clearly indicated that by visiting the sick He himself is visited . . . all our brothers must visit the sick of the hospitals of this city; that is, for each hospital three brothers of our company . . . must visit the said poor sick, giving them that comfort and consolation that God inspires in them.

The emphasis was on spiritual assistance, ensuring that sufferers died without 'any hate or obstinacy.' The confrères reserved physical aid for one another. It must be said, too, that looking after the sick pauper could become little more than a pretext, a means of obtaining salvation. What should we make of the actions of one Neapolitan confrère who promised, in 1646, to make the beds of ten sick people during the year while reciting prayers on behalf of the Jesuit general, Vincenzo Carafa? The same can be asked of the many benefactors who, in their wills, stipulated the placing of plaques or busts in hospital corridors or churches and the saying of masses on their behalf. As a tangible sign of their presence, many important Neapolitan families had side-chapels in the church of the Annunziata Hospital.

Confrères were reminded not to interfere in the running of hospitals. Nor were they to disturb the work of medical practitioners, but make themselves 'available to them, in all simplicity and humility, for the needs of those poor people,' in the words of the Santissima Annunziata confraternity of Lecce. The confraternal contribution did not end with the Counter-Reformation. Well over two hundred years after Trent several confraternities still routinely served the sick on certain days of the week at the Incurabili hospital, when 'they make the beds and serve the lunch that they themselves have prepared.' The charitable activities of the city's confraternities continued to impress visitors well into the nineteenth century.

As an extension of service in hospitals, confraternities occasionally contributed to the upkeep of a certain number of beds, presumably assuming the right to nominate who would occupy them. Early modern charity was not disinterested. When a member of the Oratorio del Santissimo Crocifisso stipulated the provision of twenty new beds for the Incurabili Hospital in 1685, the congregation decided to contribute another eight, in order to fill an entire ward. It was not seen proper to have other beds alongside their own, easily recognised by the symbol of the Oratory displayed on each one. The hospitals came to depend on such outside support. The charitable functions of confraternities were generally administered by moni, special funds or banks, which they set up for the purpose. A typical example is the confraternity of knights who set up the Monte dei Poveri Vergognosi in 1614 for the benefit of the 'shamefaced poor.' It supported twenty-nine beds at the Incurabili, as well as feeding a certain number of the hospital's sick every Tuesday. It also assisted the poor in prison, supplied twenty poor girls with dowries each year and contributed to the dowries of poor girls of noble families wishing to enter a convent.

Congregations were also set up with the specific intent of founding and running a hospital. This was especially the case among the large communities of familiari present in the capital. As soon as numbers and economic fortunes permitted, they sought to establish their own confraternity, church and simple hospice caring for the sick and poor of their community. Religious devotion mixed with notions of national prestige. Due to the kingdom's status as a Spanish dominion, there was a large number of Spanish nobility, administrators and military personnel concentrated in Naples. This led to the creation of a brotherhood 'pro pauperibus Hispanicæ nationis.' With the support of the viceroy, Pedro de Toledo, they received papal approval in 1532. This permitted them to build a hospital dedicated to San Giacomo, complete with church, cemetery, apartments and offices. Land was purchased near the Castel Nuovo, in the area then known as 'little Genoa', inhabited by a community of Genoese merchants. Work on the hospital was initiated in 1547. This was no ordinary hospice, however. In 1583 and 1585 papal bulls exempted the church and hospital from local episcopal jurisdiction, putting them under the direct authority of the Holy Sec. The hospital maintained its link with the military, taking in soldiers, but it expanded to take in the sick poor. During the middle decades of the eighteenth century it came to function as a teaching hospital, equipped with an anatomy theatre, museum, library and surgery. Practical anatomy, physiology, pathology, practical medicine and surgery were taught to twenty-four live-in students, plus various supernumerary and day students, who served in the hospital whilst undergoing instruction.
The wealthier and larger confraternities might even found their own hospitals. The nine-hundred-strong confraternity of Santa Trinità dei Pellegrini founded the hospital of the same name in 1579, which specialised in taking in vagabonds, for three nights at a time, and convalescents from the other hospitals. Outside the capital, analogous foundations were more modest, on a scale compatible with local populations and financial means. Gravina, with some nine thousand inhabitants, benefited from a twenty-two-bed hospital founded and run – not without serious problems – by the Santa Maria del Piede confraternity, the town’s richest.52 The same could be said of the Sacro Monte di Pietà Hospital in nearby Bari, founded in 1593. Here the governing body – a prior and two mastri nazionali in charge of accounts – was consistently drawn from the ranks of the hospital’s confrères. Except, that is, on those rare occasions when the confraternity was able to tempt the archbishop into serving as prior. The hospital’s annual income varied widely, but averaged in the five hundred to six hundred-ducat range.53

Most of the kingdom’s confraternities could not aspire to such works of charity and prestige. Instead they were dependent on the alms they collected in order to carry out their visits to hospitals and prisons. In practice, however, hospital visits by confrères may not have been as consistent as implied by the rousing words of the confraternity statutes. The Santa Croce confraternity statutes were mentioned above; but the subject of hospital visits never came up at any of the confraternity’s meetings or featured in its registers over the centuries.54 This is to say nothing of those confraternities which functioned sporadically, were underfunded or otherwise fell into decline. The impressions of English visitors notwithstanding, there was a lack of basic provision for the sick in hospitals of the time. Constant nursing care was virtually non-existent. The situation was that much worse in hospitals operating on a shoestring, in debt or governed by officials more concerned with their own careers. In 1601 the officials in charge of Gravina’s Santa Maria del Piede hospital were denounced for mismanagement. Hospital patients complained that they did not buy the medicines the physician prescribed. Moreover, it was said of the officials that ‘if they drink wine, they give water to the sick; if they eat chicken, to the paupers they give leaves.’55 Just over a hundred years later an apostolic visitation severely criticised the confraternity responsible for not having spent ‘even a penny’ on the hospital, allowing it to become totally derelict.56 Ecclesiastical visitations, which frequently provide descriptions of the conditions – physical and otherwise – of a diocese’s hospitals, remind us that lists of charitable institutions in a given locality tell us only part of the story.

The Ministers of the Sick

It was to provide continuing, reliable care – spiritual and physical – that the Abruzzese Camillo de Lellis set up his male nursing order, the Ministers of the Sick, in 1586 (figures 7, 8). Sanzio Cicatelli, already cited, sets the scene. The description is obviously rhetorical – it forms part of an early hagiography of de Lellis – but it alludes to features of hospital life that must have been widespread:

Who could ever recount the number of inconveniences from which the sick have been freed by the continuous presence or residence of our own [priests] in the hospital? How many times before this, for lack of someone to help them or feed them, did the sick go entire days without tasting any kind of food whatsoever? How many seriously ill paupers, because their beds were not cleaned even once a week, rotted amidst vermin and filth? How many weak paupers, in getting out of bed for whatever need, died or seriously injured themselves falling down? How many, delirious from thirst, could not obtain a little water to rinse out or freshen their mouths?59

The Ministers of the Sick was to be a congregation of priests, along the lines of other ‘clerks regular’ like the Jesuits, Theatines and Oratorians. This arrangement, typical of the Counter-Reformation, gave individual members and houses a certain degree of freedom to adapt to differing pastoral situations. De Lellis’ association with Philip Neri in Rome contributed to this decision. Its contribution was to be similar to that provided by the confraternities, but more systematic and better organised. According to its statutes, members of the order were to tend the sick according to physicians’ wishes, informing physicians of any changes in the patients’ conditions. They were to help the sick to eat, wash them, make their beds and help them to die a ‘good death.’ The statutes distinguished between priests and lay brothers, the former performing the more spiritual tasks, the latter primarily nursing duties, though there was a substantial degree of overlap. There were very few conditions put on what was referred to as ‘complete service’ in hospitals: but they were not to undertake portering, kitchen work, pharmacy or care of the insane. Sensing possible sources of conflict with hospital administrations, de Lellis stressed that they were to resist the temptation to become ‘syndic or controller’ of the hospitals in which they served.

Tentative beginnings were made at Milan’s Ospedale Maggiore in 1594. Ten years later they were firmly established in Naples, under de Lellis’ direct supervision. Twenty-four Camillians were serving at the Anunnziata, fourteen at the Incurabili and six at San Giacomo degli Spagnoli.60 What, exactly, they did is not easy to say. We know little of their actual day-to-day routine. At the introductory hearing into de Lellis’ canonisation, held in Naples, it was said that ‘he conferred with physicians on the things necessary for the health of the sick, of which he had made a list.’ This could include fairly specific nursing tasks. He would make the rounds of the sick, ‘carrying a box with four or five jars of various kinds of water, according to the needs of the sick, to refresh them, wiping their tongues and rinsing their mouths.’ In addition, he ‘carried a chamber pot at his belt for the use of the sick, even bearing the necessary pots for them.’61 Members of the order, like medical practitioners of the time, also visited the sick at home. They were recognisable because of the small red cross on their habits, for which they were soon known as ‘Padri della crocetta.’ Once their founder acquired a reputation of saintliness, the priests would bring along a relic of his on their visits, if requested. The more important the sick person, the more important the relic. A well-connected sufferer like Vittoria di Ferrante was brought a reliquary in the shape of de Lellis’ head.62 Given
the belief in the powers of relics to bring about a saint's miraculous intercession to heal disease, they form another aspect of the charity offered to the sick.

Just as it is difficult to ascertain the practical role of confraternal assistance and how it fit into the day-to-day management of a hospital, the same can be said of the contribution made by the Ministers of the Sick. The fact that they were allowed into institutions like the Annunziata on a full-time basis suggests a need and desire for what they offered. Despite the obvious need for people prepared to carry out the most menial, not to say disgusting, tasks, the relationship with hospital administrators was not always easy. Tensions did occur, beginning with de Lellis' own early decision to found the house in Rome outside the auspices of the hospital of San Giacomo degli Incurabili in Rome. In Sicily - like Naples a Spanish dominion, though with a distinct administration - the Camillians were never permitted to enter into service at any of the island's hospitals. The authorities preferred to have them tend to the poor who died unassisted in their own homes. And in Naples itself service to the Annunziata was withdrawn in 1639, only to be restored the following year. An otherwise rich source for details on
daily life and illness, the canonisation processes, are of little help in this regard. Any tensions arising in the performance of their duties are not referred to, even obliquely. The superior of the Annunziata, Rev. Scipione Carrozza, gives no particular details about de Lelli’s workaday relations with the hospital. Indeed, he seems most impressed by the fact inkeepers would take down profane images if they knew de Lelli was staying the night, replacing them with sacred ones, since de Lelli was known to change innns if there were no images of saints decorating the walls.64 Even an assistant physician at the hospital, Giovanni Conca, sheds no light on the situation, making only generic references to de Lelli’s ‘ardent charity’ in serving the hospital’s sick.65

There is no doubting the difficult and sacrificial nature of their work. From the start the Camillians were given the most thankless tasks. When Spanish galleys were quarantined at Pozzuoli, outside Naples, in 1539 because of an epidemic of pestilential typhus on board, the viceroy turned to the Camillians to give succour to the sick and minister to the dying.66 Their commitment was tested to the full during epidemics. During the plague of 1566 three Camillians entered into service at the San Gennaro pesthouse. The archbishop – from the relative safety of the mountain-top monastery of San Martino – sent others to the parishes of Santa Maria della Scala and Sant’Arcangelo agli Arreni to assist plague victims. Others alternated between day- and night-time duty in various places in the city. While the epidemic raged through the city some Camillians had to be withdrawn from active service to tend the increasing numbers of Camillians who were themselves becoming plague victims.

In all, forty-three Camillians died of plague in Naples, almost all as a result of tending plague victims throughout the city.67 A typical victim was Fr Pietro Suardi, from Bergamo, who had been serving at the Annunziata for over thirty-five years, since just after his ordination. There was a handful of other victims serving in the nearby towns of Gaeta and Aversa, as well as in the towns associated with de Lelli’s place of origin, Chieti and Bucchianico. The plague was a disaster of unprecedented proportions for Naples (to say nothing of the kingdom as whole). For the Camillians it resulted in the suspension of regular service at the city’s hospitals. The provincial superior was amongst the victims, as were the prefects of each of the order’s three Neapolitan houses. Complete service to the Annunziata was restored only in 1678, along with only weekly visits to the Incurables Hospital.

The monti

Mention of the monti as a form of charity has already been made. The kingdom’s first charitable bank, the Monte di Pietà, was founded in 1539, lending small sums of money at low rates of interest. It was located at the Annunziata until the latter founded its own bank, the Monte Ave Gratià Plena, in 1587. Six additional charitable banks were established over the next fifteen years: at the Incurables, San Giacomo, San’Elenio, Santo Spirito, the Monte dei Poveri and the Monte della Misericordia. These were the kingdom’s largest banks throughout the early modern period and many trade guilds and confraternities invested the funds of their own smaller monti in these banks. All of the kingdom’s monti were dissolved by the Napoleonic government, though some were re-established after 1815.68

Religious brotherhoods were often behind their foundation and running. The Incurables’ monti was established in 1590 by the confrères of the Jesuit-run Immacolata congregation. Revenues were to be employed in helping the sick of the hospital, as well as the shamed poor.69 The latter aim was typical of aristocratic confraternities. Poverty applied not only to those whose very survival was in question, but to those who lacked the means to live as their status in society required. In a 1631 deliberation the Pio Monte della Misericordia declared that whilst ‘the poor of the people . . . by themselves without great repugnance can expose their necessity to the pious affections of others . . . the nobility, out of human reserve, most often remain in the wretchedness that, in accordance with adverse events, is often wont to occur in the human condition.’ The monti were a typically baroque mixture of charity and ostentation, piety and prestige. The Pio Monte della Misericordia was founded in 1602 by a small group of Neapolitan noblemen who had already been meeting regularly at the Incurables Hospital. It went on to become the city’s wealthiest monti. Each of its seven governors had equal standing: changing position every six months during their term of office (which lasted three years and six months), which entailed rotating around a seven-sided inlaid table. Membership was only open to noblemen, through payment of thirty ducats. Nobleswomen were admitted as benefactors through payment of twenty ducats. As early as 1627 it had enough funds to pay Caravaggio the enormous sum of four hundred ducats for his painting entitled Our Lady of Mercy, depicting the seven acts of mercy. In 1658 – barely two years after the calamitous plague of 1656 – it began work on its own palace and church and by the eighteenth century had an annual income of some sixty thousand ducats.

By this time the Pio Monte gave alms to specific cases of needy people, maintained a number of poor noble boys at the Jesuit noble seminary, distributed dowries and assisted the friars of two Capuchin monasteries. The alms were destined primarily to members of the titled nobility who had met with misfortune, death or disease: widows, women abandoned by their husbands, priests, Monte members, soldiers, doctors. Once the Pio Monte had decided to award an individual a monthly allowance, the recipient continued to receive it until death. Assistance was revoked only if their status changed. For men: if they came into new wealth, took in a concubine, took up paid manual labour, publicly begged or were found to have faked their poverty. For women: if they remarried, lived immodestly, left the city, became domestic servants or begged.71 The Pio Monte was able to respond to conjunctural crises affecting numerous families, such as the failure of the Annunziata’s bank in 1700. During the eighteenth century it supported forty-five beds at the Incurables Hospital, and provided lunch for the hospital’s sick every Friday. The latter activity alone cost the Pio Monte two thousand ducats a year, more than the income of most town hospitals. In addition, the Pio Monte ran a hospice on the island of Ischia for the mineral baths, to which it organised two trips a year of some
two hundred people, including accompanying clergy. It provided 206 girls with dowries each year. And with the rise of Paris hospital-based medicine, the Monte funded the study of surgery in Paris of a local student for four or five years, following a legacy left by Luigi Tortora.72 By this time, however, it would appear that the Pio Monte's original charitable impulse had been lost to routine and bureaucratisation. Rather than expand its sphere of operations to new kinds of needy, it tended to go on helping the same families (we see the same surnames reappearing) and groups (aged and ill doctors eventually account for a third of all allowances).73

Smaller-scale moni were a typical Counter-Reformation response to the threat of hardship, mingling piety with practical concerns. Thus the Spanish in Naples had their hospital of San Giacomo. A monte was also set up with the specific intent of helping Spanish residents who had fallen on hard times: poor girls, widows, the sick, prisoners and pilgrims. It even made funds available to pay for a voyage back to Spain.74 Monti existed for any sort of group sharing similar interests, in addition to national communities: trade guilds, family lineages, a town's peasants. In fact, notions of poverty and poor relief were dominated by ideas about the group. It was considered the business of the group and helped to define it. The kingdom can be seen as a network of moni, which existed in even the smallest towns. Moreover, the dominance of the group in providing various forms of charity, from dowries to health care, helps explain the relative absence of state involvement in poor relief in the kingdom.

For the kingdom's guilds and artisan confraternities moni were the most common form of mutual assistance. Whilst many of these trade corporation-cum-religious brotherhoods had been in existence since the Middle Ages, many more had sprung up after Trent. Piety overlapped with trade protection, even attempts at wage control. In 1599 the archbishop was prompted to remark that, in Naples, 'the number of confraternities and congregations claiming to have charitable purposes has multiplied greatly.'75 A guild's monte was administered by the guild itself, by appointed governors, either to assist guild members or to undertake a variety of welfare schemes. The monte set up by the apothecaries' and grocers' guild was to be administered by four masters resident in Naples, though its assistance extended beyond the capital.76 The members of the guilds would contribute either a monthly quota or a percentage of the trade's total output. When a guild member fell sick a guild representative would visit him to ascertain his condition. A visit from a physician would be arranged if necessary. The physician might then issue a medical certificate stating the nature of the illness, which would determine the financial recompense due to the guild member. The amount was usually around one or two carlini a day for the first month (a figure approaching what a labourer might expect to earn); then half that rate for the second month. If the invalidity lasted a third month the governors of the monte would meet to decide on eventual further payment. In the case of a guild member who could no longer practise his trade because of disability, the governors were to use their discretion to decide on a monthly allowance, 'so that he does not go begging.'77 Allowances were also issued when old age or imprisonment (as long as the cause was 'honourable') prohibited a member from earning a living. And widows might receive a pension to permit them to live an 'honourable life', though the sum was relatively low three or four carlini a week.

The greatest expense the guild moni faced was not the care of its own members, but their daughters: the funding of or contribution towards dowries for marriage or (less commonly) to enter a convent. Most guilds would dowry from two to four members' daughters each year.78 Dowries ranged from the twenty-four ducats of the poorer guilds, like the carpenters', could afford, to those of eighty to one hundred ducats offered by the richer guilds, like the goldsmiths' and the tailors.79 The stress was on mutual assistance within the group. Dowries were an investment in the future: if no children resulted from the marriage – and thus no future guild members – the dowry would have to be paid back to the guild (just as an aristocratic father would claim back the dowry if his daughter died without heirs). Poverty was often only introduced as a criterion in the awarding of dowries later on, as funds proved inadequate. Thus the monte of the apothecaries' and grocers' guild stated in 1602 that it would 'always prefer the neediest poor girls and the eldest, and this to avoid the disorders that have occurred in the past in [awarding] these marriage dowries.'80 The monti also supported refuges and 'conservatories' for orphaned girls or women at risk related to guild members.

Much the same could be said of the monti set up by another type of social grouping – family lineages. They reinforced a family's sense of identity and belonging, recognised in the meetings of governors which often took place in the family chapel, a fact which might be stipulated in the founder's will.81 Their expansion during the sixteenth and seventeenth centuries was less a result of religious fervour and charity towards the poor, than an increasing tendency to exclude women from inheritance, providing them only with a dowry. To this we must add notions of honour that the old Neapolitan noble families possessed, resulting in the requirement to provide ever larger dowries for the daughters. In addition, fallen branches of the clan affected the status and reputation of more well-off ones.

Attempts to protect and provide for 'vulnerable' women were a crucial aspect of early modern charity. The establishment of conservatories went hand in hand with the provision of dowries. The aim was to ward off the threat of prostitution, which contemporaries worried was the only recourse for women lacking male support or without a means to maintain themselves. In the case of family and guild moni the main criterion was membership of the group and the possible threat such helpless women might pose to the group's honour. The confraternities could afford to be more outward-looking. The Oratorio del Santissimo Crocifisso stipulated that candidates for its dowries must be genuine: 'poor Neapolitan girls, honourable virgins [who] never have been in the service of others.' But their motives in providing dowries were similar. One girl, who proposed herself, seemed to have the necessary attributes, or at least knew what the aristocratic confères were looking for. In 1646 Grazia Bocana petitioned (in the third person) that she found herself in such wretchedness that she had no place to sleep, staying at the house of a woman in the Arinella [quarter] out of charity, where the said woman keeping her can no longer
support her. 'Worrying that she would descend into vice', Bolcana concluded, 'and having found someone who wants her... she beseeches Your Most Illustrious Lordships to grant her a marriage dowry from the de Curtis monte that it would be an act of charity.' Yet even the confraternities' notions about poverty were not absolute. They still referred to the inability to lead a life consistent with one's station. Charity existed to prevent this from happening. Husbands of the girls provided with dowries were of a similar status to the girls themselves; that is, their status prior to the accident or misfortunes which had left them poor. For the most part they were artisans (carpenters, tailors, weavers, shoemakers), domestic servants and shopkeepers (including the occasional apothecary).

Similar to the guild monti were the monte established and run by various groups within the capital's large public administration. The clerks and fiscals of the Court of the Vicaria (the central civil and criminal court) set up a monte for their own welfare and that of their families in 1604. The notaries of the court did likewise fourteen years later. Not that there was anything especially dangerous or threatening about working at the Vicaria; all groups had to look after their own interests. Even the officials employed at the Annunziata hospital set up their own monte, in 1663. In the latter case it might have been particularly prudent. It has been calculated that a childless man in Naples could not survive on less than eighteen ducats a month. The charitable institutions charged rents of ten ducats a month for the very basic, ground-floor rooms, known as bassi, they owned. The result was that even some of those employed by the Annunziata, such as the porters, earning twenty ducats a month, were often confronted with very real poverty. Whether they could afford to pay into the monti schemes was another matter. They formed part of the estimated two-thirds of household heads who might have required the services of charitable institutions at one time or another.

Throughout the kingdom towns also set up monti for the benefit of their own inhabitants. They varied a great deal from place to place. The most basic and specialised were the grain banks, monti frumentari, which made seed corn available for the next year's planting. They originated and spread rapidly as a result of the crisis in the countryside. Hunger forced peasants not only to eat their seed, but go into debt for the following year. The monti frumentari also sought to protect peasants from unscrupulous landlords who made loans which forced the peasants into lifelong debt. But during years of dearth their loans of grain were more likely to end up in the stomachs of famished peasants than be planted in the soil.

Many towns also set up more generalised monti for the poor. Changing attitudes towards poverty and the poor had an effect on the way these monti operated. In 1783 the governors of the nascent monte dei poveri of the town of Salice received instructions from Naples concerning the nature of the recipients. 'The earnings', the approval specified, 'are to go in aid no longer of pilgrims, who are for the most part lazy, nasty and useless to the State because of their indolence, but rather to just those citizens [who are] truly poor and who are declared to be such by the parish priest and administrators of the municipality.' In any case, the monte proposed financial assistance of no more than one carlini per person at a time, with the exception of 'some wretched sick person or cripple' whose need was greater.

The setting-up of monti was not the only sort of charitable initiative that towns could take. Feudal structures put great demands on the kingdom's towns, but they were able to show some vitality nevertheless. For instance, the mayor and elected officials of the village of Cava, bereft of 'any shop whatsoever', decided to run a small outlet selling foodstuffs at regulated prices. In terms of medical provision, most towns would seek to bring in a community physician (medico condotto) and surgeon (chirurgo condotto), or at least the latter. The arrangements were usually for a fixed period, during which the condotto was to reside in the community and treat the poor gratis. Factors like the town's size and the amount its budget could permit would affect the nature of the contract, as we saw in chapter three.

The capital was a special case. In Naples the city government's six elected officials controlled the import of grain and were responsible for the city's food-provisioning measures. The latter less than welcome task fell to the elected official from the popular assembly. Naples was privileged in having a regulated and more or less guaranteed supply of grain, a fact which attracted thousands of people from the surrounding countryside and provinces each year, especially during times of dearth, as we have already seen in previous chapters. Giulio Cesare Capaccio's ironical tone in describing the influx hides a real fear of popular revolt:

Calabrians, Apulians, Abruzzesi, and closer, people from Costa and Cava, have so filled the whole city with their presence that they make up almost a third of it... Naples is full even of those who come to live in it... Such that, speaking of inhabitants of this kingdom, when some are here [in Naples] they seem to be reborn and their customs change and that village rusticity becomes civility. A freedom characteristic of Naples makes itself felt, and they want bread at the best possible price, the whitest and biggest loaves, and they forget about the barley and millet bread they used to eat.

The difficulties inherent in the job of food provisioning were demonstrated by the treatment meted out to the Eletto Giyan Vincenzo Starace. In May 1585, during a wave of rioting over the price of grain, Starace was assaulted by the populace, put on trial and killed. Then his corpse was dragged through the streets, from the working-class district of the city (the Selleria), along the main thoroughfares to the vicerey's palace.

Poverty, public order and the state

The thousands of migrants arriving from the provinces each year in search of work or food each year made it a national issue. This was a problem faced by capitals of all the Italian states. Naples's large size made the problem particularly acute. Any increase in the kingdom's population was felt almost exclusively in the capital, or at least such was the conclusion reached by a 1726 report by the Collateral Council. During the years immediately before and after the famine and epidemic of 1764, some twenty-five thousand to fifty thousand desperate migrants entered the city.
The result was begging. Even in normal years beggars and vagrants were said to form one-tenth of the city's population. As one description put it: 'crowds of wretched people and prostitutes, children without families, homeless, naked and sickly, infest the inhabitants with their laments, surviving on bark, corpses and badly made bread, sleeping in the streets piled one on top of another.' They were known locally as lazzari, a term first used during this period and probably derived from the Spanish word lazaria, meaning wretched and ragged (occasionally, leprous).

It was concern with beggars that occasioned the only concerted activities by the state with regard to poor relief. Not that the government's response ever formed part of a coherent policy or strategy. The Spanish viceroys never sought to institute a magistracy for the poor. In this they differed from other Italian states. Even Spanish Sicily had its Ufficio della Carità from 1555. On the plus side, this relative inaction meant that no serious attempts were made forcibly to enclose or segregate the poor. In any case, the reasons for this lie in part with the presence of separate organs of government, which dealt with problems as they arose, on an ad hoc basis.

In serious cases, the viceroy intervened directly. What health care and charity existed for the kingdom's poor remained largely the province of the various groups and communities into which society was divided: confraternities, guilds, towns, families. As we have observed, Naples had a network of charitable institutions, like any other large city. But this activity remained uncentralised and piecemeal.

The only appreciable government initiative before the founding of the Albergo dei Poveri in 1751 consisted of turning the city's plague hospital into a hospice for the poor. This was done under instructions from the viceroy, Pedro Antonio de Cardona, in 1667, creating the 'Real Hospicio di SS. Pietro e Gennaro extra moenia.' It was not the first time that a viceroy had involved himself in the founding of a charitable institution. In 1616 the Duke of Osuna founded the conservatory of Santa Maria di Costantinopoli for girls, and in 1649 Iñigo-Velez de Guevara founded the conservatory of San Nicola a Nilo for children orphaned in the 1647 revolt. But the 1667 initiative was on a much larger scale, in line with initiatives taken elsewhere in Italy. As early as 1581 Genoa had converted its former pesthouse to take in beggars, used as such until the next plague epidemic, of 1648. The analogy between plague sufferers and beggars - both threats to social order and public health - is clear. So on 14 February 1667 all of Naples' beggars were ordered to present themselves at the Hospice within eight days. Eight hundred would be distributed into its five divisions or quartieri: for young girls, women, boys, married and unmarried men. In December the viceroy announced that the city's ministers, noblemen, knights, citizens and guilds would be taxed to support the nascent hospice. So too would all of the kingdom's municipalities, once it had been discovered that one-tenth of its inmates were from outside Naples.

In line with responses typical of Catholic Europe, the Hospice mixed the provision of charity with repressive measures. Its seven governors had numerous duties, which included touring the city to identify and punish beggars who had not presented themselves, helping boys into a trade, finding places for girls as servants in 'honourable houses' and ensuring that the alms that were collected were deposited in public banks to make the best use of the money. But despite all these provisions the Hospice was a failure. Three years after opening, it was already in deficit. Most of the inmates had managed to distance themselves from it and an edict of 1671 was unsuccessful in obliging them to return. Not that it was the only one. In 1587 Pope Sixtus V had founded the Hospital for Poor Mendicants in Rome. Although it took in as many as 850 beggars in its first few years, by 1601 it was taking in fewer than 150, beset with financial difficulties. The institutions in the Italian states fell far short of their original intentions to eliminate begging. This was due in part to inadequate funding and misplaced goals of being able to support themselves on the labour of their inmates. They were unable to keep inmates from coming and going, and economic realities soon forced them to restrict entry to certain categories.

In the longer term, the Neapolitan Hospital did manage to acquire something of a working routine, though on a much reduced scale and with a very different emphasis. It maintained two conservatories for women, in addition to taking in the shame-faced poor: 'people of lineage, [who] have become invalids.' The latter group, known as the 'poor of San Gennaro', numbered over two hundred and appeared as standard bearers in the funeral processions of the nobility.

Eighteenth-century developments and continuities

As early as the mid-sixteenth century, Padua had become renowned for its hospital training, the surgical education given physicians and the presence of physician-surgeons (medici chirurgi). The hospital of San Francesco there had an important role in instruction, providing practical demonstrations of the medical theory imparted at the university. In the early seventeenth century Neapolitan hospitals were being regarded as useful training grounds by at least one author. In his treatise for the aspiring barber-surgeon, Cintio d’Amato recommends that in order to acquire a knowledge of anatomy 'it will be exceedingly advantageous for them to seek engagement either in hospitals or in the infirmaries of monasteries or convents, or in other public places.' He gives the example of the viceroy, the Duke of Osuna, who called for an experienced surgeon after having been bled by an inexperienced one. At the recommendation of his physicians he was provided with a surgeon who had practised at the San Giacomo Hospital, who immediately found the correct vein. Indeed, numerous physicians and surgeons served in Neapolitan hospitals as postici - assistants training under a recognised practitioner. Marco Aurelio Severino, for example, had several assistants under his charge at the Incurabili. By the 1790s there were over one hundred 'young practitioners' at the Incurabili Hospital.

Yet the medicalisation of the Naples's hospitals was a very slow and uneven development. The Incurabili Hospital was in no way exceptional in having far more ecclesiastics at the hospital than medical and nursing staff throughout the period. Like other Italian hospitals, it continued to spend far more on foodstuffs than on medical care. None the less, by the mid-eighteenth century the Incurabili had become to all intents and purposes a general hospital. In 1759 a total of 8,215 patients
were admitted. In keeping with the traditions of its foundation, twelve per cent (996) of these were described as syphils sufferers. Another seventeen per cent (1,430) suffered from a range of skin diseases and sores. In previous centuries, however, it would probably not have admitted fever sufferers, a policy common to Italian hospitals for incurables. But in 1759 it treated more fever cases than any other single disease category: 2,271, or twenty-eight per cent of patients. The Incurables also treated large numbers of consumption sufferers. It also admitted a certain number of insane, the only hospital in the city to do so. This group, totalling 159, were exceptional in being from Naples alone. Overall, sixty per cent of patients came from the city and its surrounding province. But the fact that the Incurables was open to non-Neapolitans is shown by the thirty-three per cent who were natives of other provinces, though it is impossible to know how many were resident in Naples at the time. A small number – just under seven per cent – came from outside the kingdom. What is perhaps most striking about the records for 1759 is that even such a large hospital as the Incurables was admitting and treating mostly men – almost two-thirds, in fact. 100 Women were still cared for at home whenever possible.

At the same time, the Incurables began to institutionalize its teaching role. Its Medico-Surgical College was founded in 1764, the same year when the city was struck by famine and epidemic. The then director of the hospital also established the College of Young Practitioners. Its purpose was to assist poor students from the provinces and, through their services, better care of hospital patients. The students attended lectures at the hospital on a wide range of subjects and obtained practical training assisting the sick. These were the years when much of the city's medical teaching took place at the Incurables, under Domenico Cotugno, usurping the role of the hospital of San Giacomo, which had formed a previous generation of medics – including Cotugno himself (though his actual degree was from Salerno) and Domenico Cirillo. There were chairs in logic, metaphysics, physics, chemistry, physiology, practical medicine, efficacious medicine, practical surgery, efficacious surgery and anatomy. As of 1777 there was also a chair in obstetrics at the hospital.

Lest this conjure up images of a modern technologically advanced, research-based institution, it is worth remembering that the remedies used, at the Incurables as elsewhere, had changed relatively little over the centuries. In the middle of the eighteenth century the Hospital was treating ringworm with a special oil, the principal ingredient of which was ‘a mountain toad.’ It was left in olive oil for twenty-four hours and the oil was then filtered and rubbed on to the patient’s shaved head. 101 I mention this not out of any sense of ridicule, but to put other developments into their proper context. Despite its being the centre of medical learning in the kingdom, these were difficult years for the Incurables. Galanti called it the city’s worst, located ‘in a pestilential place, where all the diseases accumulate and multiply.’ 102 Not only was it spending far more than its income every year, but in 1788 it was forced to borrow heavily in order to replace all the roofs of the hospital, the monastery, the church and various other buildings. A major fire in 1795 had resulted in a deficit of over twenty-five thousand ducats two years later. 103

The final two decades of the eighteenth century witnessed many calls for reform of the kingdom’s hospitals, especially those of the capital. A perceptible decline in conditions coincided with increased expectations as to the role of hospitals. The dual functions of health care and poor relief were both regarded as necessary, but hospitals were accused of being woefully negligent of both. Cirillo did not regard the two functions as contradictory. Hospitals, however, required charity, love and kindness to succour the suffering; instead, they were run by ‘an army of apathetics . . . the lowest of the earth’, paid a pittance for their services. Everything was ruled by chance, ignorance and whim: foodstuffs (fit only for ‘the most abject animals’), medicines (leftovers of the most inert drugs), sanitary conditions (which ‘corrupt the air and greatly increase the strength of the diseases’). 104 Expectations regarding the hospital’s role in society had changed. The ceremonial activities of hospitals, both religious and civic, which had been such an important feature during earlier centuries, were no longer considered appropriate. The same could be said of the selfish involvement of local elites in governing bodies. ‘It is not possible to watch humanity suffering in this way with disdainful indifference’, concluded Cirillo, ‘while we know which and how many riches are destined for the maintenance of our hospitals and charitable institutions. But everything is ruled by boastful ignorance, destructive idleness and all-consuming fraud.’ 105 Galanti continued in much the same vein. Hospitals, he argued, were a necessary evil: ‘Given that the political laws have created so many wretched people, hospitals must be tolerated so that they can redress the disorders of indigence. We must lodge, feed and treat all the needy reduced to the level bare survival.’ As for the hospitals’ more specifically medical functions, they were the last places one would expect to be cured. Here he went much further than Cirillo. Indeed, he put the blame on the physicians themselves: ‘physicians who cannot diagnose a gentleman’s disease in his own palace then treat all manner of diseases in hospitals’. Add to this the dire state of the institutions themselves. For Galanti the best treatment for disease would always be ‘good air, good food and cleanliness’, the three things that hospitals most ignored. 106

And yet, the difficulty of reconciling the hospitals’ dual functions remained. One solution, it was suggested, was to take the able-bodied poor out of hospitals and have them earn the cost of their support, employing them in the construction of much needed irrigation canals, for example. 107 The Florentine Luigi Targioni, resident in Naples from 1783, went further, calling for a separation of poor-relief and health-care functions. The hospitals’ activities in taking in vagrants and beggars, providing them with room, board and clothing, was ‘to turn an act of piety into a most serious vice’. Because the hospitals did not put their able-bodied inmates to work, they had become ‘the chief shelters of idleness’. Little had been done to oversee public health in the kingdom, he argued. The hospitals had become the natural repository of enormous numbers of paupers seeking refuge ‘under the false pretext of disease.’ The physicians were all too easily taken in by this deceit. Targioni’s solution was to reserve hospitals for the treatment of contagious and debilitating disease. Hospitals would offer ‘medicaments and medical and surgical assistance’ for less serious diseases, but treatment would be carried out at the patient’s home as much as possible. 108
HEALERS AND HEALING IN EARLY MODERN ITALY

The reforming climate under the French increased expectations still further. With Joseph Bonaparte as king, the pro-French Domenico Pignataro proposed confiscating a number of monastic buildings, along with their revenues, throughout the kingdom and turning them into hospitals. Some tentative steps in this secularising direction had been taken from the middle of the previous century. In 1741, in a Concordat between Charles III and Pope Benedict XIV, the number of the kingdom’s convents and monasteries was reduced and the entire ecclesiastical patrimony put under stricter juridical and fiscal control. The effects of this were mixed. Some streamlining of charitable institutions occurred through the creation of a mixed tribunal intended to supervise them. At the same time, the charitable functions of confraternities and guilds were limited and began to decline. The role of the state regarding hospitals was further increased in 1796, at the expense of the Church. But the reforms were piecemeal. More radical reforms were made in 1809 when a general council was set up to oversee the administration of all the interests of hospices, hospitals and other institutions involved in the assistance of the capital’s poor, sick and foundlings. Hospitals were no longer to be administered by their own governing bodies but by this council, composed of twelve men chosen by the Interior Minister. The capital’s hospitals were to be ‘rationalised’, in the sense that each was to have different specialisations. A separate insane asylum was designated, just outside Naples at Torre del Greco, removing this long-standing function from the Incurabiles Hospital. The effects of this legislation on the provinces was minimal, although some new hospitals were created in some small towns. In fact, by removing ecclesiastical sources of income, the situation may have deteriorated.

The only major development during the eighteenth century — and this was a long time coming — was the construction of the Albergo dei Poveri. Built as the ‘Royal hospice for the poor of the whole kingdom’ (‘Regium totius regni pauperum hospitium’), words that can still be read on the building’s crumbling façade, it was intended to provide housing, a Catholic upbringing and a trade for able-bodied vagabonds and orphans. Despite the Enlightenment rhetoric behind the initiative, the state’s contribution was minimal. The income derived from the collection of some minor duties and fines were awarded to the Albergo, such as the fines collected from those caught poaching on royal lands. In addition, some thirty-four thousand ducats were put towards the building following the abolition of eleven Augustinian monasteries, in the wake of the 1741 Concordat. Given this, it is somewhat ironic that most of the funding came from traditional, religious sources, including some fifty thousand ducats from the city’s wealthier religious orders. And despite its centralising intentions, traditional forms of charity persisted. A lay association, based at the Albergo, was founded to go about the city collecting alms and organising work for the inmates. Its members included the elite of society: government ministers, courtiers, magistrates, aristocrats, merchants and ecclesiastics. The Albergo increasingly attracted legacies that would previously have gone to more standard forms of charity, but testators still targeted their donations in traditional ways, restricting them to specific categories of beneficiaries. Money was thus left to the Albergo to establish dowry funds for orphan girls from the benefactor’s town of origin, for instance, or to support branches of the benefactor’s noble clan unable to support themselves.

There is little that was coercive or authoritarian about the Albergo’s activities during its first fifteen years. Rather it seems to have adapted to the non-conflictual structures of traditional private charity. However, the famine–epidemic of 1764 saw a massive increase in the number of inmates, leading to routine mass interments by century’s end. Annual intake rose from under 100 to 1,500 during this period, large numbers of paupers being required to work the Albergo’s woollen mill, producing clothing for the troops. There was an accompanying shift in the Albergo’s image and fortunes. At the outset, the Albergo and its inmates were to project a unified image. Consistent with the grand appearance of the building, the attempts to make the inmates presentable and decorous. They were to be taught good manners, religious doctrine and a basic education. They had a special uniform which they were to wear when outside the building, consisting of jacket, hat with ribbon, cloth necktie, cotton stockings and leather shoes. But by the end of the century these standards had fallen into abeyance: the clothes became basic, the instruction drastically reduced, the work harder and the food more meagre. And, of course, the building was still incomplete; only one-fifth of Ferdinando Fuga’s grandiose plan was ever realised.

One interesting feature of the Albergo is the way the poor used it as a temporary source of relief, admitting and discharging themselves as they chose. In the years 1751–58, according to the Albergo’s own registers, fully one-fifth of inmates were voluntary arrivals, mostly coming from within the city. It was part of a strategy on the part of the city’s textile workers, manual labourers and domestics to cope with lean times, going themselves or sending one or more of their children. Most stayed only briefly, if repeatedly, seeking to leave as soon as possible. This chapter has focused on hospital care and poor relief from the top down, examining the supply; it is important to remember that there was also a demand. That is to say, forms of poor relief were used by the sick and the poor as part of a strategy, a network, to obtain treatment and care. We have seen how the simple presence of a community physician in a given town did not ensure that the large majority of people — the community’s peasants — would make use of his services. Remarks of an anecdotal nature suggest that people could admit themselves into hospital, obtain the treatment they sought and then discharge themselves when they were ready. One patient, due to have his gangrenous leg amputated, left hospital following a vision in which Bishop Lucci told him he could get up and walk out, completely cured. Treatment — even in hospital — was ultimately in the hands of the sick themselves. This is still the case when a timely miraculous intercession could spare painful and crippling surgery. And let us not forget the wet nurses. Although they were paid a pitance for their services, it was not unheard of for women to leave their own infants in the nota, only to present themselves as wet nurses at the foundlings home to nurse them, pocketing the small income for their services.

Finally, with this same active spirit the remedies administered to patients could find their way into popular healing rituals. In 1697 an out-of-work farm labourer,
Donato de Quarto, denied having used witchcraft to treat an acquaintance suffering from the French disease. The treatment consisted of spreading sour grapes over the kidneys and genitals. It was one he had observed during his five-month stay in hospital in Lecce, where he says it was used for fever. In addition to his own application of the remedy, de Quarto added a twist: he had two masses said first and bought some ribbon blessed in the name of St Francis de Paola, which he also applied to the sick man. The role of the sacred in illness and healing has run like a strand through the texture of this book. It is to this theme that we now turn.

NOTES

39 Cavallino, Charity and power, p. 85.
40 Muto, ‘Form and content’, p. 231.
41 A.S.N., Capelletto Maggiore: statuti e coponazioni, b. 1190/1544; in Muto, ‘Form and content’, p. 233.
42 He concluded that ‘since the same charity and piety, the foremost noblewomen serve sick women in the hospital of the Incurabili,’ Vita di P. Camillo de Lellis Fondatore della Religione di Chierici Minori dell’Infermi descritta brevemente dal P. Sanzio Cicatelli Sacerdote della stessa Religione, 1608, MS, Archivio Generale dell’Ordine dei Minutri degli Infermi, Rome, ed. R. Corghi e G. Martinogno, Un uomo venuto per servire: Camillo de Lellis nell’antica cronaca d’un testimone ocuale (Milan, 1984), p. 83.
48 Ibid., p. 142.
49 Eustace, Tour through Italy; in Seward, Naples, p. 281.
50 Archivio Oratorio SS. Crocifisso Cavalieri, Naples, Libro di conclusioni, b. 63, fol. 14v.; in Rienzo, ‘Attività caritativa’, p. 262. Founding beds may also have been a form of investment, attracting interest, as in Turin. Pastore, ‘Ospedali in Italia’, p. 74; Cavallin, Charity and power, pp. 141–3.
53 Galanti, Nuova descrizione, vol. 3, p. 151. All the hospital buildings, with the exception of the church, were demolished in 1819, to make way for the projected Palace of the Minnster, now the Naples city hall (Palazzo del Municipio).
56 The requirement to visit hospital disappears from the Santa Croce’s statutes of 1779.
58 A.D.G., Fondo Vescovile: Epistola, 1D 6, f.; in D’Agostino and Ragusa, Confraternite, p. 60 n. 21.
60 Cicatelli, ‘Vita’, p. 83.
62 A.S.V., Riti, 2651, fol. 41v–42r.
63 Ibid., fol. 139v.
64 Sannazzaro, Online Camilliano, p. 61.
65 A.S.V., Riti, 2651, fol. 66v.
66 Ibid., fol. 29gr.
78 As the statutes of the salt-dealers’ guild put it. A.S.N., Capelletto Maggiore: statuti e coponazioni, b. 1182/1548; in Muto, ‘Form and content’, p. 217.
79 During the seventeenth century the total number of dowries made available by Neapolitan confraternities and guilds amounted to 665, according to one contemporary estimate. Gardiner, Naples: an early guide, p. 39.
80 Muto, ‘Form and content’, p. 218.
82 Visceglia, Bisogno di eternità, p. 136.
83 Archivio Oratorio SS. Crocifisso Cavalieri, Maritaggi, b. 24, folder 199, file 2; in Rienzo, ‘Attività caritativa’, p. 269.
85 The kingdom has more than one town named Salice and it is unclear which is being described. A.S.N., Reali dispos. ser. 1, 8, fol. 7; in De Rosa, 'L'emarginazione sociale', p. 9.
87 Giulio Cesare Capaccio, Il fossato (Naples, 1634), p. 690; in Aurelio Musi, 'Pauperismo e pensiero giuridico a Napoli nella prima metà del secolo XVII' in Politi, et al., Timone e cartelli, p. 263.
88 Villari, Revolt of Naples, pp. 23–5. One of those sentenced to execution for his part in the revolt was Giovanni Leonardo Pisano, apothecary, captain of the Selleria district and brother of Giovan Antonio Pisano, former protophysician of the kingdom and professor of medicine. Pisano fled from the city, never to return. In 1586 the vicerey had his house razed to the ground and erected a monument on the site, complete with niches containing the heads and hands of the executed citizens.
95 Galanti, Nuova descrizione, iii, p. 147.
96 Cintio d'Amato, Nuova e utilissima pratica di tutto quello ch'è diligentemente appartenne (Naples, 1671), pp. 11–12.
97 The prattis were not necessarily humble servants or faithful followers of their master. Severino's 'interventionist' approach to patients was deemed by two of his assistants to cause too much pain in the name of success. The resulting rivalry had Severino temporarily expelled from the Hospital and accused before the Inquisition. See the discussion in José Elia, 'Il medico a rovescio: per la biografia di Marco Aurelio Severino (1586–1656)', Rivista storica calabrese, iv (1983), pp. 177–84.
98 A.S.N., Ministero delle Finanze, 2nd inventory, b. 2176, 2177; in Vittorio Donato Catapano, Medicina a Napoli nella prima metà dell'Ottocento (Naples, 1990), pp. 17–18. Many of the young practitioners were active participants in the French-inspired Neapolitan Republic of 1799, treating injured French soldiers, fighting their opponents, and even planting a tree of liberty in the hospital courtyard. When Bourbon order was restored the College was abolished. Vincenzo Cuoco, Saggio storico sulla rivoluzione napoletana del 1799, ed. N. Cortese (Florence, 1926), pp. 327–9.
100 Rucicini, Universalità, pp. 354–5.
103 A.S.N., Oper piev. navire, 8; in Catapano, Medicina, p. 94.
105 Ibid., p. 203.
107 Domenico Grimaldi, Piano per impugnare utilemente i forzati e col loro travaglio assicurare ed accrescere le nausole del piane nella Provincia e nella proteste provincie del Regno (Naples, 1781).
110 Catapano, Medicina, pp. 98–100.
111 A.S.N., Gran Corte dei Conti, 3669, 3 March 1789, fols 1–6; in Moricola, Industria della carità, pp. 74–5.
113 Moricola, Industria della carità, pp. 38, 48.
114 Ibid., pp. 57–8.
116 A.S.V., Rit., 279, fol. 405v.
117 Guidi and Valenzí, 'Malattia', p. 1175 n. 12.
CHAPTER SIX

THE CHURCH, THE DEVIL AND LIVING SAINTS

During their rural mission in the diocese of Potenza in 1687, the Jesuit missionaries commented on the widespread use of ‘superstitions.’ According to the definition of the time this meant any of a wide range of popular rituals to heal, cause injury, predict the future or bind someone in love, the efficacy of which – the Church believed – was due to an expressed or tacit pact with the devil. In this case, the missionaries reported that the principal practitioner was a nun whom the local populace believed to be a living saint:

Above all, the people were freed from a great error, that of regarding and extolling to be a saint a woman of a town not far away, to whom they had recourse for all their necessities, and from whom they obtained remedies, all consisting in superstitious things. All these things were gathered together, and having made a great bundle out of them, they were consigned to the flames in front of the people, and God favoured this in such a prodigious way that the people, terrified, did not stop weeping and promised God never again to have recourse to the mentioned witch. And we shall try to notify her Superior of the superstitions, so she receives the punishment she deserves.¹

Why was this nun such a threat to the Church, personified here by the Jesuit missionaries evangelising in the ‘deep south’? Why did itcampaign so virulently against the use of ‘superstitions’, even when they brought relief from illness? In this chapter I shall examine the opposition of the Counter-Reformation Church authorities to local attempts to tap the power of the sacred, particularly in response to disease, at a time when these authorities were seeking to define and regulate the access to such power, by laity and clergy alike. These include figures like the cunning man or woman, exorcists and ‘living saints’. The latter are a special case, in that they embodied the sacred in themselves, while the cunning folk and exorcists simply employ the tools and techniques at their disposal in their healing rituals. Because of the power of these living saints – recognised locally as wonder-working and holy, but not canonised by the Church – and the ever-present threat that the devil might be using them and deceiving them for his own ends, the Church felt that it could never let up its vigilance. In addition to the Church’s response I shall also discuss the interpretation of the medical community and how it perceived the diabolical menace, especially with regard to disease causation. But the control exercised by the Counter-Reformation Church over sacred healing will form the underlying theme. The increasingly numerous forays of the Church into the period’s medical pluralism – attempting to regulate it, while at the same time encouraging its growth and proliferation – constitutes one of the paradoxes which characterise the Baroque. Its regulatory efforts were sometimes parallel to those of the medical authorities, like the protophysician, sometimes in direct contact. Their aims and outlooks were at times complementary, at times competitive, as we shall see here and in the next chapter.

A tale of two Congregations

One fundamental aspect of medical pluralism in the kingdom of Naples, as in the rest of the Catholic world, was the recourse to the healing powers of saints, through their miraculous intercession or the touch of their relics. Intercession could be the result of prayer, pilgrimage or a vow made to the saint. Many diseases had their own ‘patrons’, to whom the sick could turn when in need: St Roch for plague (throughout Catholic Europe), St Donatus for epilepsy and St Paul for tarantism (in southern Italy), to name but three.² The unceasing demand for sources of healing also explains the thriving trade in relics, which the Church sought to regulate. Church synods forbade people from circulating or making use of new or previously unknown relics, in an attempt to stem the commerce in false relics. They also sought to prevent relics from being taken out of churches and loaned to devoted patients. Even exorcists, who frequently used the saintly relics as part of the ritual means of forcing the devil out of the possessed person’s body, had to obtain permission for their use.

Devotion to saints thrived, and new canonisations kept up the supply, despite the more rigorous and standardised procedure of saint-making adopted by the Church in the years following the Council of Trent. The middle decades of the sixteenth century had seen something of a ‘crisis of canonisations’ within the Church, due in no small part to the Protestant Reformation.³ Confidence was restored with the establishment of the Congregation of Sacred Rites and Ceremonies in 1588, responsible for canonisations. The revival could be said to have culminated on 12 March 1622 with the canonisation of four ‘servants of God’ in one triumphant ceremony: Teresa of Ávila, Philip Neri, Ignatius of Loyola and Francis Xavier. The official making of saints was thus controlled from Rome. However, the initial impetus came from the local level, wherever a cult sprang up around a holy man or woman. For the faithful, the ‘living saint’ meant a source of sacred power, the function of which was to provide healing, as we shall see further in the next chapter. But the Church was looking primarily for saints of the edifying variety. As a result, of these many local cults, some would be recognised and approved by the central authorities, others would be suppressed, and still others would be put in abeyance, neither rejected nor approved, awaiting further developments. Thus, depending on ecclesiastical reaction, the living saints would end up as either canonised saints,
saints-in-waiting or failed saints. The Church regarded devotion to living saints as something of a battleground: where the eager faithful saw visions, ecstasies and healing wonders, the Church saw the possibility of diabolical trickery to lead men and women to damnation. While word of new miracles circulated rapidly amongst the faithful, the Church declared that nothing should be made public as miraculous until it had first been investigated and approved by the local bishop, for fear that fakery or the devil lay behind it. The result was that a large number of living saints were to be examined by that other entity of the Catholic Reformation designed to define and enforce access to the sacred, the Congregation of the Holy Office of the Inquisition, founded in 1542. In Naples this meant the archbishop's tribunal, with the involvement of a representative of the Holy Office. Several Neapolitan cases have been studied, although they represent only the tip of the iceberg of the phenomenon. New cases are continually coming to light, such as to the two late seventeenth-century cults which sprang up around two young boys. The younger of the two, Francesco Belli, was only five and was known as the santobillo, or ‘little saint.’ For this reason a quantitative approach to the phenomenon would be premature. Virtually nothing is known about the presence of living saints outside the capital, so I shall concentrate on two previously unstudied provincial cases.

Whereas popular religion, in practice, did not stress the differences between the divine and diabolical, grouping them together under the power of the sacred, the Church, of course, did. This included the ecclesiastical concept of disease and calamity. On the one hand, they could be caused by the wrath of God as punishment for unrepentant sinners. On the other hand, and more menacing still, were the activities of the devil. He could bring about any sort of malady or misfortune, either of his own accord, or through the influence of spells cast by those in his service. And let us not forget, that even the most humble and devout cunning woman, healing the sick of her village, was considered by the Church to be in league with the devil. The Church stressed that only its trained exorcists could ascertain whether an ailment was caused by sorcery, and if this was the diagnosis, only they had the power to treat it. Of course, the sufferers themselves and their families were generally prepared to use whatever remedy was thought to be efficacious, in a pragmatic search for a cure. But theologians saw the devil everywhere, even in the healing rituals of wise women. Such was the devil’s insidious astuteness that under their apparently pious prayers and ‘signings’, could lie the threat of eternal damnation. Because it realised that popular healing was so often employed in good faith or ignorance, the Counter-Reformation Church focused its campaign against it around the enforcement of orthodox teaching on matters such as sorcery, demoniacal possession and divine intervention. The activity of parish priests, confessors, preachers, episcopal and inquisitorial tribunals was crucial in this campaign, though its impact was a question of centuries rather than decades.

The emphasis placed on the power of exorcists to ‘liberate’ the possessed from diabolically caused diseases resulted in the mushrooming of extra-canonical exorcists to meet the increased demand. The latter were simply laymen or clerics who practised exorcisms without episcopal training or approval. Sometimes the fame of an extra-canonical exorcist was such that he developed a reputation and a clientele, in much the same way as the living saints we shall examine below. Diocesan synods frequently decreed that no one should perform exorcisms without episcopal licence. If caught, they would be tried by the episcopal courts or the Inquisition. But the typical exorcism was both extremely complicated and vague, not unlike the learned magic of the period. In terms of the ritual performed, therefore, it was often difficult to distinguish official from unofficial exorcists. It would also seem that there existed a ‘low’ domestic form of exorcism used against diabolically caused maladies, and a ‘high’ public form, used for demoniacal possession.6 This situation was exacerbated by the fact that until the Roman Ritual of 1614 there was no standard exorcism format or rite. Even after that date unapproved manuscript exorcisms continued to circulate widely. To explore how the devil was believed to operate in early modern Catholic society, let us turn at last to our two living saints, Maria Manca and Suor Giglia di Fino.

Manca was born in 1571 in the town of Squinzano, near Lecce. Married at the age of nineteen to a local parishioner, she was widowed four years later, and made a vow to God to remain chaste and never remarry. However, a local tradesman—a repairer of windmills—fell blindly in love with her. When Maria told him of her vow to God, the tradesman, Lupo Crisostomo, realised he would have to employ other means to win her love. He thus turned to a local cunning man for a love philtre, which consisted of some powder sprinkled on a mushroom, Maria’s favourite food. Brought to her that evening for supper, she ate the mushrooms and soon felt the burning passions of love. Her hagiographer refers to it as ‘burning in her guts.’7 She immediately went out to find Crisostomo, arriving at his house late that night. When he answered the door she told him that her mill needed repairing, to which he replied that it was her brain that needed repairing. The whole town was soon gossiping about the affair and Maria’s relatives decided that she would have to marry him in order to save her honour. The love philtre allows the hagiographer to account for Maria’s breaking of her vow and subsequent remarriage, unusual events in a candidate for canonisation. But more importantly, it explains the terrible torments that were soon to afflict Maria, after the death of her first child. Demons had been introduced into her body through Crisostomo’s spell and started to cause havoc. They began by beating her and causing her terrible visions at night, including a ‘black Ethiopian’ and ‘most shameless embraces and a hundred and a thousand dirty and foul acts.’8 Visions like these were regarded as real manifestations of the demonic presence.

The physical manifestations began after the death of her second child, immediately after birth. Comparing her to Job, Maria’s hagiographer describes her torments:

By reason of the fever having left almost by accident her most worn-out body, which resembled a corpse, having almost nothing more to consume, she soon saw herself covered with wounds, abscesses, gangrene and with the most dreadful pains, which tormented her with all their power all the time, without ever letting up. She offered
her most gentle limbs to the knife, flame and every other similar and most painful remedy with a most exemplary and incomparable constancy, but the surgeon worked in vain, because he was incapable of finding a remedy and cure for the grievous diseases of Hell. The wounds grew more cruel in such a way that her most delicate flesh rotted, so as to generate nauseous worms, and these ulcers emanated such a pestiferous stench that whoever came to visit her, fled at once from her presence and held her in abomination, like a plague victim.9

Seeing her suffering, Crisostomo asked forgiveness and took her to the Greek Rite church in Lecce, whose priests were believed to be expert exorcists. They concluded that she was possessed but could not liberate her of the demons. The same negative result was obtained by Catholic priests who performed exorcisms repeatedly over the next nine months. Crisostomo even went back to the cunning man who had cast the original spell, but he said he was unable to undo it. From this point on, Crisostomo was miserable and melancholic, developed pleurisy and died.

After the medical practitioners and exorcists, Maria offered her ailments up to God, allowing the hagiographer to exercise his descriptive skills once again:

Her disease having become harsher and she herself having become a dungheap of putrefaction, a centre of filth and a sink of rot, overwhelmed by unbearable pains, eaten alive by worms, held in abomination, abandoned and shunned by everyone, in imitation of Agatha, she held up her wounds to the Celestial Doctor and, scorning human industry, placed all her hope in him.10

Meanwhile, her habit of going to a tumbledown chapel outside the town and praying to an image of the Virgin and child there eventually paid off. One day a young woman appeared to her and gave her a carnation, telling her to take it to a certain church in the nearby town of Galatone. The rumours of her divine favour spread and the clergy arrived at once to perform an exorcism, taking advantage of what seemed to be a propitious moment. A demon announced he would depart her body the following day on the way to Galatone. Maria was thus finally liberated, vomiting the charm: 'a round bone the size of one of the larger tari coins, perforated in the middle with a piece of string and a few hairs at the tip.'11

It is interesting that on several occasions during the narration of these events Maria's hagiographer, Mauro Paticchio, intervenes with lengthy asides on the means employed by demons to bring about illness. Here, Paticchio puts to use his theological training with the Dominicans in Lecce, citing Scripture, church councils, demonologists and theologians in support of his statements. The reason that the physicians' cures were ineffective was due to the diabolical, as opposed to natural, origin of Maria's ailments. Spells like the one employed by Crisostomo (maleficium venefico or anatormia) frequently led to possession and disease, for which Paticchio cites the authority of demonologists like Del Rio, Sprenger and Torreblanca.12 He also criticises the 'mad presumption' of 'the Englishman Doctor Mead', who suggested in his Mediae Aetatis that the possessed men and women of the Bible were in fact suffering from incurable natural disease or insanity.13 The treatise in question by Richard Mead was published in 1749, a time of great change in medical thinking. Paticchio's hagiography was published twenty years later, and it is clear that he is seeking to affirm the traditional viewpoint of the Church on the subject of possession and disease causation against those of an increasingly secular science. Yet as Paticchio must have been aware, during the lifetime of Maria Manca (1571–1668) – the period that concerns us here – the worlds of learned medicine and the Church had been in harmony concerning the belief in diabolical disease causation.

The devil and disease

The traditional ecclesiastical view of the manner in which the devil brought about disease is summarised in Francesco Maria Guazzo's 1608 work, the Compendium maleficarum.14 After citing Galen and Avicenna, he quotes the work of the Spanish physician Francisco Valesius to describe how the devil brings about disease.15 Melancholy sickness is brought about by disturbing the bile and dispersing a black humour throughout the brain and the internal cells of the body; he then increases the black bile by inducing other irritations and preventing the purging of the humour.

He brings epilepsy, paralysis and such maladies by a stoppage of the heavier physical fluids, obstructing and blocking the ventricle of the brain and the nerve-roots. He causes blindness or deafness, bringing a noxious secretion in the eyes or ears. Often again he suggests ideas to the imagination which induce love or hatred or other mental disturbances. For the purpose of causing bodily infirmities he distils a spiritious substance from the blood itself, purifies it of all base matter, and uses it as the aptest, most efficacious and swiftest weapon against human life: I say that from the most potent poisons he extracts a quintessence with which he infects the very spirit of life.16

Citing the physician Andrea Cesalpino, Guazzo notes that the 'human skill' of physicians is all but helpless against diseases caused in this way. This is because the devil's poison 'is too subtle and tenacious, too swift and sure in killing, and reaches to the very marrow of the bones.'17

Many of the authorities cited by Guazzo in support of his arguments were used by another writer on medicine and magic, Pietro Piperno. Piperno, the diligent protoprophis for the papal enclave of Benevento, published his De magiis afflicibus (On magical afflications) in 1634, along with a treatise on the walnut tree of Benevento, the supposed site of witches' sabbaths.18 The work which concerns us here, the first one, is divided into six sections: magical maladies, superstitious remedies, medical treatment, inexistant magical maladies, religious therapy and case studies. According to Piperno a malady can be considered 'magical' (i.e., diabolical) if the symptoms are 'beyond the common order of nature without manifest cause, as they do not correspond to the essence of the disease, for which wise men and medics themselves expert in practice are at a loss in getting to know the affliction.'19 He goes on to list the seven signs which indicate the 'transnatural' nature of a disease:
physicians tended to look first to natural explanations of phenomena. And for this reason clerics often suspected them of irreligious tendencies, as we shall see in the next chapter regarding miraculous cures. It is easy to overgeneralise: physicians like Codronchi and, of course, Piperno, seem happy to put their trust in and even use ecclesiastical remedies. But how typical were they? At least one exorcist writer was convinced that they were the exception. Candido Brugnoli, friar and vicar of the Inquisition in Bergamo, was convinced that physicians were as much part of the problem as the solution. In his 1668 Alexianus he criticised physicians for looking only at the indispositions of the body in attempting to recognise and treat every physical malady. They went out of their way to exclude preternatural causes of disease. Physicians who denied that there was any truth in witchcraft and in the ability of demons to cause disease, ruling out the role of God in testing sinners, remained ‘locked behind the gates of nature’. They were guilty of atheism. Physicians should not be so proud as to imagine they could deny the exorcist’s role. Instead of trying to use natural remedies against diabolical disease, they should trust in the work of experienced exorcists and their spiritual remedies. Only the latter possessed ‘the keys of divine science’ to make judgements on such matters, where ‘medical science’ was not enough.

If Brugnoli showed a professional jealousy with regard to physicians, he was also critical of those exorcists who made too much use of corporeal remedies. The use of medicines should be left to qualified physicians, he argued. Nor could the devil be made to stand in for nature (just as nature could not replace the devil). In fact, one of his aims was to separate and distinguish the functions of physician and exorcist. But he was fighting an uphill battle; one of the central features of medical pluralism during this period consists of attempts by the authorities, medical and ecclesiastic, to separate healers and forms of healing that kept intertwining. Shortly after warning exorcists away from corporeal remedies against demons, Brugnoli himself lists various unguents that can be used against them, including one ‘composed and tried by the author’.

To express the debate in chronological — as well as Neapolitan — terms, theories about the nature of spells had shifted from the natural magic of Giovann Battista della Porta, Giordano Bruno and Tommaso Campanella, to the demonological magic of Bishop Leonardo Vairo and Piperno. Not even the Neapolitan Enlightenment put an end to the belief in fascination: it simply secularised and ‘rationalised’ it, calling it iettatura. In the last two decades of the eighteenth century this theory that certain individuals had the power to harm others through even involuntary eye contact spread from the educated elites of the city throughout the kingdom. The approach was a mixture of the deadly serious and the facetious. This is evident in the study by the professor of jurisprudence Nicola Valletta, who came to believe in it after his infant daughter’s death — not unlike Codronchi’s ‘conversion’ two hundred years earlier. The physician and medical author Gian Leonardo Marungi went so far as to explore iettatura in scientific terms, employing recent discoveries in the field of electricity. During the nineteenth century the phenomenon was destined to be reduced to the status of folkloric curiosity in the eyes of foreign tourists travelling
to the 'backward south.' In any case, the link with Renaissance natural magic was more apparent than real. Marugi has argued, was in fact a typical exponent of the scientific enlightenment. He was convinced that all forces—even evil ones—could be rationally explained. For this reason, the *iattatura* debate is best appreciated in the wider European scientific context of the time, which includes figures like the Viennese physician Franz-Anton Mesmer.30

This same enlightenment spirit also had an impact on clerical attitudes towards the devil and the exorcism ritual. The bishop of Trani, Giuseppe Davanaz, was highly critical of the powers generally ascribed to the devil. In a study written in 1739 he asserted that only God could overturn natural laws, as these had been expressed by Galileo and Newton. The demonological treatises that had conditioned Catholic thinking for so long, he reasoned, were nothing but 'figurative narratives.'31 Exorcists, and especially the unsuspecting laity who made use of their services, became prime targets for satire. The Neapolitan political theorist Pietro Giannone delighted in telling of one exorcist, 'in a village near Naples', who decided to alter the rite, so tired was he of having to minister to the hordes of 'possessed' women who came to him for exorcisms. The new rite consisted of a simple stick, with which he beat the unfortunate possessed, promising to double the dose if they should return. As Giannone concludes, the devil never again put in an appearance in either that village or the others nearby.32 The exorcist— if he was ever anything more than a figment of Giannone's imagination— was, like Davanaz, an indication of new trends within the Church. And yet, one has the impression that the traditionalist Paticchio was probably more representative of the provincial cleric when it came to interpreting and responding to the actions of the devil.

It is striking that the exorcistic treatment was the reverse of the 'superstitious' rituals used to bring about the disease. Divine mirrored diabolical. Such a conception was typical of the period. The demonological, in fact, lacked a language of its own; it was merely the antithesis of the divine.33 Thus the descriptions of the ecstasies of the mystics and the experiences of the witches have much in common: the rapturous flights to paradise resemble the witches' flights to the sabbath; the languorous ecstatic visions of Jesus compares to the exhaustion of witches after being visited by the devil; the mystical marriage to Christ is analogous to the pact with the devil. One living saint was even known as 'the witch of God', transported by angels instead of demons, to worship God rather than the devil.34 So close were the two categories, that the woman held to be a living saint and the woman suspected of being a witch could be victims of the same thing. Women were believed to be especially prone to the devil's deceits, whether in the form of diabolical pacts or simulated sanctity. Their inferior powers of reason, childish curiosity and insatiable lust meant that they were more easily seduced by the devil than men. Paradoxically, the credulity and simplicity that gave them an advantage over men in attaining mystical union with God, also made them more apt to be victims of the devil's snares.35

The Church tried to stress and enforce the differences between divine and diabolical visions, as it did the opposition between God and Satan. But in popular culture the devil was but a trickster, easily duped by those sly enough to do so. The pact with the devil was not completely different from a vow made to a saint, and they both could be used to seek protection from malady and misfortune. The divine and the diabolical together formed the sacred and were not yet the opposing forces of good and evil, moral and immoral. Following the Council of Trent the Church did its best to diabolise popular notions of the devil. A soul not on constant guard against the devil's presence could easily be deceived and eternally damned by him. This was as much the threat of Protestant heresy as anything else, and the living saint was particularly dangerous in this regard, because she would lead other people astray along with her.

Paticchio's account of the life of Maria Manca is careful to stress her orthodoxy, as well as her practice of the saintly virtues to a heroic degree. In addition to her obvious piety, her charity, humility, patience, obedience and modesty had resulted in her receiving the gifts of healing and prophecy. The Church taught that these gifts were the result of divine favour, its outcome. In other words, the saintliness led to the power to heal. For most of the laity and much of the clergy, however, it was the other way around: the ability to heal was of itself an indication of sanctity, its cause. The living saint was thus torn two ways. Paticchio goes to great length to show that despite Manca's reputation as a saint, she insisted she was not and remained humble throughout. But the temptation to exploit her powers for an increased role in local society must have been great. The people of her town, as well as from other towns further away, all came to see her, 'very important and notable personages, to obtain graces, favours and advice.' When she walked past, people would shout 'There's the saint, there's the saint.'36 In true orthodox fashion, Maria attributed her healing favours to the Virgin working through her touch (the touch of her 'embalmed hand' which had held the divine carination).37 She treats the difficult pregnancy of the Marchioness of Campi by placing her hand on the woman's uterus and addressing the Virgin with the words, 'Madonna Mia, I touch her, you heal her.'38 Whereas pregnant women were regarded as being particularly vulnerable to witches, the living saints are frequently seen in this role of aiding difficult pregnancies. And of course, Paticchio takes advantage of the account to demonstrate the well-bred nature of her clientele: not just 'dull-witted men and empty-headed women' (*uomini balordi e femminicci*) who are easily swayed by claims of sanctity. The belief in her holiness was universal, as demonstrated by the general hunt for relics, such as pieces of her clothes, not only whilst she was alive but after her death. Thus— in a *topos* common to saints' Lives — if she had not been protected and surrounded by guards assigned for the purpose, since Maria was held by all in great regard and opinion of sanctity, they would have torn her clothes from her body, and divided them in many pieces out of devotion.39

**Life strategies and ecclesiastical responses**

In Maria Manca we have the careful construction of sanctity, following accepted Tridentine models of what qualities and activities constituted holiness. The hagiography itself was compiled by Paticchio from the writings of her spiritual director and other 'reliable' contemporaries.40 The order to write everything
down regarding one’s spiritual life was a common practice in convents, for example, allowing for a measure of control over the nuns or even to legitimate future calls for canonisation. It permitted the hagiographers to record those events which would add to the candidate’s reputation, and eliminate those which would detract from it, especially suggestions of beliefs or practices which might be considered heretical. Print became the ideal means of promoting a cult because it fixed the image of the candidate for canonisation according to accepted ecclesiastical models. It also served to spread the fame of living saints beyond the local area, complementing the traditional modes of diffusion: preaching, travel and within single Orders.41

Yet the women themselves, rather than being ‘heterodoxes’, were usually seeking a more prominent role in society, employing a religiosity which responded to the affirmation of their own individuality and search for forms of charismatic power within small groups. This put them in a potentially dangerous position. Such is the conclusion of a study about the Sicilian nun and living saint Suor Maria Crocifissa (1643–99). She, at least, had a whole ‘apparatus’ surrounding her – consisting of convent, well-placed family and spiritual directors – which put a complex system of supervision and control into operation, guiding her into safer territory.42 Less fortunate was the attempt of another seventeenth-century nun, Suor Benedetta Carlini (1590–1661). Her ecstasies, prophecies and healing certainly brought her recognition; but without powerful patrons to protect her, she was examined on several occasions by the Church authorities, suspected of simulated sanctity. Any chances she had of persuading her judges of the authentic nature of her achievements were put to an end by testimony describing lesbian acts with other nuns.

The visions and healing activities of Benedetta and women like her were increasingly suspect because they remained outside the sacramental structure of the Church. Furthermore, in the words of Judith Brown, who has brought us Benedetta’s story, the Church ‘sought to weaken all competing conduits for grace and to limit the propagation of heresy by well meaning but ignorant visionaries whose flawed interpretations of their experiences could inadvertently lead them and their followers into doctrinal errors.’43 Yet even Benedetta had the relative security of the convent walls and the recognised status that being a nun gave. More fragile still was the condition of the tertiary or Third Order nun, from whose ranks most of the living saints were drawn. Our second living saint, Suor Giglia di Fino of Altamura, was just such a tertiary. Whilst Maria Manca was careful enough to remain humble about the nature of her achievements – which anyway remained within acceptable bounds – and so receive no opposition from the local Church authorities, Giglia’s career was to end in disgrace before a representative of the Holy Office.

Known in the kingdom as bizzocche, in 1714 there were well over eight hundred tertiary nuns in Naples. They were loosely linked to various Orders: 297 were Jesuit terri taries. 191 Dominican, 144 Franciscan, 98 Carmelite and so on.44 The tertiary nun was a woman who had taken a simple or private vow of chastity, wore a habit, observed some sort of religious rule, and lived either in the community of other terri taries or on her own. A typical tertiary was a single or married pious woman who lived at home (for this reason they are sometimes referred to as ‘house nuns’ or monache di casa), wearing a habit she had made for herself. Why would women join a Third Order as opposed to entering a nunnery? Primarily, given the low social status of most terri taries, it was because they simply could not afford the dowry payment required to enter a convent. In addition, many may have felt that a cloistered life was too restrictive and the combined life of a tertiary was the ideal compromise.45 The decision to become a tertiary nun allowed one to partake of both the secular and sacred life. It was an important part of a woman’s life strategy, particularly if she had no other well-defined role in the community or institutional protection. But because they straddled the sacred and secular worlds they were regarded with suspicion by the Counter-Reformation Church, which kept a watchful eye over their activities. As for those women who sought to follow established models of sanctity through their role as tertiary, it suggests an awareness of self and individuality, whilst at the same time a greater capacity to adhere and conform to these pre-set models.46 But seeking to imitate the models of canonical women like Catherine of Siena and Teresa of Avila was a dangerous business, with the Church on the lookout for sources of heresy or scandal. In the stricter climate of the Counter-Reformation institutional protection was required for the visionary and healer, a protection which the Third Orders did not provide. Sainthood outside cloistered convents was rendered all but impossible.

While the living saints at the courts of the Italian cities in the first half of the sixteenth century have come down to us through hagiographies, the stories of those mystics, visionaries and miracle-workers esteemed as living saints after Trent are generally told by the surviving records of the Inquisition.47 Even those living saints who were later canonised, like St Teresa of Avila, had first to pass the test of the Holy Office. Most, of course, never made the grade. All channels to the sacred – and the sources of healing it provided – were now being increasingly regulated and controlled by the Church in order to combat heresy and incorrect belief, as we have seen with regard to cunning folk, relics and exorcisms. But the living saints posed a special threat. First of all, they were predominantly women. The influence they had over their followers meant a disruption of the accepted patterns of relations between the sexes. This, at a time when the Church was seeking to enclose all nunneries and limit the public activities of nuns. Secondly, living saints subverted the established ecclesiastical hierarchy by posing as direct channels to divine inspiration and revelation.48

The trend of increasing ecclesiastical control over paths to sanctity was common to all the Inquisitions, Roman, Spanish and Portuguese. Despite being part of the Spanish Dominions, Naples had successfully opposed the introduction of the Spanish Inquisition, as already mentioned. This opposition had much to do with the desire of local elites to preserve their own spheres of influence. These elites could expect to have connections with representatives of the Roman Inquisition, familial and otherwise, offering them some scope of protection. The Spanish version would have deprived them of this. For this reason developments within the
with her because the said Suor Giglia was reputed to be a saint, and they became attached to the spiritual life, penitential exercises and advice of Suor Giglia as spiritual mother, who had told them that God had revealed to her that she would adopt them as her spiritual children.53 One of her 'spiritual children' was Rev. Roberto Campanile, cantor at the church of San Nicola. He asked for prayers and advice on God's intention regarding his decision to retire to the Dominican monastery in Naples and will his possessions to his brother now, rather than when he died. Her response was to sprinkle holy water in the direction of the door through which she said two devils were fast approaching, and tell him that he was a terrible sinner and ought to perform acts of penitence. She left him with a meditation which she said had been written by her guardian angel.54

It was her guardian angel who was ultimately responsible for some of her healing. He had brought her a piece of the Cross, housed in an ornate reliquary, and she used it to heal the sick by having them drink the water in which the relic had been placed momentarily. One man who was at death's door had drunk the water, vomited 'matter of different colours', and was healed. Suor Giglia's physician noted succinctly that 'by making a sign of the cross [along] with a Salve Regina' with the oil from the lamp which burned before her crucifix 'she healed every infirmity'.55

A boy was healed in the following more roundabout way:

having approached Hell, she touched him and, saying Our Father and Hail Mary to St Dominic so that he would pray Our Lady of the Rosary for the health of the boy, she held her hand on his stomach, after which the boy vomited certain matter of different colours, asked his mother for food and got better.

On another occasion she sent an ailing priest the relic. His condition improved for eight days, then worsened again and he died. Suor Giglia explained that he had died because he did not want to believe that he had been 'liberated' by virtue of her prayers.56 Liberation from disease is analogous to liberation from evil spirits – a concept we shall explore further in chapter seven. But even more interesting is the suspicion in which Suor Giglia is beginning to be held, at least by some. If her guardian angel was in fact the devil in disguise then the relic would be false as well, and the healing attained through diabolical rather than divine favour.

Her guardian angel was also at the centre of her numerous ecstasies. Whilst she was in rapture, enjoying the beatific vision, her body stayed on the ground, her guardian angel directing her, speaking for her and performing other normal actions, like embroidery work.57 One of Suor Giglia's spiritual children was convinced of the divinity of the spirit speaking through her because it spoke articulate praises of the Virgin, the dignity of the priest, the Blessed Sacrament and Christ's Passion.58 Her levitations also aroused considerable public interest and curiosity. During them many people would come and watch from behind a closed door. The atmosphere was one of tension and suspense as onlookers took turns peering underneath the bottom of the door to catch a glimpse of the 'saint' in levitation five or six palms off the floor with a crucifix in one hand. On one occasion a cape fell to the ground on the inside of the door, blocking the view, and

kingdom of Naples also influenced the course of local inquisitorial activities. The investigation of Suor Giglia follows in the tradition of the controversial case involving Suor Orsola Benincasa (1547–1618), a Neapolitan tertiary nun. However, it lacks some of the dogmatic urgency that accompanied the former investigation, which occurred only a few years after the closure of the Council of Trent in 1563. Suor Orsola was born into a family of noble origin and from a young age she demonstrated great piety accompanied by frequent ecstasies and revelations. She set up a hermitage in 1576, where her fasts, ecstasies, acts of healing and elementary preaching brought her great fame amongst Neapolitans of all classes. By this point, she had already been examined by the archbishop, and the agents of the Inquisition continued to keep an eye on her. In 1582, without the archbishop's permission, she arranged an audience with the pope, Gregory XIII, to tell him of the dire warnings she had received from God. She went into ecstasy three times during the audience and was unable to deliver her message. The pope, thinking her experiences might be evil spirits, set up a committee of nine judges to examine her, headed by Philip Neri (and also including one of the chief inquisitors, Cardinal Santoro, and the General of the Jesuits, Claudio Acquaviva). Rigorous interrogations, exorcisms and purgations continued for the following nine months. This included being completely stripped and shaved to see if she had on her, in any place, anything prohibited and pertaining to witchcraft that might be causing the ecstasy.50 Rumours even circulated in Naples that she had been burnt at the stake. The committee concluded that her spirit was ‘good’ and her soul pure and simple.51 She was allowed to return to Naples but forbidden to preach or prophesy. Her new role was to be private rather than public. In the years that followed pressure was put upon her community to come under some sort of Church control, and the enclosed convent she founded in 1617 was placed under Theatine supervision. When the plague of 1636 seemed to verify her prophecies, devotion to her spread to official circles, and she was proclaimed venerable (the first stage to canonisation) in 1793.

Even while alive Suor Orsola had become something of an archetype for the bizzosa in the kingdom of Naples. Most women, of course, were only able to imitate her model on a much smaller scale, in part due to their humbler origins. Orsola, however, was somewhat exceptional in having had her achievements recognised as divinely inspired. Most of the women who imitated her model and that of other living saints were not so lucky.

Suor Giglia di Fino's story is typical.52 Giglia (1601–?) was a local tertiary nun, reputed to be a saint because of her visions, ecstasies, prophecies and healing power. Her fame brought her case to the attention of a local delegate of the Holy Office, the Dominican friar Vincenzo di Ferrandina. Aware that such feats could have any of three origins - divine, diabolical or simulation - he began an investigation in 1628. Testimony comes largely from those men who had formed a group around her, calling themselves her 'spiritual children.' In the same way that some living saints had become counsellors and advisers to the princes and courts of Europe, although on a smaller scale, Suor Giglia was asked for advice by her spiritual children based on the revelations she was said to receive from God. They 'associated
causing great fear when people tried to move it and it resisted, all of which was followed by a loud thump on the door. A woman named Isabella who lived nearby recounts that she too wanted to watch from under the door, but while Suor Giglia was raised up in the air she [Giglia] put her hand inside her sleeve and threw a book impetuously at her where she was watching, and the said Isabella, terrified, never wanted to go again.59 Giglia accounted for this by saying that her guardian angel did not want her watched when she was closed in her room.60 In order to prevent her levitations from becoming too much of a public spectacle — especially when doubts about their divine origin were beginning to arise — her confessor had a bar put across the bottom of the door.

In many ways Suor Giglia’s experiences imitated those of the female mystics who had gone before her. Indeed, she claimed that St Teresa, recently canonised, as we have seen, appeared in all her visions alongside Christ. During one of her ecstasies Suor Giglia had undergone the mystical marriage with Christ in the company of saints and angels (similar to that of St Catherine), although the ring was visible only to her. Other ‘wondrous deeds’ (opere maravigliose) included being taken up into paradise during the feasts of Christmas and Easter, and celebrating Palm Sunday with the blessed, during which she was given blessed palms for herself and her spiritual children. On the feast of Corpus Christi, unable to go to mass to take communion, Jesus gave her communion with his own hands.61 On another occasion an angel of paradise brought her a jar of ‘celestial liquor’. It was the special food of paradise and she drank it ‘for the nourishment of her soul’, but its intense warmth and sweetness caused her to be sick. Finally, like St Philip Neri, she claimed that the gift of grace had caused her heart to dilate and break her ribs apart (going even further than Neri, whose ribs had only been raised up). Campanile — who was especially devoted to Neri — was told to feel Suor Giglia’s ribs by the guardian angel. He did this, and was amazed to be able to put four fingertips into the space.62

It was probably this self-confidence and boasting which were Suor Giglia’s undoing. Her attempts at constructing her public role as saint began to misfire. It was one thing to justify her status by referring to her saintly childhood, early manifestations of holiness and daily acts of self-mortification (the most standard of saintly models),63 quite another to claim that she was more favoured than St Philip Neri. Suspicion about the divine nature of her achievements was aroused when several of her prophecies went wrong. On one occasion she told Dr Cornacchia to cheer up since his pregnant wife was going to give birth to a baby girl; but, instead, she became ill and died within a few days.64 She was suspected of spending the alms she had supposedly collected for the poor. She was accused of giving such harsh penances to followers that they were brought close to death. Furthermore, a priest from Naples had told Campanile about the blood of a holy man there which had been put inside an ampoule and which occasionally boiled inside it, as well as performing numerous miracles. The model is that of the famous Neapolitan reliquary containing the blood of St Januarius. Campanile resolved to try this with Giglia’s blood. So, with the help of her physician Cornacchia, a pretext was found to have her bed, and the blood was put into an ampoule. However, the ampoule was then taken by another of Giglia’s spiritual children, Rev. Serio Moro, her favourite. First a word about Moro. Several witnesses say that Suor Giglia was seen in his house one night, Moro naked to the waist, causing much scandal. Serio is also the only one who still frequented Suor Giglia at the time of the trial, despite the charges against her. Be that as it may, Serio dropped the ampoule, spilling the contents, an event which Campanile blamed on the devil. When asked why by the inquisitor, Campanile replied that he and Cornacchia had planned to take it, along with Giglia, to the shrine of Monte Sant’Angelo, to give the alleged guardian angel the chance to prove himself before the priests there. The rector of the Jesuit College in Bari had also shown interest in the ampoule. But the trip would have resulted in the clear discovery of the deception, if deception it was.65

Suor Giglia’s case was weakened further still when her guardian angel told her spiritual children that she had gone to church and had been exercised by her confessor and another priest, both of whom were now firmly convinced of the guardian angel’s divine nature. Campanile decided to ask Giglia’s confessor to ascertain the truthfulness of the account, and he responded by saying that the story was a complete lie and advised Campanile not to have anything more to do with her, for the good of his own soul. In fact, Giglia had not even told her confessor and spiritual director about her guardian angel for fear of arousing his suspicion. As Campanile told the inquisitor, he now came to the conclusion

that the intention of the devil was none other than to have the said Suor Giglia credited as a saint in order to prepare some great evil. And I believe that the Lord allowed me to know this because I prayed to him many times that he not let me fall into some evil and I recommended myself to St Philip, who is my particular devotion.66

At this point another of her spiritual children, Rev. Giovanni Chiuro, was even courageous enough to confront Giglia’s guardian angel with this. On the eve of All Saints (just a coincidence?), Chiuro was reasoning with her on how she was being deceived by the devil and how this had occurred to many other holy and devout people, when she mentioned paradise and seemed to be leaving herself (astarsis) to make way for her spirit. He insisted: ‘Stop! Stop! Stay with me and listen to what I say.’ But in vain, so he addressed the spirit now in her: ‘Evil beast, infernal demon! By lying you have kept this poor creature and we others for a long time, pretending to be a good angel. But now the deceit and the lies you told have been discovered. . . Infernal beast, what are you doing inside the body of this creature?’ In confusion, the spirit seemed to bow his head and look towards the ground, and then said in a low voice, ‘God sent me here’. ‘How could you have spoken about the greatness of Mary and call her Our Lady?’, Chiuro demanded. To which the spirit responded that since he was an angel she was Our Lady for him as well. Then the spirit began to impersonate Suor Giglia, taking her rosary and small reliquary from the head of her bed and kissing it. Chiuro asked where the relic came from, and Suor Giglia — having now returned inside herself — said it was a splinter of the true Cross.67
into the construction of a new church. Suor Giglia, on the other hand, was not aware of the limits and the risks of what she was doing. Her model of sanctity was becoming increasingly outmoded as far as the Church was concerned, even if it still satisfied local demands for sources of sacred power for healing, revelation and other wonders. The deeds of living saints would be defined as divinely or diabolically inspired, according to the outcome of the inquisitorial investigation. The women would then be labelled and their actions interpreted accordingly. A 'good' living saint was the antithesis of the witch; a 'bad' living saint, the witch's counterpart.

Despite the risks inherent in being a living saint, or in seeking her cures or forming part of her cult, the cultural type survived throughout the early modern period. This is testimony to both the role of saints in medical pluralism and the unceasing quest for manifestations of the sacred. The Church's ongoing struggle to regulate such phenomena—without discouraging their development—demonstrates the ecclesiastical interpretation of sacred healing after the Council of Trent. The boundary between orthodoxy and unorthodoxy, divine and diabolical, holy and sinful, was a very fine one indeed, and one the Church reserved for itself the capability of distinguishing. Those in error, whether wise women, lay exorcists or living saints, risked not only their souls but, like an evil contagion, those of the entire community.

What changes over the period covered by this book is the participation of the local elites in such cults. During the seventeenth century physicians, for instance, are frequently found amongst the disciples of living saints. By the next century, however, the Church's view of orthodoxy was firmly implanted at these levels. Moreover, the spirit of Enlightenment rationalism that swept through Naples had the effect of limiting the array of occurrences that could be accepted as supernatural. Tarantism was one such casualty, the virtual cult that had developed around the devil another. The response of the Church authorities was ambiguous, sometimes rejecting rationalistic conclusions (as in its continuing acceptance of tarantism), sometimes embracing them. The ecclesiastical elites were now more hostile than ever to purported visionaries and mystics in their midst. In 1736 the kingdom's chaplain major and founder of the Academy of Sciences, Celestino Galiani, was quick to brand one such woman, Suor Maria Celeste Crostarosa, an impostor. He accused her of 'faking visions and heavenly appearances.' Reason was increasingly the yardstick by which both living saints and miracle cures were measured.

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The inquisitor would seem to have been convinced of the deceit. But the fault was recognised as the devil's and not Suor Giglia's. She was regarded as a poena illius, a poor dupe, the devil having taken advantage of her simple piety to further his own ends. When confronted with the deceits and told to pray for God's guidance, she replied, in tearful resignation:

What I have done, I have done and do for this Christ [pointing to the crucifix], who has done and suffered so much for me, and this I understand, if this Christ then in remuneration of my works wants to give me a demon who becomes master of my soul, as master let him do what he wants.68

Even Suor Giglia's spiritual director—about to whom she had lied, and whose instructions she had not respected—believed that she was a good Christian, but for the extravagant things which he saw in her life suspected that she was duped by the devil.69 The inquisitor was also concerned with Giglia's current reputation in the town, for it was important that no one be led astray by the delusion. The three clerics Campanile, Chiuro and Loizzo reply that she is commonly regarded as pious but possessed and deceived by the devil. Only Cornacchia, her physician, left the court with some doubt, suggesting that her healing and prophecy were still in demand:

For much time the said Suor Giglia was commonly held to be a saint. But when it was discovered that she did not confess with her spiritual director about her things, or with us, we then considered her a liar, and her usual confessor did not want nor want to confess her. The people are divided into those who consider her good, and those who consider her possessed.70

Once women like Suor Giglia began to lose their respectability because of an impending inquisitorial investigation, they were quickly abandoned by many of their followers and soon found themselves all but isolated. After they had recognised the error of their ways, they were generally sent to a convent where they would spend the rest of their days. This only demonstrated that they had returned to the fold of the Church, but also kept them under strict supervision and prevented them from having contacts with any followers that might be left. This is not to say that people in the community ceased to believe in their healing powers. On the contrary. When Benedetta Carlini finally died after thirty-five years of solitary confinement, crowds of people gathered to collect relics from her unburied corpse.71

It is not simply a question of the Church reform of 'popular' culture. First of all, the power and influence of these living saints could rise to such heights precisely because all levels of society participated. The difference being that the more highly placed her clientele, the more protection the living saint would have, and the more likely that she would have the guidance of those in tune with the accepted limits of holiness. This is what saved Maria Manca. She worked within the confines of what were considered acceptable expressions of piety. Her holiness was of the edifying rather than wonder-working variety, and her piety channelled

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3 Peter Burke, ‘How to be a Counter-Reformation saint’ in Burke, The historical anthropology of early modern Italy: essays on perception and communication (Cambridge, 1987), p. 49.
5 Appropriate to his tender age, Belli acquired a reputation for healing childbirth and nursing difficulties, making the sign of the cross on the sufferer. Pietroberto Scaramella, I santalliti: culti dell’infanzia e sanità infantile a Napoli alla fine del XVII secolo (Rome, 1997), pp. 26–7.
7 Mauro Paticchio, Breve ristretto della vita di Maria Manca della Terra di Svinzano (Naples, 1769; reprinted Galatina, 1971), p. 36.
8 Ibid., p. 42.
9 Ibid.
10 Ibid., p. 74. St Agatha was a Sicilian virgin and martyr whose breasts were cut off and then miraculously healed after a vision of St Peter. Maria Manca was also a devotee of St Teresa of Avila.
11 Ibid., p. 92.
12 Ibid., p. 33. The Belgian Jesuit Martin Del Rio was author of Disquisitionum magorum libri sex (Louvain, 1600); the German Dominicans Jakob Sprenger and Heinrich Institoris (or von Kriemer) compiled the Malusse malefactorum (1486); and the Spaniard Francisco de Torralbinc y Villaplano wrote the Epitomes delictorum, in quibus aperta, vel oculta invocatio daemoni intervenit (Seville, 1618).
13 Paticchio, Breve ristretto, p. 41. Richard Mead (1673–1754) was physician to George II for a time, and such was his fame in Italy that the king of Naples wrote to him asking for his works and inviting him to the palace. In his Medica Sacra, a Commentary on the Diseases mentioned in Scripture (London, 1749), he discusses leprous, palsy and possession, identifying Job’s ailment as elephantiasis, Saul’s as melancholia, and so on.
14 Francesco Maria Guazzoni (or Guaccio), Compendium malusseum in tres libri distinctum ex pluribus autornibus (Milan, 1608); English trans. E. A. Ashwin (London, 1929).
15 Fransiscus Valesius, De occulti naturae minacibus, bk II, ch. 1.
16 Guazzoni, Compendium, bk II, ch. 8 (Ashwin trans., p. 160).
17 Andrea Cesalpino, De daemonum investigatione (Florence, 1580), ch. 16.
18 It quickly went into a second edition, from which I cite: Pietro Pippino, De magiciis affectibus lib. vi (Naples, 1635). See also Michele Miele, ‘Malattie magiche di origine diabolica e loro terapia secondo il medico beneventano Pietro Pippino (+ 1642), Campania sacra, iv (1973), pp. 166–223.
19 Pippino, De magiciis affectibus, p. 57.
20 Ibid., p. 59.
21 Ibid., pp. 169–207.
24 Candido Brugnoli, Alexicton, hoc est opus de maleficiis et morbis malfruis (Venice, 1668), vol. i, pp. 158–9.
26 Ibid., pp. 2–3.
29 Nicola Valletta, Cicalata sul falsario, volgamente detto jettinato (Naples, 1782); Gian Leonardo Marugu, Capricci sulla jettinata (Naples, 1788). The latter was also author of a detailed study of diseases associated with flatulence (Le malattie flatuose: opera medico-fisica scritta con metodo matematico, Naples, 1786–87) and a treatise on the sciences, including medicine (Stato attuale delle scienze, Naples, 1792).
31 Giuseppe Davanzati, Dissertazione sui vampiri (Naples, 1774), p. 117; in Ferrone, Professi dell’illuminismo, p. 32.
32 Pietro Gianferrone, L’opera ingegnosa ovvero raccolta di varie osservazioni sopra le opere di natura e dell’arte, Biblioteca Reale, Turin, Varia, 324, fol. 73v; in Ferrone, Professi dell’illuminismo, p. 372 n. 30.
36 Paticchio, Breve ristretto, p. 54.
37 Ibid., p. 125.
38 Ibid., p. 145.
39 Ibid., p. 164.
40 Ibid., p. 11.
41 Zarri, ‘Sante vive’, p. 379.
43 Brown, Immodest acts, p. 51.
44 If the memory of Maria Manca is still alive today in Svinzano it is because she is offered as a model of devotion, and the veneration itself is channelled to the image of Our Lady of the Carnation in the church she built in the town. A more modern-day example of this is the healer and seer Marietta D’Agostino of Orta Nova, near Foggia. As observed by the ethnologist Annabella Rossi in 1968, she performed healing activities in a shrine she had set up in her two-room house, attributing her powers to Our Lady of Altomare, to whom the shrine was dedicated. Hundreds of people came every day for cures and predictions and their contributions enabled her to build a small church in the vicinity. It was consecrated by the bishop, despite earlier troubles with the clergy over her alleged visions of and conversations with the Virgin. Annabella Rossi, Le feste dei poveri (Palermo, 1986 edn), pp. 61–4.
Such was the case in places like Mantua, Ferrara, Milan and Florence in the first half of the sixteenth century, as discussed by Zanetti, ‘Living saints’, pp. 418–20. After the Council of Trent the activities of such ‘court saints’ became much more circumscribed and they were subjected to inquisitorial scrutiny. For example, the case of a priestess from Lisbon, Sr Maria de la Visitación, whose visionary powers and stigmata resulted in her becoming one of the most influential women in Europe during the 1580s – consulted by secular rulers and Church officials – before she was discovered to be a fraud. E. Allison Peers, Studies of the Spanish mystics (London, 1951), vol. 1, pp. 30–1.

This was to be the principal case against the many Spanish beatas tried by the Spanish Inquisition, some of whom were linked to the earlier Alumbrado heresy. Mary Elizabeth Perry, Beatas and the Inquisition in early modern Seville’ in S. Haliczew (ed.), Inquisition and society in early modern Europe (London, 1987), pp. 147–68.


At this point in his hagiography Maggio criticised Gregory XIII for not recognising the need for reform and acts of penance which Osola had repeatedly called for, the result being the succession of calamities that had followed her death and showed no signs of abating. Maggio, Vita, pp. 305–8. This criticism no doubt had a lot to do with his book being placed on the Index. S. Menchi, ‘Osola Bennacasa’, Dizionario biografico degli italiani (Rome, 1966), vol. 8, pp. 527–30. One calamity which Maggio did not include in his list occurred the year after the book’s publication, the 1656 plague, as mentioned in chapter one.


Deposition of Rev. Roberto Campanile, ibid., fol. 22–3r.

Cornacchia, ibid., fol. 19v. The crucifix was itself imbued with sacred power, for it had ‘talked and conferred with her’ (fol. 15r).


Campanile, ibid., fol. 4v.

Chiuro, ibid., fol. 22r.

Ibid., 20v–21r.

Deposition of Rev. Agostino Loizzo, ibid., fol. 35.

The inquisitor made a point of asking how Jesus gave her communion and the answer was like a priest, giving her the host. Campanile, ibid., fol. 6v–7r.

Campanile, ibid., fol. 7v–8r.

Loizzo, ibid., fol. 36v.

Campanile, ibid., fol. 12v.

Campanile, ibid., fol. 8v–9r.

Campanile, ibid., fol. 5r.

Chiuro, ibid., fol. 23r–24r.

Loizzo, ibid., fol. 38v–39r.

Cornacchia, ibid., fol. 14r.

Cornacchia, ibid., fol. 19r.

Brown, Inmodest acts, p. 137.


the various stages of ecclesiastical recognition: venerables, blessed and saints. And this is to say nothing of those whom the Church rejected outright, like the 'living saints' examined in chapter six. In any case the number was substantial. For example, Jean-Michel Sallmann has identified cases for 105 servants of God during the period 1540 to 1750. In 1588 the Congregation of Rites and Ceremonies was founded within the Catholic Church as a standing committee of cardinals to examine the causes of candidates for canonisation. It adopted a rigorous judicial procedure, of which the examination of witnesses was an important part. The witnesses were called to give evidence at these hearings responded to and commented on a series of questions and declarations regarding the holiness, Christian virtues, miracles, prophecies, quality of death, and so on, of the candidate for canonisation. In fact, it is the narratives of miracles performed by such holy people, both whilst alive and after death, that form the larger part of the processes and that would go on to constitute episodes in the published hagiographies and miracle collections so numerous during the period. The narratives frequently permit the historian to reconstruct entire courses of treatment leading up to the miraculous intercession. They also contain a vivid description of aspects of everyday medical attitudes and practice, to which those of the miraculously cured sick people, the miracolati, can be compared.

To judge by these narratives, the principal function of saints was to perform miracle cures. The witnesses, in their own words, describe these miracles, which represented a source of hope in cases of imminent death, where medicine could provide no relief or cure. As in the Middle Ages, miracles formed part of the expectations of mankind in early modern Catholic Europe. They were part of accepted, everyday experience. They provided a source of healing at a time when resistance to disease was low and pre-modern medicine was of little efficacy. Indeed, in this medically pluralistic society the intervention of physicians was but one source of relief, and not necessarily the most common. As outlined in the preceding chapters, the period's network of healers consisted not only of regular medical practitioners, but cunning folk, exorcists and saints, to say nothing of widespread domestic medicine.

The early modern body was a battleground for differing interpretations of diseases: natural, divine and diabolical. Miracle cures exemplify this ambivalence. They represent a useful focus for study because with them 'the body finds itself at a limit: between health and disease, life and death, nature and the supernatural, the real and the imaginary.' Rather than deal with miracles per se, however, the focus of this chapter will be on what miracles - and stories about them - can tell us about the healing process in general. In the first section, I shall consider how the miraculously cured sick people represented illness and the healing process. What can the miracle stories tell us about the links between medicine and religion in Catholic Europe during the early modern period? To answer this we must return to religious and medical concepts of disease. The second and third sections will therefore focus on how different professions - physicians and ecclesiastics - competed over self-definitions, skills and roles, as evinced in the miracle cure.
my bed, and... I got dressed into my clothes, which I had not been able to do in the past, and with anxiety I saw that the said tumours had already ceased and settled down with the other parts to their natural place, as if they had never been there, and the wounds were closed with natural skin, that you could hardly tell they had been there, having no other scar than that of a flea bite.

Orecchio was convinced the cure was a miracle. He became assured of this when, with some anxiety, he urinated. To his relief, 'it came out through the natural channel, as before the cut.' He praised God and Giannini's intercession. And, Orecchio concluded, when the surgeon saw him healthy for the first time, he too was convinced that the cure was miraculous, 'since humanly I should have been dead.'

We can compare Orecchio's account of events to that related by the surgeon who treated him, the thirty-five-year-old Gennaro Sarno. It differs in several respects. Sarno deposes that he had first begun to treat Orecchio as far back as 1740, and identified Orecchio's malady as the French disease, a fact which Orecchio, perhaps out of shame, had neglected to mention. Nor did Orecchio mention that he had spent a month at the Incurabili Hospital. This was at Sarno's behest, who was aware of the seriousness of Orecchio's condition and his poverty. Orecchio had gone there for the removal of a chancre, though he was forced to return home due to unspecified family reasons before the treatment was complete. This resulted in what Sarno referred to as a 'serpent herpex' and led to the tumours which Sarno incised, but which had failed to heal. Around this time Orecchio's wife had died of a related form of consumption (etia gallica). Orecchio then resolved to go to the baths of the Sacred Mount of Mercy at Ischia, though Sarno advised against it. When Orecchio returned home after the sixth bath, in worse health than ever, he sent for Sarno in repentance and desperation. Sarno concluded that the case was hopeless and advised him 'to go to some hospital to end his days there more comfortably, since in his house he had no comfort or means of protecting his health.' In September of the same year one of Orecchio's daughters told Sarno of her father's miraculous recovery. As Sarno told the hearing, at first he did not believe the news. But, when he saw Orecchio alive and well, and later examined him, he became convinced that the cure was indeed miraculous.

Typically, illness narratives start by identifying the genesis of illness, making use of a particular explanatory model to give it meaning. The story's beginning is anchored in a particular time and place. This was the case with Antonia Jurlano's account of her daughter's illness episode, with which I began this book. No doubt it was also true of Orecchio's experience. However — presumably because Orecchio was ashamed of his French disease — he did not tell the ecclesiastical investigation how and when his illness first began. The next stage in narratives moves from genesis to the period when the physical symptoms become a major disruption in the person's life. It is interesting that Orecchio's narrative began not with the beginning of his disease (in 1740), but when it took on a much more frightening appearance and reached a life-threatening stage with the tumours (1746). This situation was exacerbated by his wife's death. At this point in narratives, the relief from pain and the search for a cure come to the fore. Various events pertinent to the illness and its treatment are related, such as Orecchio's desperate trip to the baths at Ischia — against the surgeon's wishes. But Orecchio's account only became really loquacious when he entered the second phase of his story. This began with his daughters' chance encounter and visit to Giannini's tomb. This shift into 'sacred time' is something that we shall return to below.

Narratives like this one are important for the historian, since telling stories about particular experiences is the primary human mechanism for bestowing meaning upon them. They reveal so much actual happenings as the underlying meanings attributed to the events. Disease is seen to occur not only in the body, but in time, in place, in history and within the context of lived experience and the social world. In a world shattered by illness, the construction of narrative allows the sick person to 'reconstitute' the world. Being a miracolato assured ample opportunity to tell and retell the story, as new sources of cure were added to the pre-existing explanatory model of illness. The relating of miraculously cured illnesses to ecclesiastical hearings investigating the holiness of servants of God was an extension of this function. The narratives given as testimony share many of the characteristics of similar stories told to relations, friends and neighbours. Yet the hearings were directed and conditioned by the ecclesiastical authorities. As a source, therefore, the canonisation processes do have their limitations, and it is worth bearing them in mind as we proceed.

First of all, the structure of the hearing consists of a series of numbered articles compiled by the cause's postulator, to which the witnesses responded in turn. The comments of witnesses were thus structured, and often restricted, by the formulation of the article itself. But there was always a question of the sort — 'describe any further miracles that you know about' — which gave the witnesses relatively free rein, allowing for greater variety in the narratives and bestowing a more direct oral quality upon them. Even here, however, we are not dealing with the episode exactly as recounted by the witness, but as taken down by court clerks. Often this involved translating dialect testimony into Tuscan Italian and the paring-away of any tangential remarks, with a resulting loss of spontaneity. The involvement of a postulator in shaping the cause meant that witnesses were not representative samples of medical practitioners, or of the community as a whole. Only privileged witnesses — those with something positive to contribute to the cause — were singled out by the postulator to testify before the Congregation or at a local hearing. The role of the postulator is one to which we shall return in section three.

Events were not necessarily recounted as they occurred, or even as they were perceived to have occurred. Witnesses were often speaking about events and impressions of many years prior to the hearing. Memories could undergo the deleterious effects of the passage of time, as witnesses themselves occasionally noted. There was also a conscious reshaping of testimony on the part of witnesses, conditioned by the servant of God's local fame and a desire to present him or her favourably. But of greater relevance to this study is the similar process of
self-representation by witnesses before the Congregation. For example, in order to give more weight to the miracle cure, witnesses almost always described it as having taken place as a result of the sick person's invocation of the saint only after all other remedies had been exhausted and the physicians had given up hope. This made the miracle more acceptable to both the medical community and the Church authorities. But in fact, saints were generally invoked from the very start of the illness, alongside other forms of treatment, in a form of double recourse. The entire illness episode was thus reinterpreted in the light of the miraculous outcome. Yet this is not so much a limitation as a characteristic that can be turned to our advantage. Although the narratives were structured by the way the hearing was conducted, they provide us with an indication of how such stories were told and the importance they had in relating illness experiences within the community.

What can they tell us about how illness was perceived? The language used to represent illness is remarkably similar to that used to describe possession of the body by demons. The popular healing rituals of the period made use of exorcising formulas to conjure disease out of the body. But the possession-illness link is clearly evident in the miracle narratives, too, uniting learned and popular traditions. Disease is represented as an active force, which enters and advances through the body. It "assails", "assaults", "oppresses", "comes upon", "strikes", "crushes", "buries" the body. A war between sickness and health ensues, the body becoming the field of battle. The disease "grows", "spreads" or "winds its way" (serpere) through the body, "clinging to it, becoming rooted." During this corporeal encounter the sick person is somehow dispossessed. The doctors, after having tried their remedies on the body, abandon it. The sick person reacts to the loss of his or her body by seeking a miracle. The miracle is the "moment of struggle when, despite the laws of nature, the defeat of the disease is decided." The disease "withdraws", the body is "liberated", "cleansed." The sick person has been singled out, the body reunited with the self and its functionality restored. The miracle cure is at once unique and part of a timeless corpus of similar cures. But for the physician recounting the same event, the miracle is often presented as something of an anti-climax, which does not involve him directly. After all, the sick person's life has not only been saved by the miracle; it has been marked, singled out. The physician's life is affected to a much lesser degree, if at all (except, of course, in those cases where the physician is also the miraculatus).

In the canonization processes there is remarkably little difference between the terms used by sick people and those of their doctors, though they did often differ on what constituted a miracle cure. At least as far as "natural" illnesses were concerned, there was a substantial convergence between lay and professional medical outlooks and attitudes, though lay knowledge was practical know-how based on experience, without the medical-theoretical underpinnings spelt out. In the case of one miracle cure, both the nun cured of a paralysis, St Maria Rispoli, and the helpless convent physician, Giovanni de Turris, were agreed on why the cure could only have been miraculous:

Nor could I have recovered otherwise [Rispoli recounted], given that the medications were of no help to me, as was seen by my four months' experience [with them]. I recovered instantaneously, having stopped taking medications several days before; nor was any crisis brought about in me, either by sweating or other evacuation, by which the humour causing my illness could have been dissipated and digested.21

De Turris likewise said that the cure was a miracle because it had taken place without the necessary fever or other "movement of the body" (stoigimento di corpo) to act as a purge.22

The evacuation of evil humours was one of the pillars of Galenic medicine. A cure brought about in its absence helped to define that cure as miraculous. But, as far as many non-medical witnesses were concerned, saints could also use their miraculous intercession to bring about the vital purge. The miracle is depicted as a crisis. The sick person's condition gets dramatically worse, the bad humours spread throughout the body, until the miracle intervenes to expel them from the various orifices.23 In any case, popular and learned traditions shared the concept of "flow" within the body. A blockage in one part of the body could manifest itself elsewhere. This is particularly evident in women's perceptions of their bodies. Thus a woman who had just given birth linked her swollen leg, so painfully she could not move it, to her difficult labour. She refused to be examined by a surgeon, consenting to be treated only by the midwife who had delivered the baby.24 In 1623, the domestic servant Rosata Tomasi recounted how several years earlier her mistress had been suffering from sharp pains in her belly/womb (ventre) and was losing an abundant quantity of blood. The ailing woman fetched the Jesuit Bernardino Realino (1530–1616), held locally to be a saint. Whilst he was kneeling at her bedside, reciting a litany to the Virgin Mary, she took his biretta, which he had removed to say the prayer. She placed it – like a relic – over her womb, where she had the pains. Tomasi concluded her account thus: and as soon as she touched her ventre with that biretta, a large piece of putrid and congealed blood came out of her body, and all her pains ceased. This discharge was dangerous though necessary element of the cure. This is true whether or not the expulsion was a mola, a fact which is never specified. A bodily growth was not identified as pregnancy until the quickening occurred. In fact, the belly/womb ambiguity indicates the way in which this space was hidden and mysterious. The womb was not yet a part of some medicalised reproductive apparatus.25 What is interesting in this context is the woman's control over her own body. No medical practitioner figures in the story.

Physicians and sick people also shared the need to describe and identify the disease. Objectifying the illness and its symptoms brought a certain sense of control over it, as well as exerting a powerful influence over behaviour.26 The narrative process was a crucial element in this. Talking about illness and comparing previous experience was basic to an understanding of the malady and seeking a cure. If professional care was sought then the medical practitioner depended on the sick person's often harried and urgent description of the illness in order to formulate a diagnosis. This was facilitated by the existence of vividly descriptive and figurative
popular and regional terms for illnesses, used, or at least understood, in all levels of society. When using such illness terms in their narratives, witnesses sometimes preceded them with an expression like ‘as popularly called’ (volgamento detto). Such was the term le coca, literally swellings or pusules, to refer to smallpox (vaiuolo in Tuscan Italian); i pori (literally, leeks) to refer to warts, as opposed to the learned term verruche; mal di punta (in the sense of stitches or sharp pains) for pleurisy; and mal mazzucco, literally hammer sickness, to refer to a kind of frenzy.

Let us take cases of fever. To analyse them it may be useful to bear in mind what Byron Good has called ‘semantic networks.’ These consist of the ‘words, situations, symptoms and feelings which are associated with an illness and give it meaning for the sufferer.’ Fevers were considered diseases in their own right, not symptoms of something else. They were the most prevalent form of illness in the narratives, both in their sheer numbers and in their variety. If very dangerous, fevers were at least familiar. Sick people and physicians alike sought to identify as early as possible the variety of fever in question. The canonisation processes reveal shared ideas about causation as well as terminology. Both popular and learned traditions saw fright or fear as possible causes of fever. This was possible because sudden and strongly felt emotions were thought to block the flow of fluids in the body. In a conception very different from our own, fevers ‘occupied’ the body; they could then be described as ‘leaving’ it. As for the numerous expressions used to indicate fever, they can be broken down into types (pestiferous, aerial, lymphatic, frenetic, hectic, rabic), into degrees (malignant, acute, ardent) or into rhythm (slow, continuous, intermittent, quotidian, tertian, double tertian, quartan). Adjectives used to describe the fever vary from the common ‘great’ to ‘fermentative.’

Statements about pain also suggest how the sick body was perceived by early modern Europeans. Because pain could not be understood objectively, it had to be described. The language used was therefore metaphorical. During pain the body became an object, the sick person outside it, looking down on it. The reality of pain, as a natural part of both sickness and medical treatment, explains the number of miracles which intervene to save the sick from dangerous physic and surgery or alleviate pain during the course of an operation. Pain itself was frequently linked to the emotions. This helps explain why a nun could ‘find herself oppressed by evil thoughts and other pains.’ Pain was even perceived to lead to madness. One illness episode exhibits these various features. In 1729 Benedetto Jurleo recounted how he had been suffering from sciatica and had exhausted various remedies, and how on 18 November the pain had increased so sharply that he thought he would ‘die mad’ (more frabbato). But following a vision of the sainted Carmelite nun Rosa Maria Serio (1674–1726), during which she told him she was cured, Jurleo said he ‘immediately felt [as if] a one-cantaro weight had fallen from my aching thigh, and in an instant I was relieved and healthy, and the next morning I walked through town, as if I had never suffered any malady at all.’ The moment of release from pain can be described as vividly as the pain itself and the moment when it first began. Jurleo’s sense of relief is at once poignant and palpable.

The minacelli often refer to specific dates or phases in the illnesses. In addition to naming – identifying – the illness, it was important to locate crucial moments in its course. The narratives did not seek the dispassionate representation of the illness experience, but to elicit a particular understanding of the events. Witnesses privileged certain times in their narratives: the exact moment when they discovered their illness, times of medical intervention, sudden changes in conditions. These are times of extreme uncertainty, when a person’s life is suddenly and patently in the balance. Entry into the marked time of illness is thus carefully recorded by sick people, distinguished from the rest of their lives. When she testified in 1725, the articulate nun Maria Rispoli remembered the exact date when she had had her apoplectic fit, even though it was nine years earlier (4 February 1716). We may have doubts about the general use of numerical dates in society at this time, but at the very least she was able to calculate them for the benefit of her deposition. She remembered, too, the day when she began invoking the intercession of the saintly Jesuit preacher Francesco de Geronimo, shortly after his death in nearby Naples (11 May 1716). She remembered when her pains got much worse, now affecting both sides of her body (4 June), followed by the application of relics, which took these new pains away but left the original paralysis intact. She remembered the night when she had a vision of de Geronimo (14 June), for the following day she awoke without pain and was able to walk. The onset of her illness was in fact reinterpreted and given new meaning in the light of her devotion to the saint and the subsequent miracle.

For those suffering from chronic or fatal illness the devotion to and invocation of a saint offered an opening-up of the ‘bounded time’ of illness. Illness is wholly ‘present time.’ Sick people have difficulty remembering when they were well or will be well again. Devotion to a saint opens a way out of this present time and space by allowing the devotee to express confidence in the future actions of the saint. Religious devotions and vows to saints structure and give meaning to time outside that of the illness, and faith in a cure offers a future beyond illness. For those who testified, belief in the imminent possibility of a miracle was crucial. For this reason relics were always applied to the body and saints invoked ‘with keen faith,’ ‘with great trust and hope.’ Indeed, the act of invocation itself often brought an immediate sense of relief and ‘a certain internal consolation’, as one witness put it. For this reason miracle accounts put great emphasis on how the sick person first found out about the particular saint and when and in what circumstances that saint was first invoked. The transmission of such knowledge was fundamental for cultural models of illness. Invocation brought the illness into a new, symbolic phase. This is evident with the onset of ‘sacred time’ in the Orecchio narrative described at the beginning of this section. Illness was not something restricted to specific sites in the body. It was located in imagination and experience, in history and in social relations.

The wording of the invocations made to the saints indicates the link they provided to times and spaces outside the bounded ones of illness. They express a desire for the recovery of a functional body, guaranteeing reinsertion into society or community. A paralysed nun prayed to have her ability to walk restored, so that she
could at least 'go to confession and communion in the places where she used to.' As this request suggests, devotees do not always ask the saints to 'cure' them. The early modern idea of the functional body was different from ours. The complete recovery of health, in the modern sense, is not necessarily the sick person's main desire or expectation. There is a gap between 'health' as defined by modern biomedicine and what people of other societies, past and present, are prepared to put up with, while considering themselves free from sickness. Even Paolo Zacchia (see below) admitted that miracle cures could consist of having one illness transmuted into another or shifted to another part of the body: the supernatural equivalent of the Galenic procedure of conducting disorders from vital to less important regions of the body. He gives the example of a patient of his suffering from a tumour, ulcers and painful haemorrhoids, much to her great personal shame, who, after invoking the intercession Cardinal Bellarmine, awoke to find herself suffering from articular pains and nothing else.

Other miracles permitted sick people to confess their sins before they died. Dying the 'good death' was of great importance throughout the early modern period. Any illness was to serve as a warning of what would ultimately befall everyone. When illness forced people to bed, with the threat of death hovering over them, it gave them the chance to put their things in order. In 1743 serious illness gave Angela Intano both the motivation and the opportunity to confess to having stolen a host from church eight years earlier, secretly removing it from her mouth after taking communion. She had been asked to do so by an acquaintance and was worried that the host might have been used in magic. Later, when I was bedridden with blood flukes,' she told the ecclesiastical tribunal of Gravina, 'and having confessed to my father confesser, he made me feel a remorse of conscience for having performed such an action.' Her appearance before the court was the result. Although pious writers had shifted the emphasis away from the memento mori of previous centuries, and on to lifelong preparation for and meditation on death, the faithful continued to regard the time immediately preceding death as crucial. In 1765 the apothecary Onofrio Stiffa recounted the following incident, which outlines the elements constituting a 'good death':

The late Pietro Aloca, Neapolitan, was struck down by an illness which caused him to cough up blood through the mouth, and he bled in such great quantity when I was fetched... that I was unable to look at him, [and] I thought then that he was about to suffocate. Forced to make a decision, I suggested, as was my wont, that he recommend himself to the said servant of God [Ludovico Sabbatini], by touching the said relics to himself and praying to him for the grace of his soul and body, depending on [Sabbatini]'s will. And immediately I saw the vomit of blood cease, and the said Pietro was moved into a position in which he could make confession, take communion and put all his things in order. And within five or six days he died peacefully, the servant of God having, I believe, granted the grace of his soul, considering it expedient, perhaps, that he should die.

Miracle cures and the medical community

Educated physicians recognised that only the Church had the authority to decide whether something was miraculous. Legal medicine had much to say about presumed supernatural activities of all kinds, from possession through to the miracles and ecstasies of saints. The Roman protophysiologist and pioneer of forensic medicine Paolo Zacchia dealt with the subject at length in his wide-ranging treatise Questions medico-legales, parts of which were first published in 1623. In the questions devoted to miracles, of special interest to us here, Zacchia remarked that the unlearned were quick to call cures miraculous. The number of ex votos covering the walls of saints' shrines was testimony to this. Moreover, physicians heard of 'miraculous cures of sick people daily, or rather by the hour, even by the minute.' Due to the number of apparent miracles, Zacchia advised caution in defining something miraculous. Apparent miracles could be brought about by 'evil men' and demons, to say nothing of the deliberate staging of fake miracles. The final decision was therefore to be left up to the Church.

Zacchia devoted question eight (book iv, title 1) to discussing 'the miraculous healing of the sick.' Cures could be miraculous, but there had to be no doubt, in particular instances, that the cure had not come about naturally or 'through art.' Thus the illness had to be impossible, or at least very difficult, to cure. Zacchia gives the example of blindness. Its symptoms had to be very severe, as in the case of 'burning and malignant fever.' And the illness could not be in its final phase at the time the miracle occurred, since the illness could have declined naturally shortly afterwards. As for the miracle cure itself, it had to take place suddenly and instantaneously. It had to be in every way perfect and absolute. In no way must a miracle cure resemble a natural one, so that where a crisis or evacuation took place - 'namely by vomit, haemorrhage, diarrhoea, sweating, urination' - the cure had to be categorised as natural, not miraculous.

When it came to the category of so-called 'magical' or diabolical diseases, physicians were willing to recognise their impotence. Because the demons behind such illnesses were of spiritual and metaphysical substance, nothing natural, corporeal or physical could work against them. In cases like this physicians advised the sick person to visit a priest or exorcist for supernatural - that is, sacramental - remedies, in keeping with the Church's teaching. Yet early modern medicine was also prepared to draw the line when it came to naturally caused afflictions. Miracles form part of this grey area. Physicians had no difficulty in accepting the theoretical possibility of miracle cures. The guidelines may have been strict, but miracles were seen to occur. Zacchia himself, examining the depositions of witnesses - which included at least three doctors - certified as miraculous the case of an Arcata woman who had been saved from certain death whilst giving birth in 1625. By its very nature, the miracle cure meant that the physicians were recognised to have done all that was humanly possible. The miracle only took place once the patient was 'given over' (spedito) by the doctors, who could thus distance themselves from the miraculous event. In this way there was no question of the saints competing
with doctors. In fact, they complemented their powers. In theory, at least, the medical community was thus not diminished.

Yet the physician who recounted a miracle cure before the Congregation of Rites found himself in a rather ambivalent position. On the one hand, he was giving glory to God and the candidate in question. On the other hand, he was admitting to the limitations of his art. There was a way out, however. With regard to plague, for instance, physicians could allow for primary (divine) causes, whilst concentrating on their own efforts on secondary (natural) ones. A similar theological distinction allowed them to preserve their professional dignity in this context, by adopting the categories of 'miracle' and 'grace'. Through these, the physician could reclaim a voice lost in the wake of the miracle cure and, at the same time, distance himself from the unlearned. It allowed the physician to be at least cautious, if not sceptical, in his interpretation of the event. Many witnesses, especially the uneducated, made no distinction between miracle and grace. One midwife replied that 'as a poor woman, I do not know what difference there is between miracle and grace; I call and say a grace and miracle what is obtained when we recommend ourselves to the saints.' Physicians were expected to know the difference. A twenty-nine-year-old doctor from Cosenza, with a degree from the University of Naples, confidently explained the difference in this way:

Because I am a medical practitioner, I have studied philosophy and therefore, under the name of the natural event, I include all that which happens and the way in which it happens in all its circumstances secundum vires causarum naturalium [according to the force of natural causes]. This is in contrast to the miracle which, whether in substance, manner, time or place, exceeds the powers and properties of secondary causes and recognises God directly who operates through his omnipotence. I also know that amongst the common people the recovery of a sick person from a disease in very great danger of death is held to be a miracle; but, according to my thinking, this recovery of health obtained by means of the intercession of some servant of God, whether dead or alive, is not a miracle but a simple grace.

In actual usage the distinction physicians made could be vague. It was sometimes simply a question of degree, a decreasing scale of the wonder the cure provoked. 'Pure miracle', 'miracle', 'special' or 'singular grace', and 'grace' - to say nothing of the fudge 'miraculous grace' - is the range of terms used (somewhat uncritically) by just one physician.

How typical of the profession as a whole were testifying physicians? On the one hand, it could be argued that because of their education (with its classical stress on the natural) and training physicians tended to be more sceptical than laymen when it came to miracle cures. As a group, physicians were often suspected of impiety and materialism. However, in this period of religious orthodoxy - which extended to control over the teaching of medicine at Naples University - such sentiments were rarely manifested openly. It is difficult to ascertain to what extent the few physicians tried before representatives of the Holy Office in Naples for 'irreligion' represented more generalised trends. One example is the 1584 denunciation of Giuseppe Perrotta, future lecturer in anatomy and surgery at Naples University, 'for irreligion and possession of prohibited books.' Perrotta told the court that his accusers were really motivated out of envy for his earnings. He was eventually sentenced only to payment of a surety and obliged to treat the sick of the monastery of Santa Maria de Novas gratis and visit the shrine of Piedigrotta three times. A century later, one physician, Gioacchino Senatore, was caught up in the series of inquisitorial trials against the Neapolitan 'atheists', though the group consisted primarily of lawyers and clergies. Nor can we expect illumination from the canonisation processes. Scepticism regarding miracle cures is too much to ask of a procedure designed to celebrate them. Those who testified before the Congregation of Rites were orthodox Catholics: unreliable witnesses would have been screened out of the process by the cause's postulator. On the other hand, we should not assume that all practising physicians shared the ardent devotion to saints shown by some of their number who testified. There was a middle ground which allowed for both proper devotion and practical caution. If they wished to distance themselves or express scepticism, the most participating physicians could do was refer to a grace rather than a miracle. This served to limit the importance and the exceptional nature of the event. One physician, upon being confronted with his suddenly cured angina patient, recounted that 'both [the patient] and her daughter, when telling me about the occurrence, called it minoration; and I, believing their account [and seeing] what was left of the malady, became truly convinced that it had to be attributed to a grace obtained through the servant of God’s intercession.'

I have come across only one episode which hints at scepticism; and, in keeping with the nature of the source, these sceptics are proved wrong in the end. A nun of Fasano, Rosa Maria Serio, was reputed to be a 'living saint': popularly venerated as a saint while still alive because of her visions and wonder-working. It was believed Serio could predict the outcome of serious illness. This may have served as a source of tension with the area's physicians. Zacchia noted that medicine had a natural prophesying function in predicting the course of a patient's illness, yet it could not promise unerring predictions of future events. Mistakes would be made. Servants of God, on the other hand, had supernatural aid. When the parish priest of a town near the convent was taken seriously ill with a catarrhal flux, his brother, a physician, was informed. The latter went to see Sr Serio, who handed him a note on which was written: 'Your brother's disease is fatal, and only God can help him.' When he went to see his brother the priest, he found him up on his feet, apparently healthy. With a mixture of scepticism and relief he showed the note to those present, 'and they all made fun of the prophecy made to them . . . and everyone said that it was the servant of God's vanity, and laughed and ridiculed her.' Certainly, an account with this sort of ending would not have made it into the canonisation process. In fact, unnoticed by the doctor, the priest’s disease got worse 'internally', and he died three days later, 'so that everyone was bewildered, and confessed that the said Sr Rosa Maria was truly a servant of God.'

Both the medical witnesses we have just heard were avid collectors of relics and were confident that the relics had brought about cures. Giannini's physician believed
so fervently in the holy woman's powers of healing while she was alive that he referred to her as 'a living relic.' It should come as no surprise that members of the medical community participated in the widespread 'hunt for relics' that testifies so vividly to a belief in the healing powers of saints. In a symbolic way, relics extended their own limited powers. Moreover, physicians and surgeons were favored by their proximity to the diseases of 'living saints'—always convenient sources of relics. Thus the physician at Sr Serio's convent, when he saw her cloth bandages soaked with blood during one of his calls, had them surreptitiously wrapped up and took them away. With pride he told the 1729 hearing how the relics had been used by an exorcist to liberate a possessed woman. The same relics were also used by the physician to provide 'supernatural help'—the physician's words—during a potentially fatal childbirth. It is noteworthy, however, that he was the only physician, in all the processes I have read, to have witnessed at first hand the miracle cure he later corroborated. Many had relics, and gave them to their moribund patients to help bring about a saint's intercession; but even they were almost never present when the narrated miracle actually took place. In fact, it often seems that it is the physicians who are the most put out by the occurrence of a miracle cure. Invariably the doctor's patient confronts him with a fait accompli, at which the doctor can only wonder. This reflects the fact that the social dynamics of healing— including both natural and supernatural remedial sources—were driven largely by the sick person. In the first section we saw how Giuseppe Orecchio went to the baths at Ischia of his own accord. In 1621 a certain Giulia Pagano began her deposition by describing the great pain and blindness she had suffered in her left eye the year before. The doctors told her that it was a cataract, and that if it had not got better by the 14th of the month, 'the eye was most assuredly lost.' While the doctors carried out their own treatment of syrups, sudatories and other remedies, she asked for a relic of Father Camillo de Lellis from a visiting member of his Order, the Ministers of the Sick. She put her faith in the intercession of de Lellis, so the actions of the doctors became inconsequential. As she remarked: 'the doctors continually told me that the said eye was lost, and they made their remedies to do what they could as far as they were concerned.' But it was the relic that eventually brought about a cure.

In the reinterpretation of illness episodes in the light of miracle cures the physicians often figured as helpless bystanders. Initiative was taken away from them and put in the hands of the sick person, who turned to the saints. The Neapolitan physician Giovanni Comes, who counted the kingdom's protophysician amongst his acquaintances, recounted how he had treated a woman with sciatica for many years, with only moderate improvement in her condition. But she had taken supplementary measures:

and returning to her house to examine the said infirm woman as usual, I found her healthy, and so I asked her how she had received this health, given that the infirmity was long, troublesome and almost incurable, and she replied that it was not for use of the remedies, but by a sign of the cross made on her by Father Camillo, who had come to her house that morning and made the sign of the cross on the said afflicted part.

It is striking that other sorts of practitioners seem less put out by such eventualities. Indeed, they seem to welcome them without hesitation. Surgeons, barbers, apothecaries and midwives were often actors, not mere bystanders, in the miraculous events they proudly related. They often represented themselves as playing a prominent role setting the stage for the miracle. They were also more frequently present when the miracles actually occurred. Finally, they were more inclined to ascribe a cure to a miracle, as opposed to a grace, especially if they lacked a formal education. One example will suffice. An apothecary recounted being present at a whole series of miracles, brought about through the relics he owned and his encouragement of the dying people to venerate them. In 1765 Onofrio Stiffa told the hearing investigating the cause of the Piarist Sabbatini of an episode involving a woman dying from rabic cough, continuous hectic fever and chest pains. The remedies prescribed by doctors had been of no use:

I said to her frankly that she was as good as dead, since there was no further remedy or refuge, and I added that only one other medicament remained to be taken, if she wanted, that would not be nauseating for her, and she replied that she would take it if I gave it to her. I added that the medicament was this: that I wanted to bring her a relic of the servant of God Father Ludovico Sabbatini that I kept at home... a bit of his shirt soaked in his blood and a bit of his hose and habit... and that since I had had these relics I had received a great many massive miracles from them... and that if she promised me to have the same faith in them that I and the other people had, I would bring her the said relics, otherwise I would not.

Not only was Stiffa's own devotion in keeping with post-Tridentine orthodoxy, but he encouraged it in the sick people who made use of his relics. In presenting the above sick woman with the relic, he had her first kiss it, then recite three Glorias in honour of the Trinity: a special devotion of Sabbatini's, he says, so that he would 'first grant her the grace of her soul and then that of her body.' This reminds us of the close relationship between the health of the body and the salvation of the soul in Christianity.

Midwives were also more 'ready to believe' than physicians. As discussed in chapter three, the sacred frequently found a way into their techniques. The practice of placing amulets on the expectant mother during delivery was accompanied by the placing of saints' relics or images. While physicians might encourage patients to invoke the saints or lend them a relic when they felt they could do no more, midwives also made use of such devotions themselves. In difficult births, according to the testimony of midwives, recourse to saints was automatic: when 'the baby was coming out with his feet first,' 'was twisted in the womb' or 'was coming out double, that is bent at the back with head and feet first.' But such were the dangers inherent in giving birth that midwives in Chieti told a local hearing that they routinely said seven Paternosters and seven Ave Marias and invoked Camillo de Lellis—who came from the area—before each birth. As one woman told the Congregation: 'I am so convinced that Father Camillo is a saint that, as midwife in this town, there is no labour during which I do not invoke him, and I have seen many graces because of this.'
Saints and ecclesiastical views of disease

The Church taught its own interpretations of disease: it could be God-sent, as a gift, test or warning. It was to be borne with patience or regarded as an opportunity for repentance and conversion. At the same time, the Church regarded it as a state of bodily suffering which every good Christian should seek to alleviate. God and the saints provided recognised sources of healing, as did the medical community. This ambiguity was a source of some competition between natural and supernatural healing. Nowhere is this contradiction viewed more clearly than in the convents of the period. On the one hand, the medical arts were present in the physicians and surgeons who served these institutions, treating the nuns who thus found themselves in a privileged position with respect to the majority of the population. On the other hand, nuns were the first to put these aside and trust in the ‘celestial healer’, following the period’s models of holiness and devotion. Entire religious communities would routinely suspend medical visits and forego medicines while undergoing spiritual exercises conducted by Jesuit missionaries. Individual nuns looked for signs that their diseases might have supernatural causes, a sign of divine favour. It formed part of the same cultural model advocating a strenuous regime of fasting, penance and bodily mortification. This approach was especially evident in the case of those nuns and monks who fashioned themselves as, and were reputed to be, living saints. By the same token, it is striking how rarely the ecclesiastical concept of disease causation crops up in the narratives of lay men and women. While a remarkable (for us) amount of pain and illness was accepted as natural, it is as if much of the laity had no time for the niceties of pious forbearance, when sickness meant an inability to perform vital social and economic functions.

The living saints discussed in chapter six best exemplify the ambivalence of the physician’s role, because they lived face-to-face with other more secular healers. Medical practitioners, as part of the educated elite, frequently numbered themselves amongst the closest followers or ‘disciples’ of living saints, in the same way that in an earlier time they had formed circles around religious reformers. In the years after Trent, when the latter was no longer a safe option, being close to living saints was not only an expression of devotion, but a role that conferred status on the devotee. Paradoxically, however, the living saints provided the physicians with competition when it came to healing. They were able to impart the sacred through their touch. When the Dominican friar Serafino Balbi was crippled with gout in his left leg, he went directly to the living saint Maria Rosa Giannini for relief from his suffering. Though there was a physician present, who also testified at the hearing, he did not intervene, nor was he asked to. Giannini looked at Balbi’s leg and reminded him to say the Rosary several times each day. Then, according to Balbi, ‘she took her Rosary, made the sign of the cross three times on my foot with it, each time saying: through the merits of the Most Holy Virgin of the Rosary may the gout go away.’ Even dead saints possessed this healing touch, their living presence conveyed symbolically through visions. Francesco de Geronimo appeared in this way before a paralysed nun. She recounted: ‘it seemed to me that this servant

of God extended his right hand over the left side of my body, touching me from the left side of my head to the underside of my left foot, and he disappeared.’

Whilst healing the sick who came in never-ending droves to see them, living saints themselves suffered diseases with heroic humility. Such was the prevailing model of holiness, that those most gifted at performing miracle cures were also expected passively to endure their own illnesses. They regarded their illnesses as God-sent and told their physicians that they were powerless against them. In addition to natural illnesses, God also sent the stigma, every bit as real and as painful. Here the natural and the symbolic met. The surgeon of the Neapolitan nun and mystic Maria Villani (1584–1670) told a 1680 hearing that ‘such was the love that this servant of His bore towards God that she was worthy of being pierced by a spear above her right breast, in such a way that the spear penetrated through to wound the heart.’ He knew about the outer wound, ‘which no medicine could treat’; but only on her death, when her body was examined, did he see that there was a deep, open wound in her heart as well, three fingers in length. A further example is the nun Giannini. She put up with her numerous diseases ‘with indescribable resignation, never complaining, in fact, showing not a little pleasure, with the greatest peace and readiness of heart.’ Servants of God like Giannini gloried in their maladies, which were always long-lasting, repugnant and torturous. This attitude was shared by the witnesses called to testify at hearings for their canonisation, who described the diseases in the most vivid detail. Thus, in addition to her headaches, vomiting and ‘an umbilical hernia as big as a cucumber’, Giannini suffered from articulour tumours, nephritic pains, four abdominal scirrhuses, a prolapse of the uterus and, most terrible of all, two tumours or cysts, ‘each as big as a baker’s basket, so that when the servant of God had to go out she put them inside two bags, which were hung from and attached to her neck with strings.’ Giannini refused any medical treatment for the follicles, saying that ‘they were gifts from her spouse and for this reason she wanted to bear them until her burial.’ The reference to the mystic marriage with Christ and the presumed divine origin of the disease was something Giannini had in common with many other female saints, after whom she modelled herself. One witness, head apothecary at a nearby monastery, brought medicines for some of her other ills, and noted ‘the patience she had in taking certain medicaments not suited in the least to certain of her ailments, which did not have a natural origin as the doctor believed, but a supernatural one, as she explained to her spiritual director.’

If the medical elites recognised their limitations when in the presence of the sacred they were justly rewarded. The Church’s support of organised medicine is mirrored in the way it emphatically privileged those miracle cures narrated in the first person by a physician (i.e. as miraculato) or, more often, corroborated by one. As far as the Church authorities were concerned, it was crucial that the miracles be verified as closely and strictly as possible. They were to have all the characteristics of historical facts, complete with precise dates, places, names, occupations and any other relevant details. Who better than learned physicians could give the stamp of authenticity to healing miracles? ‘Professional hands that incise, tear out, treat,
examine, attest, [were] the necessary route by which the Church [could] publicly
take a stand.78 The role of physicians and surgeons extended even to the exami-
nation of the corpses of servants of God upon their exhumation, often hundreds
of years after their deaths. This status as expert witnesses was entirely consistent with
Roman-canon law, where medico-legal work was well regarded and occasionally
restricted to a privileged elite of practitioners.79 The Congregation of Rites func-
tioned as a tribunal, under the supervision of the Church’s high court, the Rota.
Indeed, Zacchia was one of the Rota’s regular medical consultants.

The verification requirement and the propaganda factor of the processes helps
to explain two important features of the records with regard to healing and healers
in early modern society. First, the complete absence of non-professional healers,
such as wise women or itinerant peddlars, as witnesses in the processes. Whilst
the medical profession sought to regulate the activities of mountebanks and charla-
tans, the Counter-Reformation Church – in the form of the inquisitorial and the
episcopal courts – was waging war against what it referred to as ‘superstitious’
healing. Wise women may make the occasional appearance in the illness narra-
tives, but their role was an entirely negative one. They provided the living saint
with the opportunity of snuffing out their charms or countering their diabolical
remedies – which always made the patient worse – with his or her divine ones.
The verification of miracle cures provided by physicians also accounts for the rela-
tively low representation of the popular classes amongst the miracoli. In addition
that when no reliable witnesses, they often chose not to rely upon
the services of physicians – physicians who could have then corroborated their
accounts.

The Church’s caution and control went hand-in-glove with a widespread
encouragement of devotion to the saints, as paradoxical as this may seem.
Enforcing orthodoxy was all about channelling devotion along recognised lines,
not limiting the number of saints. This was consistent with the widespread need
for, and occurrence of, miracles among the population as a whole. It also suited
the Religious Orders, who could thereby encourage devotion to the saints and
candidates for canonisation of their own Order, thereby increasing their own
prestige. A popular, though unofficial cult was the sive quae non of the canonisa-
tion process. The Orders collected and published miracle accounts to further the
causes of their own candidates or encourage devotion to members of their Orders
already canonised.

What explains the predominance of healing miracles in the processes? On the
one hand, they corresponded to everyday needs, fears and expectations. On the
other hand, such miracles tended to be privileged by the Congregation of Rites
and the Religious Orders. This was because miracle cures could be verified in a
way that other miraculous interventions – as in the case of accidents – could not.
Moreover, healing miracles could be edifying and instructive at the same time. They
taught a trust in divine will and forbearance in the presence of suffering. Miracles
which spared people from violent deaths – as a result of a duel, say, or judicial
torture – were not so edifying, and so are underrepresented in the canonisation

processes.80 Finally, miracle cures were most in keeping with the Biblical model.
This was recognised and encouraged, even though the types of maladies cured did
not reflect the diseases typically healed in the New Testament.81 Thus, instead of
healing the possessed, the paralysed, the blind, deaf and dumb, Counter-
Reformation miracles tended to intervene in cases of a wide variety of fevers and
pains, only to a lesser degree healing the crippled. It should be noted that where
there was less clerical mediation, the miracle typology was more varied, following
medieval models. Such is the case with the miracles recorded in shrine miracle
registers and the ex votos hung on shrine walls. For this reason, the published miracle
collections penned by members of various Religious Orders, because of their overt
propaganda uses, are more in keeping with the Counter-Reformation emphasis on
verifiable (according to the criteria of the time) healing miracles determined by the
Congregation of Rites for the canonisation processes.82 If the laity continued to
want saints who could perform miracles, rather than the purely edifying models
proposed by the Church, then the authorities were determined that the miracles
should at least be of an ‘acceptable’ sort.

The editorial control exercised by the monks compiling the published miracle
collections influenced, and was influenced by, that of the clerics in charge of postu-
ulating the causes of particular candidates for canonisation before the Congregation of Rites. The task of the postulator – usually a member of the servant
of God’s own Order – was to collect favourable evidence, screening witnesses and
their testimony before the hearing began. For the historian, it is where the centre
(Rome) and periphery (local devotion) meet. The postulator looking for miracle
accounts came face-to-face with the lay men and women for whom miracles repres-
ented an existential need, a means of maintaining the symbolic order of the world.
Who better, then, to mediate between them and a servant of God than that servant
of God’s own postulator? If the pressure exerted on priests and exorcists to heal was
great, because of their sacramental powers,83 it was that much greater on the postu-
lator and his agents. They were often seen as representatives of a servant of God
on earth. One such helpless victim was Fra Angelo da Baccarizzo, responsible for
collecting alms for the cause of the Calabrian Capuchin Angelo d’Acri
(1669–1739). The incident concerns a four-year-old boy who lay dead after a fall
from a ladder. When Baccarizzo refused to go into a village chapel where the boy
lay, and pray to the servant of God to save him, the boy’s grandmother screamed at
Baccarizzo, ‘blaspheming against all dead monks.’ Then the boy’s uncle came out
in a rage and grabbed Baccarizzo by the collar and forced him into the chapel,
leading him up to the altar, on which the boy had been placed. Shaking, Baccarizzo
knelt down. He took an image of Angelo d’Acri from inside his habit, placed it on
the boy’s chest, and – ‘to comply with the importunity of others’, as he discreetly
put it – began to recite the litany of Our Lady. In the middle of this the boy revived,
‘vomited bile and food’ and then got up. Those present ‘began rejoicing, saying
miracle, miracle of Father Angelo, [and] they took the boy and went out of the
chapel.’ Baccarizzo, having served his purpose, was left alone inside, ‘where I
remained without finishing the litany.’84
Miracles: popular, medical, ecclesiastical

Thus while the Church authorities and the medical community argued over, but mostly complied in, the construction of miracles, the bulk of the population continued to seek and interpret them in terms that most met their own needs. Miracles provided a universal possibility of cure. They complemented and extended. Images and relics made real the saint’s presence to even the poorest in society. And where obtaining corporeal or other relics was difficult, the oil, holy water or flowers from the saint’s tomb would do. Its use combined domestic remedial forms, where oil was a regular ingredient to be rubbed on afflicted bodily parts, with the power of the sacred. In this way, miracles symbolically extended the powers of nature. Likewise, consistent with the Galenic tradition, miracles could also help occasion the vital purge of fluids necessary for cure when the physicians were unable to. This flew in the face of medical teaching, however, which taught that true miracles must not imitate nature in any way.

Each illness episode generated the telling of stories about it. These narratives served to transmit vital information within the community and eased the sufferer’s anxiety. They were shaped and constructed by the need to provide meaning. The telling of stories allowed people to symbolise the source of suffering, attach meaning to experience, reconstitute a world shattered by illness. This symbolic ordering took place each time the story was retold, including the occasion when it was recounted before the Congregation of Rites. The miracle narratives reveal much about notions concerning the body and sickness. For sick people the body was objectified and distanced. It became a battlefield. Disease, like demonic possession, occupied and took over the body; a cure meant that the body was liberated. There was flow throughout the body which, if blocked in one part, could result in disease in another part. In the canonisation processes, the physicians gave up on the object of their attention, after having tried their remedies. But for the sick person this was not an insurmountable problem, since the dynamics of healing were largely controlled by him or her. It was the sick person’s own responsibility. The sick frequently turned to the help of the saints, either accompanying the treatment of physicians or when the physicians had given up on the patient.

The narratives contain a wide variety of descriptive disease terms. These helped to label and objectify the affliction, allowing both patient and practitioner to come to terms with it. This labelling process is particularly evident in the case of fever, the most frequently mentioned illness in the records. Another characteristic of the illness episode as recounted was the tendency to stress certain moments and aspects of the experience. The narratives privileged the discovery of the illness, sudden worsening of conditions, treatment strategies and interventions, all leading up to the rhetorical climax of the miraculous intercession. Although localised in the objectified body, illness was understood and related in terms of a person’s life, history and social relations. The miracle itself returned the body to functionality, restoring its place in the community. This was not necessarily a complete cure in the modern sense, a fact which suggests a difference between pre-modern and current definitions of health. Early modern expectations regarding sickness and health, like those regarding medical treatment, were remarkably different from our own.

Physicians seemed to have shared most of these notions. Yet their role in testifying before the hearing was inherently ambiguous. Whilst seeking to give glory to God and the saints through their testimony, physicians sought to distance themselves from the unlearned and protect the prestige and dignity of their profession. They were facilitated in this by the theological distinction between miracle and grace. They could thus adopt a critical stance, if not outright scepticism. Physicians often figure as mere bystanders to the miracle cure, confronted with a fait accompli. However, other members of the medical community – barbers, apothecaries and, especially, midwives – often presented themselves as actors in the event, bringing about the sick person’s cure through relics they owned and being present at the event itself. This is not to say that physicians were less devoted to the cult of saints than the rest of the population. Indeed, they often formed part of the circles that developed around ‘living saints’. Miracles were a welcome possibility for all, but the criteria adopted for defining a cure miraculous were that much stricter for university-educated physicians. These became even stricter towards the middle of the eighteenth century. By this time the limits of reason were becoming ‘those that reason itself imposed, by censorship or self-censorship, in the face of the theological province of the invisible’.

The entire canonisation procedure depended on this strict approach to corroborate healing miracles. For all those involved, from postulatores to cardinals of the Congregation of Rites, this gave them a higher propaganda value. The involvement of physicians was crucial, as far as the Church was concerned. They lent an air of objective verification to the proceedings, as witnesses to events or as participants in the exhumations of saintly bodies. Healing miracles were verifiable in a way that other sorts of miracles were not. They were also edifying and instructive. While involving the medical community in this way, the Church also taught that disease could be God-sent. It was a gift or a warning: something Christians should seek to alleviate by accepted means – this did not, however, include wise women or itinerant charlatans – or bear with saintly patience. This inherent ambivalence in interpreting disease came to a head when living saints turned down the treatments offered by their attending physicians as useless. When diseases were sent by God no natural cure could help. This was particularly evident in the case of wounds linked to the stigmata which were, of course, incurable.

The wide range of cures provided by the miraculous intercession of saints and the stories told about them can tell us much about the important role of miracles in the everyday lives of early modern Neapolitans and, by extension, of Catholic Europeans in general. Reading backwards from the miraculous event, these narratives can also reveal otherwise hidden perceptions of the body and disease. They contribute to our knowledge of how sick people and their carers reacted to illness, how they explained and described it, and how they dealt with it. As the narratives suggest, miracles represent the point where natural, supernatural and symbolic
come together, indeed collide. Illness is contested: it can be categorised in different ways, affecting the efficacy of available forms of treatment. Professions, too, come into contact. Churchmen and physicians manage to collaborate and find common ground in the miraculous healing of illness, despite an ongoing tension and ambiguity. Indeed, these two forces become more pronounced as one proceeds through the eighteenth century. Certain practitioners (and not a few ecclesiastics), influenced by broader enlightenment trends, were less willing to participate as equal players in the time-honoured medical pluralism. They were less likely to share in, or be sympathetic towards, the aetiological categories I have called ‘ecclesiastical’ and ‘popular’. More and more, the medical consensus which we have stylised as three overlapping rings was giving way, in their minds, to two separate cultures: the high and low, learned and folk, so dear to nineteenth-century folklorists like Giuseppe Pitre.87

NOTES

3 Linda Garro, ‘Chronic illness and the construction of narratives’ in M. J. Del Vecchio-Good, P. Brodwin, B. Good and A. Kleinman (eds), Pain as human experience: an anthropological perspective (Berkeley, 1992), pp. 19–57; Byron Good, Medicine, nationality and experience: an anthropological perspective (Cambridge, 1994), ch. 5.
5 David Gamalbor, From bishop to witch: the system of the sacred in early modern Toscana d’Oriente (Manchester, 1992), ch. 1.
The Bolognese physician Ippolito Albertini (1662–1738) wrote in an undated consultation, regarding a woman suffering from malignant fever, that 'directly touches and disturbs the spirits and the nerve structure, which govern movement in our fluids.' In Saul Jarché (trans. and ed.), Clinical consultations and letters by Ippolito Francesco Albertini, Francesco Tori and other physicians (Boston, 1989), no. 131, p. 214. See also David Gentilcore, 'The fear of disease and the disease of fear' in W. Naphy and P. Roberts (eds), Fear in early modern society (Manchester, 1997), pp. 184–208.

Duden, Woman beneath the skin, pp. 88–9.

A.S.V., Riti, 378, fol. 240r-240v. Women were regarded as particularly susceptible to 'hysterical' pains, or convulsions, which originated in 'the uterus and nervous structures', according to a consultation written in 1704 by Albertini; in Jarché, Clinical consultations, no. 61, p. 77. Nuns, especially those of 'melancholic temperament', were particularly vulnerable.

A.S.V., Riti, 708, fol. 389v. The Neapolitan cantaro was equal to eighty kilograms.


A.S.V., Riti, 2024, fols 2401r-2403r.

Orsi, 'Cult of saints', p. 69.

A.S.V., Riti, 2615, fol. 195r.

A.S.V., Riti, 2024, fols 2402v. (italics mine).

Paolo Zacchia, Questiones medicina-legales. In quibus ex materie medicae, qua ad legales facultates reductam pertinere, propositur, protractantur, resolvuntur (Amsterdam, 1651 edn.), bk iv, title 1, question 8, pp. 224–5.

A. D. G., Fondo Venesole, iv/Dg.c, 32, fol. 11v.


A.S.V., Riti, 1931, fols 647r–v. Sabbatini (1650–1724) was a Neapolitan Parisian.

Zacchia, Questiones, bk iv, title 1, question 8, p. 223.

Ibid., question 1, p. 198.

Ibid., question 8, pp. 223–4.

Ibid., question 8, p. 225.

Ibid., question 9, p. 226.

Ditchfield, 'How not to be a Counter-Reformation saint', pp. 397–8.

A.S.V., Riti, 2473, fol. 164.

A.S.V., Riti, 234, fol. 684v.

A.S.V., Riti, 2470, fols. 1224–1227v.


This is the somewhat hasty conclusion reached by Gabriele De Rota in his Storie di santi (Rome and Bari 1990), p. 42.

A.S.V., Riti, 1861, fols 184v–185r. (italics mine).
CONCLUSION

The preceding chapters have explored the interaction of three spheres of healing during the early modern period: medical, ecclesiastical, and popular. Each interpreted disease and the body in a different way, with a correspondingly different way of reacting to it and treating it. However, these three cultures were not distinct in any absolute sense. Their boundaries—if they had any at all—were permeable. The spheres overlapped with, and contributed to, one another. Most importantly, they competed with one another. This was competition, first, in the sense that the sick chose for themselves the form of healing they believed best suited to their affliction. It was competitive in a second sense in that the two therapeutic forms that came equipped with their own power structures—university medicine and ecclesiastical rituals—sought to influence and shape the nature of the entire medical network. In unison, for the most part, they distinguished, variously, between licit and illicit; licensed and unlicensed; orthodox and unorthodox; natural, divine and diabolical.

The interface between medicine and religion has been the most studied, particularly within the history of ideas tradition. By and large, the approach has yet to find its way into more general history of medicine surveys as anything more than an add-on extra. This book was intended as a step towards remedying this situation, exploring the manifestations of the medicine—religion overlap as it relates to a Catholic state during the period following the Council of Trent (1563). The Counter-Reformation desire for order and orthodoxy conditioned much of what happens on stage. Attention has also been paid to medical practice, as well as the behaviour of the sick. We have seen how the third sphere of popular therapeutics overlapped with the preceding two. The ‘popular’—for lack of a better term—is not somehow beyond the pale of the historian. Nor do I consider popular responses to disease and forms of healing to be simply out-of-date derivatives of elite medicine. The sources seem to tell us otherwise. Conversely, it would be inaccurate to suggest they had an autonomous existence. People did not belong or limit themselves uniquely to a single sphere—churchmen to the ecclesiastical, physicians to the medical and peasants and the urban poor to the popular. After all, in early modern Italy popes depended on their own private physicians and surgeons; physicians could find themselves the victims of sorcery or the beneficiaries of miracles.

85 See the discussion in Gentilcore, Bishop to witch, pp. 187–93.
86 Elena Brambilla, ‘La medicina nel Settecento: dal monopolio dogmatico alla professione scientifica’ in F. della Peruta (ed.), Storia d'Italia: Annali, vii, Malattia e medicina (Turin, 1984), p. 91. The restricted realm of the miraculous was not limited to physicians. It was also reflected in treatises like Ludovico Antonio Muratori's Della forza della fantasia umana, first published in 1740, and Prospero Lambertini's De servorum Dei beatificatione et beatorum canonizazione, published 1734–38. Lambertini had served as Promoter of the Faith, in charge of canonisations, from 1708 to 1727 and was elected pope in 1740 as Benedict XIV.
87 Pitré was himself a practising physician, with an approach to popular culture that was at once sympathetic and positivistic. I have in mind his monumental Medicina popolare siciliana (Turin, 1866; new edn Florence, 1949).
and the poor could make use of the services of community practitioners free of charge. In other words, people moved from one sphere to another according to circumstance and need.

All this suggests that there is a history of medical pluralism in the kingdom of Naples. If, in order to understand the interconnectedness, I have tended to stress the functional nature of the relationship, it is time to explore some of the shifts that occurred during the period. Furthermore, we must consider how the Italian model of medical pluralism presented in this book compares to the range of ‘healers and healing’ elsewhere in early modern Europe. First of all, let me say that there is no clear-cut periodisation. What there is is as pluralistic as the subject matter. The medical material is structured by the Royal Protomedicato and contains data from as early as the 1530s and extends into the kingdom’s Napoleonic period (1806–15). As far as the ecclesiastical material is concerned, the focus is provided by the Counter-Reformation and the institutions it generated, relevant to this study: the Holy Office of the Inquisition, founded in 1542, and the Congregation of Rites and Ceremonies, founded in 1588. Local bishops were entrusted with acting on behalf of these two tribunals, and they were at their busiest from the late sixteenth century to the mid-seventeenth century. Finally, our knowledge of popular forms of healing depends on the records generated by these medical and ecclesiastical bodies. This means, as far as the historian is concerned, that it must take on something of their chronology, just as its cultural contours were shaped by them.

Recent regional studies on the social history of medicine have stressed one thing: that the sick of early modern Europe were not indifferent to health but went to great lengths to preserve it or regain it when it was lost. They generally diagnosed their own illnesses, along with the help of family and friends. They also treated themselves. Where they were treated by practitioners this treatment was usually carried out in the home. All this depended on the communication of vital information about illness, achieved through the everyday recounting of illness episodes. The telling of stories allowed people to symbolise the source of suffering, attach meaning to experience, reconstitute a world shattered by illness. Disease was seen to occupy the body, while a cure meant that the body was liberated. Flow throughout the body was also crucial; if it was blocked in one part, disease could result in another. The wide variety of descriptive disease terms used served to label and objectify the illness. Stories of illness also indicate that time was not uniform. They stressed certain moments of the experience, from the discovery of illness, its various stages, through to the cure. The latter was not necessarily seen in modern biomedical terms, but in the sense of functionality: being able to resume one’s previous life.

Illness narratives privileged the search for a cure. This search was not as straightforward as it usually is for us today. It depended, first, on determining the nature of the disease, its causation. The medical pluralism of early modern Europe meant not only a range of healers, but a range of aetiological categories. These could directly correspond. When sick people ascribed their illness to magical spells, the most obvious recourse was to the wise women held responsible, in the hope that they could be persuaded to break the spells. However, in Catholic Europe, the sick could also turn to another category of healer to counter the spells: the exorcist. The Counter-Reformation Church instructed that only its trained, licensed exorcists were capable of dealing with such spells, because they depended on the intervention of the devil in order to work. The sick rarely turned to physicians for such magically-caused illnesses, for their remedies were not deemed effective against them.

Determining causation responded to the universal questions of why me? why now? I do not wish to suggest that diseases were generally put down to spells. Indeed, the most typical causation was generally some mixture of natural and supernatural factors. The emphasis varied from person to person, and changed over time. Natural, material explanations for events increasingly predominated over religious ones, especially during the course of the eighteenth century. I have mentioned the link between magic and disease to illustrate my point that to talk of medical pluralism is not synonymous with the medical market-place. Supply and demand alone did not determine the medical landscape. Economic factors were certainly an important element in decisions made by the sick regarding the choice of healer. However, they do not seem to have been the most important. People went to great lengths and were prepared to make great sacrifices to attract the services of the form of healer or particular practitioner they hoped would bring about a cure. Going to the local wise woman was not the easy option; her services could cost as much as those of a learned physician, not to mention the emotional blackmail that frequently accompanied the relationship. The same can be said of going to a saint’s shrine. The ex votos that devotees left as tangible signs of their miraculous cures were often quite costly, to say nothing of the time and effort required to visit the shrine.

Not that miracles were available to all early modern Europeans. For many, officially at least, the biblical ‘age of miracles’ was past, relegated to the level of idolatry and ‘papist superstition.’ For the Protestant churches the role of saints in healing diseases was thus severely curtailed, where it was not eliminated. This was not absolute: if Catholic Italy had its ‘living saints’, occupying the overlap between popular and official religion, Protestant England had its Valentine Greatates.7 The role of the divine was still recognised, both in causing illness and in treating it. The divine increasingly meant God alone and direct recourse to him through prayer and fasting. The devil, too, could cause illness; in this case, however, there were often no exorcism rituals to turn to, the ‘priesthood of all believers’ having sought to put an end to all such monastic ceremonies. In Catholic regions of Europe both the ceremonies and the saints survived and prospered. Well into the eighteenth century both were still central to life, as the Counter-Reformation climate persisted. The Enlightenment introduced a reason as a means of accounting for apparent miraculous events, certainly for the educated elites. Then again, the Church from the foundation of the Congregation of Rites had adopted a strict stance with regard to miracles. Reason added another critical element, but it did not eliminate the possibility of miracle cures, not even for most learned physicians.

If we continue to look at things from the view of the sick, another element determined their choice of healer: accessibility. This meant not only such things as
availability and geographical proximity, but similarities in terms of mentality and status. With the exception of the elites, the majority of people were more comfortable in the hands of a barber-surgeon than a physician. What have been called ‘ordinary practitioners’ were not only numerically strong, they also shared the attitudes of most of the sick. While the sick might turn to a physician for ‘protection’, guidance and advice, they turned to the barber or unlicensed practitioner for more practical, basic and direct treatment. While the relationship with physicians was vertical, that of inferior–superior, the relationship with other practitioners was more horizontal. The elites, however, were more particular in their choices. This seems to have been especially the case where corporatism dominated society, as in Italy and France, for instance.

Corporatism affected the interplay of practitioners, further restricting the role of the market-place, in theory if not in practice. It meant that there were recognised bodies which defined and regulated the various branches of the medical arts. This usually meant colleges of physicians, often associated with university medical faculties, alongside various trade guilds for the barber-surgeons and apothecaries. The various Italian Protomedicati all overlapped, and sometimes competed with the various trade corporations and other organs of the state. Although the state apparatus grew in size during the early modern period, this did not mean that it replaced or even weakened other centres of power. Local elite groups and traditional institutions maintained their importance in European states. Indeed, corporatist institutions were closely allied to the state. However, regardless of the system in force, governance and regulation were complex, cumbersome and inefficient, plagued by layers of competing interests. Negotiation and compromise played a greater part than principle or precedent. The Enlightenment introduced notions of improvement, reform, expedience and the common good into public health matters. Real changes, however, often had to await the nineteenth century.

Neapolitan protophysicians were regularly consulted in the wake of outbreaks of disease, but this was the extent of their public health role. Throughout the period, despite medical advances and Enlightenment reforms, the kingdom’s public health remained inadequate, piecemeal and ad hoc. This is especially evident with regard to plague where the kingdom’s response contrasted with the advanced measures of other Italian states, like the Venetian Republic and Tuscan Grand Duchy. Likewise, the Neapolitan provision of community physicians and surgeons for the poor was fragmentary and seems to have declined by the end of the eighteenth century, just when similar provision was being proposed elsewhere, such as in revolutionary France. The Neapolitan Protomedicato never acquired the greater powers of its Casilian cousin, or even the functions of the other, college-based Italian Protomedicati. Its supervisory function played second fiddle to the annual collection of licence fees from practitioners throughout the kingdom. This was just as true in 1610, when the fee-collecting was first farmed out, as it was in 1810, despite the various reforms of the Bourbon and Napoleonic rulers. The Protomedicato never evolved into a system of medical police then being advocated in German-speaking areas, nor did it foreshadow the rise of a united medical profession. In fact, it strove to keep the various branches apart.

The focus of traditional medical histories on the medical ‘regulars’ — the tripartite hierarchy of physicians, surgeons and apothecaries — tended to overlook the role of the regulars in the healing network, at the expense of ‘irregular’ healers — that is, everyone else. It also implied a kind of harmony or at least working arrangement within this group. Recent medical historiography has refined this picture. The regulars still have centre stage, but other healers are granted more than a role on the fringes of society. And we have come to see that there was as much differentiation within the ranks of the regulars as differences between them and everyone else. This was the case in countries where medical regulation was relatively weak, as in England, just as in countries where it was stricter, as in Italy, Spain or France. City physicians with rich, aristocratic patrons looked down on rural physicians eking out a living as town or monastic employees; university-educated surgeons ridiculed unlearned barbers, and so on.

The moral order of society, whether or not this was seen in specifically corporate terms, was threatened by the ‘disorder’ that ensued when practitioners overstepped their occupational limits. For instance, when barber-surgeons, limited to external treatments, administered internal remedies, the realm of physicians; or when apothecaries, limited to the preparation of medicines, prescribed them. Whether the patient benefited or not was not the question. Such disputes characterised the latter half of the sixteenth century and the entire seventeenth century, throughout Europe. Where it dominated, corporatism gave the elites a means of pursuing offenders and resisting calls by surgeons and apothecaries to practise physic. The Neapolitan Protomedicato certainly had this function, but what impact did it have? In one sense, I would like to suggest, it was only a difference of degree. Everywhere in Europe practitioners of all ranks responded to the demands of the sick — upon whom they depended for their living — even if this meant exceeding their occupational limits on occasion. This was true whether medical regulation was weak or strong, fragmented or centralised. Itinerant practitioners, too, were a common feature of the European medical landscape. This was the case whether the official attitude to medical practice tended towards the caveat emptor variety or one of more or less rigorous inspection and licensing. For the latter did not seek to eliminate charlatantry, merely to supervise it in some way, pocketing the income generated by the licence fees charlatans had to pay.

However, there were substantial differences, too. England saw the greatest unpunished mixing of occupations, leading eventually to the rise of the ‘general practitioner.’ Such a development was unthinkable where the corporatist ethos was entrenched. Even here, however, the tripartite divisions were increasingly called into question during the course of the eighteenth century. This was due in part to the diminishing status of the university medical faculties and their associated colleges, tied up with the relative stagnation of physic and the rise of surgery and hospital instruction and training. In Italy, hospitals had long served as places where practitioners could acquire experience, surgery was part of the university
Define themselves in terms of local allegiances. The kingdom – indeed the Italian peninsula as a whole – still had high practitioner-to-population ratios when compared to the rest of Europe. These were almost evenly divided between the four occupations making up the medical arts: physicians, surgeons, apothecaries and midwives. No argument is being made for the quality of medical service; simply that provision was high. A community of 1,000 people might expect to have a practitioner of each type. If anything, Naples developed a glut of underemployed provincial physicians, as the rise in the number of doctorates granted by the kingdom’s two universities in the last few decades of the eighteenth century outstripped population increases. The more usual situation in Europe was to have the barber-surgeon outnumbering all the rest. He would often have been the only practitioner to be found outside the towns. None the less, rural Europe was no medical wasteland. Despite high numbers of practitioners in state capitals, it appears to have been in the smaller towns that medical densities were highest.

It has been my argument throughout this book that the constituent elements of medical pluralism remained in place during the early modern period. What changed was their individual contours and their relationship to one another. Thus charlatanry may be as old as medicine itself, but it has a history. The Orvietan’s medical secret, one of medicine’s earliest brand names, was grafted on to a much older world of the quasi-sacred snake-charmer. It emerged just when the therapeutic practice was being revived and just as Italian troupes of actors were beginning to take the commedia dell’arte to European audiences. Even the corporatism of the Italian states was not enough to prevent the commercialisation of medicine by charlatans, over a century before similar developments took place in England. The Protomediatici and medical colleges did not seek to eliminate charlatanry, merely to contain it within what they deemed proper limits. Charlatans could be tolerated as long as the prestige and reputation of physical medicine was not damaged.

If there was a ‘golden age’ of medical pluralism as presented in this book, it was the 150-year period following the Council of Trent, when many of the values and attitudes were shared throughout society. By the eighteenth century this consensus was breaking down. This was most evident amongst the kingdom’s educated elites and numerically small bourgeoisie. Religious explanations for disease were no longer as convincing, and religious forms of cure – especially miracles – not anticipated or at least accepted as they had once been. Likewise, the efficacy of maleficent magic had been recognised by all levels of society at the beginning of our period, though to different degrees. If physicians described spells, it was to admit to the powerlessness of natural remedies to affect them. Even at their most sceptical, physicians had considered them part of that grey area shared with the miraculous: an acceptance of the possibility tempered with a suspicious approach to individual cases. This was a scepticism destined to increase over the period. The natural magic of Della Porta eventually gave way to a semi-serious discussion of the phenomenon of iettatura, akin to Franz-Anton Mesmer’s ‘animal magnetism.’ By the later eighteenth century even some churchmen were expressing doubts as to the role of the devil in causing disease, as well as the usefulness of the Church’s
exorcistic rituals. In the south-eastern corner of the kingdom, Apulian tarantism was found to be a 'fraud' by Neapolitan intellectuals, and relegated to the realm of peasant belief. And in the south-western corner of the kingdom, the terrible Calabrian earthquake of 1783 resulted in a heated dispute between figures of the Neapolitan Enlightenment, who favoured a rational, naturalistic explanation, and much of the clergy, who favoured a religious one. What had previously been a complementary relationship – for instance, between the supporters of primary and secondary causes when it came to interpreting plague, and religious and secular responses when it came to combating it – was now transformed into a struggle between the two opposing forces of reason and tradition.

NOTES

1 For example, Ole Grell and Andrew Cunningham (eds), Religio Medici: medicine and religion in seventeenth-century England (Aldershot, 1996).

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HEALERS AND HEALING

IN EARLY MODERN ITALY

David Gentilcore
HEALERS AND HEALING IN EARLY MODERN ITALY

‘Gentilcore has written a book that adds considerably to our knowledge of early modern medicine’. Laurence Brockliss.

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David Gentilcore is Wellcome Research Fellow and Honorary Lecturer at the University of Leicester