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THE TRANSITION FROM MONASTIC TO SECULAR MEDICINE IN MEDIEVAL ENGLAND

Ginny L. Gaweda

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Approved By

Advisory Committee

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Chair

Accepted by

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Dean, Graduate School

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DEDICATION

I dedicate this thesis to my family and friends who always reminded me that sometimes when you think the glass in half empty it is really half full.

INTRODUCTION

During the Middle Ages, up to the twelfth century, monasteries were the primary source of medical education in Europe and maintained medical facilities such as hospitals and infirmaries.[1] By the latter half of the twelfth-century, the location of medical education in medieval England had begun to shift away from the monastic communities to the developing schools and universities in the growing urban areas.[2] According to historian David Lindberg, the transition of medical education to secular universities corresponded with the growing trends of professionalization and secularization that were redefining medical practice.[3] At present, scholars have yet to study the quality and availability of treatment during this period of English history. This is largely due to an academic void surrounding the issue of health care provision during the late Middle Ages.[4] In addressing this gap, this thesis will rely on a combination of primary and secondary source materials as it analyzes the transition from monastic to professionalized secular medicine, the condition of secular and domestic medicine, as well as the altering state of medical education, ethics, and treatment, in order to determine how these changes affected the characteristics and availability of medical care in twelfth, thirteenth, and early fourteenth-century England, ending with the Black Death of 1348.

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[1] David Knowles, *The Monastic Order in England: A History of its Development from the Times of St. Dunstan to the Fourth Lateran Council, 940-1216* (Cambridge: Cambridge University Press, 1963), 485.

[2] David C. Lindberg, *The Beginnings of Western Science: The European Scientific Tradition in Philosophical, Religious, and Institutional Context, 600 B.C. to A.D. 1450* (Chicago: The University of Chicago Press, 1992), 325.

[3] Ibid.

[4] Nancy G. Siraisi, *Medieval and Early Renaissance Medicine: An Introduction to Knowledge and Practice* (Chicago: The University of Chicago Press, 1990), xi.

The primary literature consulted in this text includes medical treatises that, according to Siraisi, are purely prescriptive and ought not be relied upon exclusively for information regarding the actual practices of medicine and their social context.[5] Other available primary sources will be utilized, particularly those of intellectual, institutional, or legal history, including letters, chronicles, Dugdale's *Monasticon Anglicanum*,[6] the Chancery records, and many others.[7] Some of the primary sources that are used in this text include *The Rule of St. Benedict*,[8] several medical treatises by Hildegard of Bingen, translations of the canonical Lateran Councils, the *Trotula*,[9] the pharmaceutical writings of Albertus Magnus,[10] the *Patent* and *Close Rolls*, and selections from the semi-pagan text *'Lacnunga'*.[11]

At present, secondary source work covering the medical history of the Middle Ages is quite expansive and includes many comprehensive summaries and medical treatises. According to Siraisi, the extensive nature of the current state of knowledge makes it impossible to cover all aspects of intellectual and social medicine from every

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[5] Ibid.

[6] Sir William Dugdale, *Monasticon Anglicanum, vol. I-VI* (Westmede, England: Gregg International Publishers, 1970).

[7] Nancy G. Siraisi, *Medieval and Early Renaissance Medicine: An Introduction to Knowledge and Practice* (Chicago: The University of Chicago Press, 1990), xi.

[8] Saint Benedict, *The Rule of Saint Benedict: Translated with and Introduction by Cardinal Gasquet* (New York: Cooper Square Publishers, Inc., 1966).

[9] Monica H. Green, *The Trotula: An English Translation of the Medieval Compendium of Women's Health* (Philadelphia: The University of Pennsylvania Press, 2002).

[10] Faye Getz, *Healing and Society in Medieval England: A Middle English Translation of the Pharmaceutical Writings of Gilbertus Anglicus* (Madison: The University of Wisconsin Press, 1991).

[11] J. H. G. Gratten and Charles Singer, *Anglo Saxon Magic and Medicine: Illustrated Specially From the Semi-Pagan Text 'Lacnunga'* (London: The Wellcome Historical Medical Museum and Oxford University Press, 1952).

part of Europe within a single work. The majority of the secondary literature on medieval medicine consists of a number of comprehensive works that provide a general coverage of medieval medicine and its practice throughout most of Europe, and several texts that focus on specific countries, with a small number of studies covering individual groups or specialized subjects.

Two important specialized studies for this period in history include *Health, Sickness, Medicine, and the Friars in the Thirteenth and Fourteenth Centuries* by Angela Montford[12] and *Medicine Before the Plague: Practitioners and their Patients in the Crown of Aragon, 1285-1345* by Michael R. McVaugh.[13] These studies address similar issues found in this essay, but their research is directed more toward the medical establishment on the Continent. In fact, Montford's history addresses the medical traditions of certain religious orders, including the Dominicans and the Franciscans, who practiced medicine according to the Dominican Constitution, the Franciscan Rule, and the Rule of St. Augustine, which differs from the Rule of St. Benedict used in the majority of the English monasteries at this time.[14] Still, these parallel studies were very useful in researching this thesis.

Secondary sources will also play a vital role in establishing the social context of twelfth, thirteenth, and early fourteenth-century England. Recent works by Faye Getz, Darrell Amundsen, and Carole Rawcliffe each discuss medical practitioners in medieval England, the availability of medical texts, the institutional development of medicine, and

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[12] Angela Montford, *Health, Sickness, Medicine, and the Friars in the Thirteenth and Fourteenth Centuries* (Aldershot: Ashgate Publishing Company, 2004).

[13] Michael R. McVaugh, *Medicine Before the Plague: Practitioners and their Patients in the Crown of Aragon, 1285-1345* (Cambridge: Cambridge University Press, 1993).

[14] Montford, *Health, Sickness, Medicine, and the Friars in the Thirteenth and Fourteenth Centuries,* 13.

religious influences on medical practice, as well as its secular and religious regulation. Other scholars, such as Roy Porter, Lawrence Conrad, Michael Neve, Vivian Nutton, and Andrew Wear, focus on how western medicine changed during the Middle Ages. Several works by David Knowles provide detailed accounts of the monastic and religious orders and houses in medieval England. Two other works that are essential to this text include E.A. Hammond and C.H. Talbot's *The Medical Practitioners in Medieval England: A Biographical Register*, which provides expansive lists and descriptions of all the known medical practitioners in medieval England, and Albert Jonsen's *A Short History of Medical Ethics*, which is currently the only known work of its kind regarding medieval medical ethics.[15] The valuable works of these authors and many others will be used to establish the social conditions of twelfth, thirteenth, and fourteenth-century English medicine.

However, since there is hardly any research on medieval medical ethics and no existing work that determines the quality of medicine in specific locations or specific groups, this text will attempt to address some of these issues in its four chapters. The first chapter will determine the characteristics of monastic and secular medicine available in twelfth-century England by evaluating where medical practice was located, who practiced medicine, the types of medicine available, and the state of medical ethics. The second chapter will establish how the characteristics of medical education and practice changed during the transition from monastic to professionalized secular medicine and the effect this transition had on the importance and practice of medicine in monastic

[15] E. A. Hammond and C. H. Talbot, *The Medical Practitioners in Medieval England: A Biographical Register* (London: Wellcome Historical Medical Library, 1965).
Albert R. Jonsen, *A Short History of Medical Ethics* (Oxford: Oxford University Press, 2000).

communities. The third chapter will examine how English medicine was learned and practiced in the monastic and secular communities during the thirteenth century. It does this by evaluating the medical education received by the clergy and the secular community, the availability of medicine, the value of texts in medical education and ethical practice, the affect these texts had on all medical practitioners, perceptions of women in the medical field, and how all these elements influenced the quality of medicine. The fourth chapter will observe the relations between the various medical traditions and how the transition from monastic to professionalized secular medicine, in the twelfth and thirteenth centuries, affected the quality of practiced medicine until the Black Death in 1348. In doing so, it will evaluate the state of late thirteenth and fourteenth-century medicine, how medical treatment and its availability in hospitals changed, who the main practitioners were and what their place was within the medical hierarchy, who profited through medical practice, what medical standards took priority within the monastic and secular communities, and how all of these elements affected the quality of practiced medicine in late medieval England. In the end, the overall objective of this research is to clarify how the transition from monastic to professionalized secular medicine affected the quality and availability of medicinal care in twelfth, thirteenth, and early fourteenth-century England based on evidence extracted from primary materials and recent scholars.

CHAPTER ONE:

TWELFTH-CENTURY MEDICINE

In order to understand how the quality, availability, and practice of medicine began to change during the late Middle Ages, background information will be provided regarding the state of medicine in England prior to the Gregorian Reforms of the twelfth and early thirteenth centuries. These reforms serve as the starting point for the reform of the actual practice of medicine in late medieval England. To understand the consequences of the reforms, this chapter will examine the quality of monastic and secular medicine in twelfth-century England by evaluating where medicine was taught and practiced, who the practitioners were, the availability of medical care, the types of medical traditions, medical sources, and the state of medical ethics.

In twelfth-century England, monasteries were the main source of medical education. They supplied their surrounding communities with infirmaries and hospitals. As towns and cities began to grow, the number of monastic hospitals also increased.[1] Besides the larger monastic hospitals, monasteries also provided infirmaries or *infirmarias*, rooms in the monastery or hospital where the sick were cared for, and smaller hospitals for pilgrims and wayfarers that were referred to as a *hospitium*. Almshouses were also used as a *hospitium* and were sometimes located within established hospitals.[2] While only a few hospital records survived the Dissolution of the monasteries from 1536 to 1539, it is understood that hospitals were generally separate establishments that were located throughout the community or were adjoined to aligned

[1] Knowles, *The Monastic Order in England,* 485.

[2] David Knowles, and R. Neville Hadcock. *Medieval Religious Houses, England and Wales* (New York: St. Martin's Press, 1971), 311.

monasteries. All hospitals were considered more ecclesiastical rather than medical, since the focus of these institutions was on caring for the patient by giving the body relief, not curing them.[3] Different hospitals offered different services. Most hospitals were established to support the local monasteries and the poor, while other hospitals treated only lepers, pilgrims and wayfarers, men or women. Administered by the master, prior, chaplain, or other clerical officials, hospitals were sometimes managed according to the rules of their aligned monasteries, but were primarily run as lay establishments.[4]

According to Martha Carlin in her essay "Medieval English Hospitals", there has been no significant research done on the subject of medieval English hospitals. The most comprehensive work produced on the subject is David Knowles and Neville Hadcock's *Medieval Religious Houses, England and Wales*.[5] Nearly a century ago, Rotha Mary Clay did publish a significant work on *The Medieval Hospitals of England*. It is out-dated, but remains a valuable resource.[6] In this text, she discusses the existence and development of the various types of hospitals and their role in social life during the Middle Ages.[7] While there has been some recent work by Elizabeth Prescott and other authors, the scholarship of medieval hospitals has remained underdeveloped.[8] It is because of this void that Carlin's essay expands on the topic of medieval hospitals by

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[3] Rotha Mary Clay, *The Medieval Hospitals of England* (London: Frank Cass & Co. Ltd., 1966, 1906), xvii-xviii.

[4] Elizabeth Prescott, *The English Medieval Hospital, 1050-1640* (Wiltshire: The Cromwell Limited Press, 1992), 1.

[5] Martha Carlin, "Medieval English Hospitals" in *The Hospital in History* edited by Lindsay Granshaw and Roy Porter (New York: Routledge, 1989), 21.

[6] Rotha Mary Clay, *The Medieval Hospitals of England*.

[7] Ibid, xvii.

[8] Prescott, *The English Medieval Hospital, 1050-1640*, 1.

identifying the major primary sources, including the *Valor Ecclesiasticus*, the *Patent* and *Close Rolls*, the *Calendar of Inquisitions Miscellaneous,* and the Papal Letters, as well as the types of hospitals, how many of each there were, their function, and other relevant statistical data. Unlike Carlin, the lists of hospitals provided by Rotha Mary Clay do not mention the same number of hospitals that are listed by Knowles and Hadcock. Rotha Mary Clay's work only mentions 804 documented hospitals while Knowles and Hadcock list 1,103 hospitals, making it a more accurate source.[9] Carlin's research is heavily dependent on data from Knowles and Hadcock, who supply more information regarding the number of hospitals in medieval England, particularly in reference to the different types of hospitals and how they functioned. From this research, it can be understood that out of the 1, 103 hospitals Knowles and Hadcock described, 742 (67 %) were almshouses and 345 (31%) were leper hospitals that were established between 1084 and 1224, some of which doubled as almshouses, 136 (12%) were for pilgrims and poor travelers, and 112 (10%) hospitals were designed exclusively to serve the poor.[10]

In these four types of monastic hospitals, only the ten percent of hospitals designed to aid the poor were intended for the care of the sick. Of the 112 hospitals of this type, only twenty attended to the general public while the other ninety-two hospitals ministered only to their sick inmates.[11] The other hospitals mentioned by Carlin, Knowles, and Hadcock did not provide general medical care; instead they housed and fed specific groups of people, and viewed caring for the sick as an unwanted burden.[12] These

[9] Rotha Mary Clay, *The Medieval Hospitals of England, passim.*

[10] Martha Carlin, "Medieval English Hospitals" in *The Hospital in History*, 22-24.

[11] Ibid, 24.

[12] Ibid, 24-25.

other hospitals were designed to establish order and uphold the beliefs and spiritual practices of the monastery by establishing daily routines for the patients that followed monastic patterns, such as scheduled prayer, fasting, meditative silence, and uniform clothing.[13] Medical aid at these monastic institutions was minimal and limited by the capacity and wealth of the hospital. As a consequence, many of the sick were excluded from these institutions and depended on the secular practitioners in their local communities. According to Kealy, medieval towns in the twelfth century held roughly ten percent of the population. Many of these towns claimed a ratio of one physician for every two thousand people, though there still remained underserved areas throughout England. By medieval standards, England was not lacking in medical service and there is no evidence of complaints made about the availability of physicians.[14]

In the few hospitals that offered medical care during the twelfth century, the physicians were mostly monks.[15] These monk-physicians, in the 112 hospitals that offered medical care during that period, were in an awkward position, since by 1123 Gregorian reformers had begun to reestablish the spiritual and political orientation of the Roman Catholic Church through a series of four Lateran councils that sought to regulate the ministry of the faith. While these councils did not directly target the practice of monastic medicine, they still had a profound affect on the medicine practiced by monks in the monastic communities of the late twelfth and thirteenth centuries.[16] Prior to the

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[13] Edward J. Kealy, *Medieval Medicus: A Social History of Anglo-Norman Medicine* (Baltimore: The John's Hopkins University Press, 1981), 107.

[14] Kealy, *Medieval Medicus,* 49-50.

[15] Stanly Rubin, *Medieval English Medicine* (New York: Harper & Row Publishers, Inc., 1974), 17.

[16] Kealy, *Medieval Medicus,* 25.

councils of the Gregorian reforms, monk-physicians had practiced a form of medicine that was heavily influenced by the native folk craft and pagan traditions. This medical blend of Christian tradition and pagan practices was common place in twelfth-century England, but with the new Gregorian reforms of the first four Lateran Councils, these monks were not just forced to abstain from the known pagan practices of the secular community, they were also forced to regulate who was allowed to practice medicine in the monasteries and their adjoined hospitals.[17]

In Canon 17 of the First Lateran Council in 1123, monks were prohibited from visiting the sick.[18] Then in 1139, the reforms of the Second Lateran Council directly prohibited monks and canons from studying law or medicine for economic gain. These new regulations might have been expected to decrease the availability of medical care in monasteries and monastic hospitals, but the English clergy was not as dogmatic about canon law as the continental clergy, particularly since the level of interest in monasteries at this time was on the rise. This means that the clergy would have continued to practice physical medicine until the early thirteenth century. According to Kealy, the growth of the Benedictine and Cistercian orders during the twelfth century was due almost entirely to the increase in Saxon initiates who became priests, monks, nuns, canons, or lay brethren. These new members of the clergy were also closely associated with the secular community. Some of them became hermits and anchorites. These individuals were also

[17] Rubin, *Medieval English Medicine*, 110.

[18] Norman P. Tanner, *Decrees of the Ecumenical Councils* (Washington, DC: Georgetown University Press, 1990), http://www.piar.hu/councils/ecum12.htm.

very important to the function of local society since they offered social services to the community, such as local building projects and the establishment of schools.[19]

With England's new clerical recruits came an increase in monastic hospitals, medical texts, as well as, documented physicians and by the end of the twelfth century the origin of many of the monasteries and hospitals could be linked to one of these solitary practitioners. Among these new recruits were large numbers of women; however, while female nurses appear in medieval miniature illustrations, there appear to be no known female medical practitioners in the twelfth century. It is important to note that during the Middle Ages, "women's health was women's business" so undocumented mid-wives would have held a monopoly over female medical care until the sixteenth and seventeenth centuries.[20] During the twelfth century, no female practitioners were listed, but there are 117 documented male practitioners, two of whom were known to be Jewish physicians. [21] According to the lists of practitioners provided by Talbot and Hammond in *The Medical Practitioners in Medieval England*, the 117 male medical practitioners only included seventeen monks or canons, fifteen of whom were known as physicians and three were referred to as a physician and a *medicus*.[22] The term *medicus*, however, is only a general term for anyone who practiced any form of medicine during the Middle Ages so the use of this term only really has significance if it is the only description given about a

[19] Kealy, *Medieval Medicus,* 26-27.

[20] Monica Green, "Women's Medical Practice and Health Care in Medieval Europe", *Signs , vol. 4, no. 2, Working Together in the Middle Ages: Perspectives on Women's Communities* (1989), 434.

[21] Kealy, *Medieval Medicus,* 27.

[22] Hammond and Talbot, *The Medical Practitioners in Medieval England, passim*.

medical practitioner.[23] The final results from these statistics reveal a slight increase from the nine recorded medical clerics of the eleventh century listed by Edward J. Kealy. This means that while the number of monastic hospitals increased substantially throughout the twelfth century, the number of available physicians appears to have only slightly grown to accommodate the increase in medical facilities and care.[24]

After establishing the location of medical education and practice, as well as the number of practitioners and the overall availability of medical care in twelfth-century England, it is important to understand the various medical traditions that were utilized by medical practitioners and how this had an effect on the practice and quality of medical care. It is also imperative that the relations between these traditions be clarified to reveal which traditions were the most influential and how this affected the quality of medical practice. In the twelfth century, there were three medical traditions that were applied, in varying degrees, to English medical practice: the classical traditions of the Greeks and Romans that were mostly associated with university medicine, the monastic tradition of the Benedictines, and Anglo-Saxon domestic medicine.

Of the classical traditions that survived into the Middle Ages, only the school of Hippocrates, the works of Galen, some Arabic texts, and the works of a small number of Byzantine physicians were available to monastic physicians and practitioners. Most of the texts available were written in Greek and Latin. From the tenth to the twelfth century, Old English texts began to appear in England as the use of the vernacular language

[23] Siraisi, *Medieval and Early Renaissance Medicine,* 21.

[24] Kealy, *Medieval Medicus,* 31.

increased.[25] From the seventh to the eleventh centuries, Middle Eastern scholarship was undergoing a mini-renaissance that produced an abundant number of medical texts. Many of these texts sometimes expanded on or adopted the concepts present in Greek medical treatises.[26] In fact, Arab scholars had more access than did the medieval West to many of the works of Galen and Aristotle, since many works by these classical authors had been lost.[27] By the twelfth century, several of the relevant Arabic works had been translated into Latin and were used in the education of physicians at universities. These include the *Pantegni*, which was translated by an Italian monk in Monte Cassino near Salerno, and the works of Galen by both Gerard of Cremona in Spain and Burgundio of Pisa in Italy during the twelfth century. The Arabic works did not really influence the practice of English medicine until the thirteenth century, because many of the new ideas were complex and intellectually advanced and their assimilation into western medical practice took generations.[28] The extent of classical influences can also be found in the medical illustrations that were created prior to and during the twelfth century.[29] Many of these can be found in *Medical Illustrations in Medieval Manuscripts* by Loren MacKinney, which also provides a section on early medieval medicine that is depicted in the illuminated manuscripts.[30]

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[25] M. L. Cameron, *Anglo-Saxon Medicine* (Cambridge: Cambridge University Press, 1993), 2.

[26] Siraisi, *Medieval and Early Renaissance Medicine*, 11.

[27] Ibid, 12.

[28] Ibid, 14.

[29] Cameron, *Anglo-Saxon Medicine*, 19.

[30] Loren MacKinney, *Medical Illustrations in Medieval Manuscripts* (Berkeley: University of California Press, 1965).

Of the medical miniature illustrations that survived this period, only a few depict the work of physicians. In these illustrations most of the physicians were shown wearing classical clothing while a minority of the images show physicians wearing contemporary clothing. This suggests that the majority of the medieval medical practitioners were members of an ecclesiastical order and were educated in the classical traditions of the Greeks and Romans. Cameron argues that because of their classical and ecclesiastical education, the clerical practitioners were better equipped to translate the large number of Latin medical texts than anyone else. Evidence can be found in surviving texts where charms and incantations reveal a strong Christian influence on classical and native Anglo-Saxon practices. Anglo-Saxons were quite familiar with the works of the classical authors, so they would have been equally immersed in the Latin texts. The exposure and use of these Latin texts continued to fuse the Anglo-Saxon and religious medical traditions, making it hard to distinguish clearly a dividing line.[31] These texts also infused each tradition with a strong classical influence that continued to develop in later centuries. To understand how inter-twined these medical traditions had become, they must first be analyzed separately.

In order to separate the medical practices of the classical and Anglo-Saxon traditions from the clerical influences of the Middle Ages, one must first differentiate between the ecclesiastical and the pagan practices. In the ecclesiastical traditions of twelfth-century England, the care of the sick was outlined in the rules of the religious orders, especially the Benedictines.[32] The Benedictines housed all the known physicians

[31] Cameron, *Anglo-Saxon Medicine*, 19.

[32] James J. Walsh, *Medieval Medicine* (London: A. & C. Black, Ltd., 1920), 24.

throughout the twelfth century in England and had established what Knowles refers to as efficient system of medical treatment that was based on the Rule of St. Benedict and other domestic traditions of medicine.[33] The Rule of St. Benedict directed that each monastery should house an infirmary to care for the ailing, and that the care of the sick should be considered more important than any other sacred duty.[34] Other medical guidelines appear throughout the text and are generally listed in association with other topics. For instance, chapter thirty-six of St. Benedict's Rule suggests that the sick be secluded in a separate room where they are to be bathed more often than those who are healthy and that they be served meat to help them regain their strength. Once the patient has healed, he or she must then abstain from meat. Obviously, cleanliness and a change of diet were used as a means of treating the sick, and it was believed that the use of water had curative effects, though the reason for this is obscure.[35]

In chapter thirty-nine of St. Benedict's Rule, with regard to the serving of food, the ailing were told to abstain from eating the flesh of quadrupeds. When compared to the prescription of meat mentioned in chapter thirty-six, it can be understood that any prescribed meat belonged to animals that did not have four feet, such as chicken or fish, though the reason for this is not made clear. In Chapter forty, regarding the appropriate amount of drink, the rule states that the sick are allowed no more than a pint of wine daily, though this restriction seems to be in place as a way to regulate drunkenness or gluttony. Chapter forty-nine appears to support the continuation of work for weak

[33] Knowles, *The Monastic Order in England,* 518.

[34] Walsh, *Medieval Medicine,* 24.

[35] Saint Benedict, *The Rule of Saint Benedict*, 68-69.

brethren though the labor should not wear them down or drive them to leave while they are still ill.[36]

In actuality, the medical practices prescribed by St. Benedict, which were applied in the majority of the monasteries and their hospitals, were not so much medical prescriptions or cures, instead they were more about caring for the patient through the alteration of lifestyle, hygiene, and diet. According to Kathy L. Pearson, these alterations in diet would have had the most affect on the female population, which at this time was suffering from iron deficiencies due to malnutrition and frequent child-bearing. Men would have also been affected by alterations in diet since, according to Ann Hagan, the rate of food production and consumption at this time meant that the majority of the English population was malnourished.[37] This suggests that the methods of treatment prescribed by the ecclesiastical practitioners, according to the Rule of St. Benedict, may not have been very effective since the meat prescribed to the sick was not always red meat, which is a source of iron supplementation that would have counter-acted the wide-spread deficiency in iron in women and men.[38] Outside the guidelines provided by St. Benedict's Rule, the practice of monastic medicine was strongly influenced by the classical traditions of Greek and Roman medicine from the beginning of the Middle Ages.[39] This means that the ritualistic, superstitious, and magical aspects of Anglo-Saxon

[36] Ibid, 74.

[37] Kathy L. Pearson, "Nutrition and the Early Medieval Diet", *Speculum*, vol. 72, no.1 (1997), 1.

[38] Ibid, 8.

[39] James J. Walsh, *Medieval Medicine,* 26.

traditions were later added to these ecclesiastical practices and were evident by the twelfth century, since ecclesiastical and secular pagan practices had become fused.[40]

According to J. F. Payne, the heavy influence of Anglo-Saxon magic and superstitions in English monastic medicine can be identified by the six procedures that were used in this tradition. The first procedure applied prayer or invocations to the preparation of herbal medicines. Rubin explains that an example of this procedure can be found in Bald's first *Leechbook* where a type of charm is prescribed to prevent travel fatigue by holding mugwort in the hand or the shoe. First the traveler must say: "I will take you artemisia [mugwort] lest I weary on the way" as he or she harvests the herb and makes the sign of the cross while pulling it out of the ground or cutting a portion of it from the main plant. There is also a similar mugwort charm mentioned in the Anglo-Saxon Herbal for travelers.[41]

Another example appears in the *A.S. Herbarium XCIII* that is intended for the treatment of a snake bite. This charm states that one must first take hold of an *Ebulum* plant, also known as *Elderwort* or *Wallwort*, and recite twenty-seven times: "Enchant and overcome all evil wild beasts." After reciting this incantation, a portion of the plant is cut off with a sharp knife and dissected into three parts while the healer simultaneously thinks about the person who needs to be healed. Once this procedure is complete, the healer must then leave the site of the plant without looking around.[42] Then he or she must

[40] W. L. Braekman, *Studies on Alchemy, Diet, Medecine and Prognostication in Middle English* (Brussels: The Research Center of Medieval and Renaissance Studies/Omriel, 1986), 124.

[41] Rubin, *Medieval English Medicine*, 111-112.

[42] Ibid.

take the herb that was removed and pound it into a powder or salve before placing it on the injury.[43]

The second procedure involved the use of prayer or invocations either over the patient or written onto amulets and charms that were later applied to the patient's body.[44] Payne explains that amulets and charms were generally worn on the body in order to ward off disease and that they were mentioned often in medical manuscripts. The example he uses refers to the use of incantations that were written down on a piece of paper that was hung from the neck in order to cure a patient of diarrhea.[45]

There is also a list of twelve charms in the fifteenth-century manuscript of Middle English treatises known as *MS. Additional 34, 111* located in the British Library.[46] Six of the twelve charms listed in this manuscript are for non-medical purposes.[47] Two of the medical charms are meant for women in labor and are obviously a blend of Christian beliefs and pagan charms. Both the labor charms are similar in that they require that a periapt be laid on top of the womb while the woman is in labor. On this piece of paper a reference to the birth of Christ and how his blood was shed for humanity is written in Latin. The incantation ends by saying "*Christus vincit, Christus imperat*," that translates as "Christ conquers, Christ commands", while in other examples

[43] Gratten and Singer, *Anglo-Saxon Magic and Medicine*, 36.

[44] Rubin, *Medieval English Medicine*, 111.

[45] Ibid, 113.

[46] Braekman, *Studies on Alchemy, Diet, Medecine and Prognostication in Middle English*, 114.

[47] Ibid, 118.

it ends saying "*Christus vincit, Christus regnat, Christus imperat,*" which translates as "Christ conquers, Christ reigns, Christ commands."[48]

Payne's third procedure consisted of an exorcism of evil spirits, which required the use of charms like those mentioned in Bald's *Leechbook*.[49] In this text, the charms were specific to the kind of exorcism that was required. For instance, holy water and prayers were used to drive out evil spirits that caused fever from a patient, while the exorcism of mental illness was much more extravagant since it required the use of holy water and the singing of twelve masses dedicated to the apostles. The procedure was not always successful, as it was in the case of the nun mentioned by Bede who suffered from violent fits or seizures.[50] This procedure is obviously embedded with familiar Christian elements, like the use of the mass; however, the repetitive element of singing and the number of masses is potentially indicative of pagan rites or prayers, which often utilized song and were usually performed three times or several times three times.[51] In fact, in the *Lacnunga* (Entry XXIIa) singing is prescribed as a treatment for toothache. These elements do not clearly distinguish between the pagan and Christian practices, but most exorcisms did use similar practical elements which were influenced by the use of repetition in threes.[52]

The fourth procedure listed by Payne that distinguished Anglo-Saxon Medicine from other traditions, refers to the invocation of infamous people, who had suffered from

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[48] Ibid, 122.

[49] Rubin, *Medieval English Medicine*, 112.

[50] Ibid, 113.

[51] Gratten and Singer, *Anglo-Saxon Magic and Medicine*, 44.

[52] Ibid, 105.

similar ailments, through the use of narrative charms.[53] There are two types of narrative charms, a short and a long incantation. In volume one of Bald's *Leechdom,* there is a short narrative charm for stitches that is recited three times with a Paternoster after a Cross is drawn over the area of the body that is stitched. The charm states that "Longinus, the soldier pierced our Lord with a lance and the blood stopped and the pain eased." This charm was sometimes used in an attempt to stop a bleeding wound.[54]

The charm is also a clear example of Christian alterations to pagan charms that often used repetitive recitations in numbers of three and would have been used by clerical practitioners in the twelfth century. A longer narrative charm appears in *The Lay of the Nine Twigs of Woden* (Entry LXXX) and calls on Woden, a northern pagan deity of good luck, health, and death. The English translation of this charm or incantation states that: "Phol (Balder) and Woden fared to the wood, there was to Balder's foal, his foot wretched. Then charmed Woden, as he well knew how, as for bone wrench, so for blood wrench, so for limb wrench; 'Bone to bone, blood to blood, limb to limbs, as if they be glued.'" This charm for the healing of broken bones was not only very popular in Anglo-Saxon and other northern pagan traditions, it also appears in Gaelic works and there are even similar charms in the Sanskrit *Artharva Veda* from India.[55]

Payne's fifth procedure, for identifying Anglo-Saxon medicine, applies magically endowed materials as charms for the patient, such as a string of beaded amber or other beads that were used to protect its wearer from disease and danger. Plants, like vervain

[53] Rubin, *Medieval English Medicine*, 111.

[54] Ibid, 114.

[55] Gratten and Singer, *Anglo-Saxon Magic and Medicine*, 44-53.

and mugwort, and animal parts were also used in these material charms, as well as colored cloth.[56] In fact, some of the common herbal remedies fit under this category since plants were believed to have magical and healing properties. An example of this appears in Anglo-Saxon manuscripts, like the *Lay of the Nine Herbs* (Entry LXXIX), which contains the descriptions of nine herbs and their magical properties.[57] Another magical herbal charm appears in the third volume of Bald's *Leechbook*, where it suggests that a red plant should be attached to every door on a house in order to protect the building from evil influences.[58]

The sixth procedure listed by Payne was designed to transfer the disease or illness, through ceremonial rites, to another object like an animal or a stone.[59] Water was often used in these kinds of rites, since it was believed that it would wash away the disease or illness. The act of spitting was also utilized, since saliva was believed to be a way to remove evil, to counteract the negative effects of worms and serpents, and as relief for joint pains and eye diseases.[60] Certain taboos, like the use of silence or looking back during or after rituals, were often referred to in medieval manuscripts.[61] This was because, in pagan traditions, words had power in ritual and so any added speech or

[56] Rubin, *Medieval English Medicine*, 115.

[57] Gratten and Singer, *Anglo-Saxon Magic and Medicine*, 56.

[58] Rubin, *Medieval English Medicine*, 115.

[59] Ibid, 112.

[60] Ibid, 116.

[61] Ibid, 117.

outside distraction might break the spell.[62] This explains why in many Anglo-Saxon recipes, words of power are written silently.[63]

An example of the sixth procedure, that utilizes some of these practices, appears in several Anglo-Saxon magical texts. It is for the treatment of seizures.[64] This charm states that the patient or healer must take hold of a hazel stick and inscribe their name or the patient's name on it. Once this has been completed, the inscribed name must then be filled with the patient's blood and thrown over the shoulder into running water. The entire procedure should be performed silently. This ritual passes the illness of the patient into a stick through the power of words by inscribing the name.[65] It also uses running water so that the illness is washed away.[66]

Many of these Anglo-Saxon remedies have no proven effectiveness; however, according to W. L. Braekman, the superstitions that influenced these remedies had little affect on the quality of the medicine, since many of these remedies were continuously employed over centuries with some level of effectiveness or success. In fact, the difference between folk and academic medicine was barely evident during the Middle Ages, though Payne does attempt to clarify the procedures applied in Anglo-Saxon medical traditions in order to separate Anglo-Saxon influences from other traditions. Braekman also argues that once medical practice started to become categorized, what had previously been considered scientific medicine in one age became the folk medicine of

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[62] Gratten and Singer, *Anglo-Saxon Magic and Medicine*, 31.

[63] Ibid, 34.

[64] Ibid.

[65] Ibid, 34-35.

[66] Rubin, *Medieval English Medicine*, 116.

the next.[67] While Anglo-Saxon traditions were superseded by monastic practices, by the twelfth century, their influence on monastic medicine was considerable. This was because many of the folk recipes had been adapted and added to supplement the medical traditions of the monasteries, which relied heavily on the guidelines issued by St. Benedict.[68]

In order to understand how these three traditions affected one another, it is important to identify the Anglo-Saxon, ecclesiastical, and classical source materials that were utilized at this time. A few of the remaining Anglo-Saxon texts include the *Lacnunga* and its metrical charms, Cockayne's *Leechdoms, Peri Didaxeon*, and the oldest English medical text known as Bald's *Leechbook*.[69] These texts were mainly Anglo-Saxon remedy collections that mostly provided recipes for remedies and charms with only a small emphasis on the diagnosis of symptoms and disease. All these texts were also common medical recipe books; however, the *Lacnunga* is not as old as the leechbooks and is also not as well- organized. Cockayne's *Leechdoms* were translated from 1864 to 1866, though these texts predate this period to sometime prior to the Norman Conquest.[70] Bald's Leechbooks can be dated to the ninth and tenth centuries; however, only the first two books can be directly linked to Bald while the compiler of the third book has yet to be verified.[71] Other surviving medico-magical recipes also appear in

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[67] Braekman, *Studies on Alchemy, Diet, Medecine and Prognostication in Middle English*, 113.

[68] Ibid, 114.

[69] Peter Kitson, "From Eastern Learning to Western Folklore: The Transmission of some Medico-magical Ideas" in *Superstition and Popular Medicine in Anglo-Saxon England* edited by D. G. Scragg (Manchester: Centre for Anglo-Saxon Studies at the University of Manchester, 1989), 57.

[70] Howard Meroney, "Irish in the Old English Charms," *Speculum*, vol. 20, no. 2 (April 1945), 172.

non-medical manuscripts, some of which are older than the leechbooks. One example of this kind of text is the Omont fragment that dates to between 850 and 900. It contains only a single page of recipes near the end of the book. Other remaining medical manuscripts also include Old English texts that are translations of earlier Latin texts, of which two were known to be Latin works by Anglo-Saxons. These two include the *Canterbury Classbook* written at St. Augustine's, Canterbury in 1100 and the *Ramsey Scientific Compendium* that was written at St. John's College in Oxford a few years later.[72]

The most valuable of these translated Latin texts, due to the limited number of copies available, is the *Herbarium of Psuedo-Apuleius*, a composition of remedies and animal and plant origins falsely associated with Apuleius, of which only four translated manuscripts have survived.[73] Other equally important texts include the *Old English Herbarium* and the *Medicina de Quadrupedibus*, which are both compositions of herbal remedies, charms, and animal and plant origins.[74] These various manuscripts in twelfth-century English medicine were commonly used by educated medical practitioners both secular and clerical, since Anglo-Saxons were as familiar with Latin medical texts as their classically trained clerical practitioners.[75] In fact, the vast majority of the herbals

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[71] Richard Scott Nokes, "The Several Compilers of Bald's *Leechbook*," *Anglo-Saxon England* (Cambridge: Cambridge University Press, 2004), 33: 51-76. Published online by Cambridge University Press, 2005. http://journals.cambridge.org/action/displayAbstract;jsessionid=6C01047CC7858A3FCBFB255ABB801017.tomcat1?fromPage=online&aid=287326

[72] Cameron, *Anglo-Saxon Medicine*, 30-33.

[73] Linda E. Voigts, "Anglo-Saxon Plant Remedies and the Anglo-Saxons", *Isis*, vol. 70, no. 2 (1979), 250.

[74] Hubert Jan de Vriend, *The Old English Herbarium and Medicina De Quadrupedibus* (London: The Early English Text Society and Oxford University Press, 1984).

[75] Cameron, *Anglo-Saxon Medicine*, 33.

and medical manuscripts produced in England prior to the twelfth century were intended not for physicians, but for leeches among the Anglo-Saxons.[76] Those texts that were not original Anglo-Saxon herbals were generally Latin translations of Greek works and these texts were also used in the compilations of herbals and other medical manuscripts.[77]

In the three *Leechbooks* by Bald, it is evident that there were some classical influences and that some of the works that were cited were from classical texts that were not available in Anglo-Saxon England. For example, several prescriptions mentioned in these three *Leechbooks* were assigned measurements according to the standards in Latin texts which had a more precise weight and measurement system, since the Anglo-Saxons had no standard system of their own.[78] This means that the Anglo-Saxons were familiar with both their local medicine and the medical treatises in Latin that expanded on the medical use of diet, bloodletting, diagnosis, as well as, other aspects of classical medicine.[79] The pagan influences on monastic medicine were, therefore, not only from the native Anglo-Saxon traditions, but also from the classical traditions of the Greeks and Romans that were both influential in Anglo-Saxon medicine and in the classical training of clerical practitioners. Furthermore, the medical ethics practiced by monastic and secular Anglo-Saxon practitioners would have been similar since they were both influenced by the classical works of Galen, Hippocrates, and Aristotle.

The Greek author Galen of Pergamum wrote about 150 works dedicated to the medical and biological sciences that discussed both the practice of medicine and the

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[76] Gratten and Singer, *Anglo-Saxon Magic and Medicine*, 17.

[77] Ibid, 23.

[78] Ibid, 27.

[79] Cameron, *Anglo-Saxon Medicine*, 34.

theories behind them. These works continued to be the foundation of western medicine through the sixteenth and seventeenth centuries.[80] Of all of the medical works left over from late antiquity, Galen's work left behind the most influential legacy. According to Grant, no other Islamic or Greek author was able to leave a textual legacy that compared with the extent of Galen's work.[81] While Hippocrates did not rival Galen with the extent of his medical works, he did have a profound affect on medical theory and its ethical implications. This was predominantly because Hippocrates was a natural philosopher and believed that nature could only be truly understood through medicine. This belief correlates with the complex inter-relationship classical medicine already shared with natural philosophy. In fact, this relationship continued to be influential through the Middle Ages. By the thirteenth century, many of the university trained physicians wrote medical treatises using natural philosophy from the works of both Hippocrates and Aristotle.[82] In twelfth-century England, however, the classical author's influence on medical ethics had been reduced, since the application of monastic and secular medicine was influenced less by natural philosophy and more by the practical application of Anglo-Saxon remedies and monastic regulations on lifestyle and diet.[83] This was because universities in England did not produce physicians until the fourteenth century so most medical education or regulation came from the monasteries.[84]

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[80] Edward Grant, *The Foundations of Modern Science in the Middle Ages: Their Religious, Institutional, and Intellectual Contexts* (Cambridge: Cambridge University Press, 1996), 10.

[81] Ibid, 27.

[82] Ibid, 156-157.

[83] Lindberg, *The Beginnings of Western Science*, 320.

[84] Faye Getz, *Medicine in the English Middle Ages*, 17.

To a certain extent, this separation from classical medicine in the early Middle Ages can be attributed to the growing tension between the naturalist traditions of antiquity and the supernaturalist traditions of medieval Christianity and the Anglo-Saxon community. The naturalist traditions supported the belief that only natural causes were at work while the supernaturalists believed in forms of miraculous healing, as well as, the influence of the supernatural forces of good and evil.[85] These beliefs indicate that by the twelfth century, medieval medicine focused not only on treating the body, but also the soul through religious faith and practice.[86] The widespread popularity of miraculous cures supported belief in the effectiveness of supernatural cures and that an illness or event could be naturally caused by divine or evil forces.[87] This implies that any ethical regulation of medical practice would have to come from either the secular traditions, which were slowly being separated from the monastic practice of medicine by the Lateran Councils of the twelfth century, or the monastic practice of medicine.

By the twelfth century, the Anglo-Saxon traditions had been superseded by monastic medicine and what remained of them appeared only in the types of remedies and charms used in medical practice.[88] Any form of medical ethics came from the remnants of classical medicine and Church tradition. As classical medicine had only a slight impact on the practice of twelfth-century English medicine, it must be understood that religious doctrine had the largest influence over medical ethics. In the twelfth century, the Church viewed medicine as an important practice, since Christ was

[85] Lindberg, *The Beginnings of Western Science*, 320.

[86] Jonsen, *A Short History of Medical Ethics*, 17.

[87] Lindberg, *The Beginnings of Western Science*, 320.

[88] Braekman, *Studies on Alchemy, Diet, Medecine and Prognostication in Middle English*, 124.

recognized as a miraculous healer who had commanded his followers to aid the sick.[89] Within English monasteries, this teaching was taken to heart by supporting medical education and facilities in and outside of the monastery.[90] The use of secular medicine was deemphasized and medical healing in monasteries was practiced according to the belief that the salvation of the soul was more important than healing the body.[91] This was because sickness was believed to be either caused by God or only cured through the will of God.[92] This reduced the quality of medical healing in late twelfth-century England because healing the body was not considered a top priority, so only a small number of monastic hospitals in England were established specifically for the healing of the sick.[93]

Those who were healed in the English monasteries were treated using the guidelines of St. Benedict, which provides very few treatment options; however, most monastic infirmarians were trained herbalists so they were familiar with a wide variety of charms and remedies. The wealthier cathedral schools did use secular remedies and charms, but they were also known to rely, more than other English monasteries, on the classical teachings of Hippocrates while still depending on the guidelines of the Church. This was because only Christ could heal with a mere command and that the earthly physician, according to Hippocrates, must rely on the power of herbs to alter the condition of the human body. This suggests that the quality of medical expertise was best in cathedral monasteries and their hospitals, since the level of expertise available in these

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[89] Jonsen, *A Short History of Medical Ethics*, 13.

[90] Kealy, *Medieval Medicus*, 27.

[91] Jonsen, *A Short History of Medical Ethics*, 17.

[92] Lindberg, *The Beginnings of Western Science*, 320.

[93] Carlin, "Medieval English Hospitals," 24.

places would have applied the monastic, classical, and Anglo-Saxon practices to their treatment of ailments. In fact, these cathedral monasteries and hospitals were, according to Jonsen, the predecessors to the university medical programs.[94] They even applied the Hippocratic Oath in their practice of medicine. In fact, the Oath appears throughout medical literature from the eighth to the tenth centuries. It appeared as a description of religious duty and obligation. The practice of the Oath had increased prior to the twelfth century and continued to be applied by many educated clerical physicians into the twelfth century, though the actual number of those who took the Oath is unknown.[95]

The quality of medicine practiced in these cathedral monasteries and their hospitals in the twelfth century began to decline as the Lateran Councils of the Gregorian reformers sought to restrict and nearly prohibit the use of classical and secular medicine. By the end of the twelfth century, the availability of practical remedies began to shift away from the monasteries and their hospitals as reforms were enforced and the number of secular practitioners increased. Monastic medicine gradually became more focused on healing the soul rather than treating the flesh. The ecclesiastical focus on salvation meant that the quality of medicine declined in monastic settings, since the medical treatment of ailments was neglected or abolished in favor of spiritual healing. This led to an increase in the demand for secular healers, especially from the continental universities that would treat physical not spiritual ailments. The overall quality of medical care available in twelfth-century English monasteries and hospitals declined with the new Gregorian reforms, but the domestic medicine practiced throughout the country remained constant.

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[94] Jonsen, *A Short History of Medical Ethics*, 15.

[95] Ibid, 17.

This was because there was no way for the Church to impose sanctions against these practices within the community other than through Church regulation.[96] The local citizens would have relied more on the domestic traditions as monastic medicine decreased.

Improved medical training, provided by university trained physicians in the thirteenth-century, not only offered new versions of classical medicine, but it also created an environment where specialization made practitioners more adept at one or more forms of medicine.[97] Not only did this improve the quality of medical practice, but it also emphasized stronger medical ethics and standards. The change in monastic and secular medicine had a profound affect on the practice of medicine in monastic communities and throughout England. In order to understand how the practice of medicine changed during the latter half of the twelfth century and the early thirteenth century, the second chapter will discuss how the transition from monastic to secular medicine affected the quality and availability of medicine, as well as the institution of medical ethics and their effect on medical practice throughout England.

[96] Ibid.

[97] Ibid.

CHAPTER TWO:

THE DECLINE OF MONASTIC MEDICINE

During the latter half of the twelfth century, the Church convened a series of Lateran Councils during the Gregorian reformation.[1] The canons issued by these councils took effect slowly in England, since the English clergy was not controlled by canon law like the continental clergy, due to the increase in the number of Saxon initiates among the monastic ranks.[2] This led to a gradual transition, rather than an immediate shift, from monastic to secular medicine that was further prompted by the rise in university medicine. In order to understand how medicine changed during the late twelfth and the early thirteenth centuries, this chapter will discuss the Lateran Councils and the decline of monastic medicine, the rise of secular medicine, the reinforcement of its medical hierarchy, and how all these changes affected the quality and availability of medicine and medical education. It will also address the re-establishment of medical ethics and their effect on medical practice throughout England, especially within the monastic communities.

The Lateran Councils, convened by the Roman Catholic Church during the twelfth and thirteenth centuries, initiated a period of ecclesiastical reform that led to the decline of monastic medicine. During this period, the establishment of medical education and practice gradually shifted away from the monastic communities and their adjoined hospitals to secular practitioners and their hospitals.[3] The decline of English monastic medicine may have begun in 1123, when Pope Callixtus II convened the First Lateran

[1] Kealy, *Medieval Medicus,* 25.

[2] Ibid, 27.

[3] Knowles, *The Monastic Order in England*, 485.

Council in Rome and issued a series of canons that sought to reform the Church and its clergy.[4] This was the beginning of a period of Gregorian reform that continued up to 1215 with the Fourth Lateran Council.[5] Each council issued new reforms that either supported previously issued reforms or sought to institute new regulations regarding the management of the Church and the behavior of its clergy. The effect these councils had on medical practice and education within the monastic community was immense, though they did not take effect in England until the thirteenth century.[6]

In the First Lateran Council (1123), Pope Calixtus II issued only one canon that specifically targeted the practice of medicine by the clergy.[7] Listed as Canon seventeen, it formally announced that abbots and monks were forbidden "to impose public penances, to visit the sick, to administer extreme unction, and to sing public masses. The chrism, holy oil, consecration of altars, and ordination of clerics they shall obtain from the bishops in whose dioceses they reside."[8] This canon was the first attempt to separate the clergy from the practice of medical care, but with no secular alternative available other than domestic medicine, the local community continued to rely on the Church to provide medical education and care due to its accumulation of medical resources.[9] The Second Lateran Council (1139), convened by Pope Innocent II, also provided only a single canon regarding medicine. Listed as Canon nine, it declared that:

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[4] H. J. Schroeder, *Disciplinary Decrees of the General Councils: Text, Translation and Commentary*, (St. Louis: B. Herder, 1937), http://www.fordham.edu/halsall/basis/lateran1.html.

[5] Tanner, *Decrees of the Ecumenical Councils*, http://www.piar.hu/councils/ecum12.htm.

[6] Getz, *Medicine in the English Middle Ages*, 15.

[7] Schroeder, *Disciplinary Decrees of the General Councils: Text, Translation and Commentary*

[8] Ibid.

[9] Ibid.

> By apostolic authority that lawbreakers of this kind are to be severely punished. There are also those who, neglecting the care of souls, completely ignore their state in life, promise health in return for hateful money and make themselves healers of human bodies. And since an immodest eye manifests an immodest heart, religion ought to have nothing to do with those things of which virtue is ashamed to speak. Therefore, we forbid by apostolic authority this practice to continue, so that the monastic order and the order of canons may be preserved without stain in a state of life pleasing to God, in accord with their holy purpose. Furthermore, bishops, abbots and priors who consent to and fail to correct such an outrageous practice are to be deprived of their own honours and kept from the thresholds of the church.[10]

The behavior of these clergymen appeared to mimic that of tradespeople who worked for profit, which was quite common among the clergy as a whole.[11] The Church, in an attempt to control the behavior of its clergy, refused all clerical practitioners the right to earn profit for services rendered "so that the monastic order and the order of canons may be preserved without stain in a state of life pleasing to God, in accord with their holy purpose."[12] It was imperative to the Church that its clergy maintain a lifestyle in accordance with Church doctrine. Otherwise, the Church would lose its authority over its ranks and anyone could challenge its religious doctrine.

While the Third Lateran Council (1179) did not mention any specific canon regarding medicine, it did attempt to reinforce the behavioral standards of the clergy and Jews. New regulations over medical practice did not appear until the Fourth Lateran Council convened in 1215. This council mentions two canons in regard to medical practice. Canon eighteen regulated the behavior of the clergy by demanding that no "subdeacon, deacon or priest practice the art of surgery, which involves cauterizing and

[10] Tanner, *Decrees of the Ecumenical Councils*.

[11] Kealy, *Medieval Medicus,* 27.

[12] Tanner, *Decrees of the Ecumenical Councils*.

making incisions" since this act involved the shedding of blood. Canon twenty-two, alternatively, attempts to regulate the behavior of physicians of the body by demanding that "when they are called to the sick, to warn and persuade them first of all to call in physicians of the soul."[13] According to historian Raymonde Foreville, the first two Lateran councils sought to enforce ecclesiastical legislation; however, they were fragmented and undeveloped. The disorganized structure of Church legislation did not begin to solidify until the schism in the Church had ended and Innocent III devoted his attention to the Fourth Lateran Council (1215) and his ambitions for a new crusade.[14] Other than trying to control the behavior of clerical and secular practitioners, the Lateran Councils sought to bring about the gradual reform of the Church in several areas, including its role in medical practice. These reforms, which brought about the decline of monastic medicine, will be further explored by observing where monastic medicine was taught and practiced, who the practitioners were, how available it was, and how these reforms altered the practice of medicine in England during the twelfth and thirteenth centuries.

In twelfth-century England, monasteries and their adjoined hospitals were the main source of medicine and medical education.[15] These monasteries only supplied a small number of available medical clerics since only a small number of monastic hospitals actually provided medical care.[16] It was not until the thirteenth century that the number of medical practitioners began to increase, as university-trained physicians

[13] Tanner, *Decrees of the Ecumenical Councils*.

[14] John W. Baldwin, " Review of *Latran I, II, III et Latran IV,"* by Raymonde Foreville, *Speculum*, vol. 43, no. 4 (Oct., 1968), 713.

[15] Knowles, *The Monastic Order in England*, 485.

[16] Carlin, "Medieval English Hospitals," 24.

became more numerous. As a profession, medical care in the twelfth century was still very domestic and monastic in practice and was not yet as profitable a profession as it became in the thirteenth century.[17] As cities and towns grew, public need for medical care also increased.[18] With the renewed interest in monasticism and a growing population, the Church and its clergy would have realized that the need for spiritual and physical healing had grown and that it was their holy duty to aid those who were sick.[19] However, even though the social interest in monasticism was on the rise, that did not mean that medieval society as a whole was "Christian." In fact, according to historian Jon Van Engen, medieval culture only possessed a minute clerical elite that was significantly outnumbered by the lay population, which lived in a culture dominated by folk traditions. Anglo Saxon magical traditions, not Christian faith, would have influenced the religious and social context of medieval English society's practices and attitudes.[20] The growing need for monastic medicine as well as the pervasive secular practices of a partially, or at least superficially, Christianized society in the twelfth century, minimized the effect that the First and Second Lateran Councils had on medical practice in England.[21]

It seems that regardless of how hard the Roman Catholic Church worked to preserve a universal vision of Christianity in medieval society, the defiance of the local community, its kings, and local magnates always overpowered the Church's authority in

[17] Siraisi, *Medieval and Early Renaissance Medicine*, 21.

[18] Kealy, *Medieval Medicus,* 26.

[19] Walsh, *Medieval Medicine*, 24.

[20] John Van Engen, "The Christian Middle Ages as an Historiographical Problem," *The American Historial Review*, vol. 91, no. 3 (1986), 519.

[21] Siraisi, *Medieval and Early Renaissance Medicine*, 11.

England. According to Knowles, the English neglected the implementation of the decrees of the Lateran Councils because the great monasteries and monastic hospitals in England were the only places where collections of medical texts, medical traditions, and physicians were accessible in the same place.[22] This means that the availability of medical care in English monasteries and their hospitals, at the beginning of the twelfth century, would have increased as more monks and secular clerics became trained physicians. Many secular clerics became prosperous, particularly the hermits and anchorites, and used their new found wealth to improve the medical conditions in their local communities.[23]

The solitary hermits and anchorites in the secular community won social acceptance as they brought new prosperity to the monastic communities of England, but the informality of many of these secular clerics, particularly those who married, continued to make the church reformers nervous about this kind of ministry. By the late twelfth century, the reformers of the church sought to regulate the prosperity and behavior of these secular clerics through the application of the *Third Lateran Council* of 1179. In Canon ten of the *Third Lateran Council*, clerics who possessed money were removed from their office and all clerics were expected to remain within their monastic communities or with other brethren rather than to separate from the church. Canon eleven also denied the rite of marriage to clerics and demanded that male and female clerics live separately.[24] This was done so that the Church could maintain control over the religious

[22] Lawrence Conrad, Micheal Neve, Vivian Nutton, Roy Porter and Andrew Wear, *The Western Medical Tradition: 800 B. C. to 1800 A. D.* (Cambridge: Cambridge University Press, 1995), 146.

[23] Kealy, *Medieval Medicus,* 27.

[24] Ibid.

behavior of its secular clerics and enforce the long standing edict of celibacy.[25] These ecclesiastical regulations also reduced the authority of the secular clerics by denying them the local alliances they made through marriage and economic wealth, which they needed to financially support a large number of the monastic hospitals. The withdrawal of financial support for monastic hospitals was accompanied by a reduction of social services that were once provided by the secular clerics.[26] This suggests that monasteries and monastic hospitals would have been less able to accommodate the poor, the lepers, travelers, wayfarers, and the sick had it not been for the support of Henry I (1100 to 1135) and his successor Stephen I (1135 to 1154).[27]

While the availability of physical monastic medicine was being reduced by the Gregorian reforms, the types of medicine commonly used had not changed and were still heavily influenced by Anglo-Saxon practices. With the rise of university medicine and a newly reinforced medical hierarchy, domestic medicine and its practitioners became more marginalized. The various procedures found in Anglo-Saxon traditions, mentioned in the first chapter, were generally applied as a form of domestic medicine that was practiced throughout the secular community by everyone. It was only when medical expertise was needed that people went to specialists who generally existed in every community.[28] These secular practitioners each had a certain specialty, with the level of expertise originating with people who knew herbal remedies to university-trained

[25] Tanner, *Decrees of the Ecumenical Councils.*

[26] Kealy, *Medieval Medicus,* 28.

[27] Ibid, 17

[28] Lindberg, *The Beginnings of Western Science*, 325.

physicians.[29] From the early Middle Ages until the twelfth century, anyone who had special knowledge about any kind of medicine was considered a medical practitioner whether they were rich, poor, educated or not.[30]

During the twelfth century, many of the clerical practitioners relied on a combination of ecclesiastical and secular medical practices that treated both the body and the soul, since the salvation of souls was a part of clerical duty. According to Faye Getz, clerical practitioners in the twelfth century often behaved like medical tradespeople who could perform medical services and receive payment or gifts for the services they provided.[31] The church later prohibited the clergy from receiving payment for medical services with the institution of the *Third Lateran Council* in 1179. This regulation was important because a large number of the secular clerics were becoming sufficiently affluent, working independently of the church by providing the community and its hospitals with social services and funding with money they had acquired through their medical practices.[32] This in no way challenged the role of the clerical practitioner, later defined by the first four Lateran councils, which had almost always been upheld by the belief that healing was a charitable duty that should not be performed for economic gain.[33] In England, however, this standard had become lax throughout the Middle Ages and clerical practitioners of the twelfth century not only received payment like secular tradespeople, but they also applied similar medical practices. These secular practices

[29] Ibid, 327.

[30] Getz, *Medicine in the English Middle Ages*, 5.

[31] Ibid, 6.

[32] Tanner, *Decrees of the Ecumenical Councils.*

[33] Getz, *Medicine in the English Middle Ages*, 7.

included some of the classical treatments of the Greeks and Romans, as well as the local Anglo-Saxon traditions. By the latter half of the twelfth century, the regulations of the Lateran Councils began to affect the role of the clerical practitioner. Clerical practitioners were no longer the main source of medical care; instead they were relegated to the role of spiritual healer.[34] Early in the thirteenth century, Innocent III summoned the *Fourth Lateran Council*, which not only advised that monasteries and their hospitals call on "physicians of the soul" before they received treatment of the body, but it also encouraged the public to receive spiritual healing before receiving physical healing.[35] This reduced the effectiveness of treating wounds or other immediate medical conditions, but did not interfere with the healing of other minor ailments.

While ecclesiastical medicine continued to become less manually oriented in its medical treatment, the growing universities and trade guilds were producing larger numbers of secular practitioners. According to the lists of medical practitioners mentioned by Talbot and Hammond, the total number of medical practitioners increased from 117 in the twelfth century to 310 in the thirteenth century. The doubling of the number of medical practitioners was in part due to the development of scholarship at the university in Salerno. Out of the 310 medical practitioners listed in thirteenth-century England, only eighteen were monks, seventeen of whom were also trained physicians. This number appears to be consistent with the seventeen available clerical practitioners in the twelfth century although the number of trained clerical physicians did increase from fifteen in the twelfth century to seventeen in the thirteenth century. These statistics show

[34] Ibid, 6.

[35] Tanner, *Decrees of the Ecumenical Councils.*

that monastic medical training reached a plateau while secular medical training increased. In fact, as secular practitioners became more numerous, so did the number of practitioners from marginalized groups, including Jews and women. The number of Jewish practitioners more than quadrupled in the thirteenth century from two to twelve practitioners, while the number of known female practitioners increased from zero to three by the thirteenth century. Each Jewish practitioner was a trained physician, while the women were mentioned as either a *medica*, a *sage femme* or *La Leche*, or as *la surgiene*.[36]

The rising numbers of Jewish physicians in the thirteenth century were exceptions, since most physicians in England were in religious orders until the fifteenth century.[37] Both the Third and the Fourth Lateran Councils did attempt to limit the social movement and significance of the Jews, who were a marginal group within the larger secular medical community.[38] These regulations appear in Canon twenty-six and Canons sixty-seven through seventy of the Fourth Lateran Council, though they mostly address the position of Jews in public office, the practice of their old rites, and the style of dress required as a way to distinguish them socially from Christians. The Church did attempt to restrict Jews from becoming physicians with these canons, but this was never really put into practice since the number of Jewish doctors in England continued to increase. In fact, Jews who were barred from universities were still able to get their license from civil authorities like other secular practitioners. They also provided cheaper services since they

[36] Hammond and Talbot, *The Medical Practitioners in Medieval England*, *passim.*

[37] Philip Stell, *Medical Practice in Medieval York* (York: Borthwick Institute of Historical Research at the University of York, 1996), 5-6.

[38] Tanner, *Decrees of the Ecumenical Councils.*

were considered a marginal group and many popes and bishops were known to employ their services.[39] As secular medicine advanced, the Jewish physician became less regulated by the Church, liberating them socially. The new avenue of social advancement the Jews found in the field of medicine may be why the Church attempted to regulate their social status and movement. This only reflected the larger ambition of the Church as it attempted to maintain control not only over its own clergy, but over all other medical practitioners, including women and Jews.[40]

Women, as a marginalized group amid the medical hierarchy, remain mostly undocumented, though it is understood that a large portion of the informal secular practitioners in twelfth-century England were female healers who were unable to receive a medical education in either monasteries or universities.[41] In fact, these female healers became the primary caretakers of the impoverished who were unable to afford the services of the educated physicians or were unable to gain access to what little medical care was provided by the local monastic community.[42] Like the Jews during the twelfth-century Gregorian reforms, women would have held only a marginal position in the field of medicine since they also represented a group that the Church, the universities, and the trade guilds sought to regulate; however, since these reforms did not take hold until the thirteenth century, women continued to be the main providers of domestic medicine

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[39] Conrad *et al.*, *The Western Medical Tradition,* 147.

[40] Siraisi, *Medieval and Early Renaissance Medicine*, 27.

[41] Nancy P. Nenno, "Between Magic and Medicine: Medieval Images of the Woman Healer", *Women Healers and Physicians: Climbing a Long Hill* edited by Lilian R. Furst (Lexington: University Press of Kentucky, 1997), 45.

[42] Green, "Women's Medical Practice and Health Care in Medieval Europe", 434.

throughout England.[43] Along with the rising number of Jewish and female practitioners, the number of other secular practitioners also continued to grow into the thirteenth century. These practitioners were mostly medical graduates from continental universities, since English universities did not appear until the thirteenth century.[44]

The majority of the medical graduates in the late twelfth and thirteenth centuries were educated according to the teachings of Salerno, a university located in Italy, which was designed as a five year study of medicine that focused on the classical works of Hippocrates and Galen, along with coursework in the humanities and a year of supervised medical practice before licensure could be issued.[45] The average student studied from six to eight years before obtaining a medical degree. This training reinforced the classical ethical standards of Hippocrates in medical practice, along with intensive medical training, which improved the quality of medicine that was provided by university trained physicians. These physicians became professionalized and the practice of secular medicine formed a hierarchy of medical practitioners including the *medicus*, the leech, the clerk, the surgeon, the apothecary, the barber, and the physician.[46]

At all levels of the medical hierarchy, secular practitioners were knowledgeable or trained in some form of medicine; many were also educated in monasteries, trade guilds, or through apprenticeships, but only the physicians were university-educated.[47] The increase in the number of university educated physicians also led to an increase in

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[43] Nenno, "Between Magic and Medicine: Medieval Images of the Woman Healer", 46.

[44] Getz, *Medicine in the English Middle Ages*, 17.

[45] Jonsen, *A Short History of Medical Ethics*, 24.

[46] Grant, *The Foundations of Modern Science in the Middle Ages*, 48.

[47] Getz, *Medicine in the English Middle Ages*, 27.

medical standards which reinforced the hierarchy of secular practitioners that began to appear around the tenth century by assigning status to the various levels of medical expertise.[48] For instance, the physical treatment of patients, such as surgery, was considered beneath the status of a physician, which left a void that led to the emergence of surgeons. This means that physicians only treated the external body or disease and other ailments, while the surgeon performed more gruesome surgical procedures. In this way, physicians behaved very much like clerical practitioners, since abstaining from manual medical practice was a way to preserve the dignity of the wealthy. This form of manual medicine was also eventually considered a lower form of medical practice.[49]

The establishment of trade guilds followed the hierarchical development in medicine. Physicians used these new guilds to establish standards of medical practice and ethics that defined status rather than medical quality. These standards attempted to establish control over the status of other developing medical trades, which created a power struggle that led to status confusion within the medical profession as a whole.[50] During this period of disorder amid the social hierarchy, the number of physicians increased from the eleventh century which helped pave the way for future universities in England, since these physicians were housed in the wealthier monasteries, which were the precursors to the university as a place of medical education.[51] While the new medical

[48] Vern L. Bullough, "Education and Professionalization: An Historical Example", *History of Education Quarterly*, vol. 10, no. 2 (1970), 162.

[49] Ibid.

[50] Vern L. Bullough, "Status and Medieval Medicine", *Journal of Health and Human Behavior*, vol. 2, no. 3 (1961), 207.

[51] Rubin, *Medieval English Medicine*, 180.

standards took hold on the Continent, England progressed much more slowly, since it did not acquire its own universities until the thirteenth century.[52]

The quality of monastic and secular medicine did not change dramatically as twelfth-century monastic medicine declined and secular medicine advanced. It was only the venues for treatment, the availability of treatment to the public, and the standards of medical ethics and practice that changed over the course of these two centuries. The decline in monastic medicine only reduced the availability of medicine in monasteries and their hospitals. This change did not take away from the public's ability to receive medical treatment; it merely increased the demand for secular medicine and practitioners. This made medicine more widely available to the public, and with the increase in availability came the increase in standards and ethical practice. At the same time, the number of hospitals continued to increase throughout England and by the end of the thirteenth century over five hundred had been built.[53] This was largely due to the generous support of King Henry I and his successor Stephen.[54] Religious healing took precedent over physical treatments, which placed the health of patients who needed more immediate medical attention at risk, and ethical standards were established by the universities according to the classical teaching of Hippocrates and Galen.[55] This did not necessarily mean that the medicine applied to the patient was effective or better in quality, but it did mean that more attention was being given to the standards of medical

[52] Getz, *Medicine in the English Middle Ages*, 15.

[53] Prescott, *The English Medieval Hospital, 1050-1640*, 1.

[54] Kealy, *Medieval Medicus*, 17.

[55] Jonsen, *A Short History of Medical Ethics*, 17.

care, such as the development of clinical medical treatment according to specified procedures.

Secular herbal remedies and charms had been applied for centuries with some measure of effectiveness and may have been a more effective treatment than that provided by the Church and the university trained physician.[56] This means that the poor could have received better, if not the same quality of medical treatment, as the wealthy since the preparation of remedies, charms, and surgical procedures were practiced predominantly by the lower ranks of practitioners. The transition from monastic medicine to secular medicine did not greatly affect the quality of medical remedies and charms in twelfth-century England. Instead, it was the quality of medical treatment that suffered due to the emphasis of spiritual healing over physical treatment. Not only did the practice of monastic medicine in the twelfth century change from physical to spiritual, it continued to retain a strong level of influence over the growing secular medical profession and its practice into the thirteenth century.[57]

[56] Braekman, *Studies on Alchemy, Diet, Medecine and Prognostication in Middle English*, 113.

[57] Jonsen, *A Short History of Medical Ethics*, 17.

CHAPTER THREE:

THIRTEENTH-CENTURY MEDICINE

By the beginning of the thirteenth century, the availability of medical care in English monasteries and their monastic hospitals had decreased. The location of medical education for clerical practitioners remained primarily in monasteries, but some were educated alongside secular practitioners in the continental universities. For secular medical practitioners who were not educated in universities, medical education of some form was acquired through local training, apprenticeships, or family traditions. The majority of university-trained physicians were of the elite, some of whom were clerical officials, while other secular practitioners were generally from the lower classes.[1] In thirteenth-century England, however, none of the physicians received medical degrees from Oxford or Cambridge since these universities had just been established. Physicians did not graduate from these English universities until the fourteenth century.[2] Instead, they journeyed abroad to attend the continental universities in France and Italy.[3] To understand how English medicine was learned and practiced in the monastic and secular communities during the thirteenth century, this chapter will evaluate the medical education received by the clergy and the secular community, the availability of medicine, the value of texts in medical education and ethical practice, the affect these texts had on all medical practitioners, status of women in the medical field, and how all these elements influenced the quality of medicine.

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[1] Getz, *Medicine in the English Middle Ages*, 15.

[2] Vern L. Bullough, "Medical Study at Medieval Oxford," *Speculum*, vol. 6, no. 4 (1961), 603.

[3] Getz, *Medicine in the English Middle Ages*, 17.

At the end of the twelfth century, the monasteries and monastic hospitals of England were under a series of Gregorian reforms that appeared in the form of the first three Lateran Councils.[4] These reforms were designed to eliminate any secular practices that had been adopted by clerical officials, including clerical medical practitioners, and were meant to reinforce the authority the Church had over its clergy.[5] As established in Chapter One, these reforms did not take hold in England, because the population growth of the twelfth century led to an increase in demand for monastic and secular medicine in a partially-Christianized society. The defiance of the community, its kings, and magnates overruled the authority of the Church and its reforms throughout the English monastic communities, which continued to practice both monastic and secular medicine.[6] It was not until the end of the twelfth century that these reforms began to take hold. Once enforced, these reforms then sought to reduce the influence of classical and Anglo-Saxon practices in monastic medicine by reinforcing the importance of spiritual healing over physical treatment.[7]

In the thirteenth century, many members of the clergy received their medical education inside the monastery or from continental universities.[8] They may have also begun to receive some kind of training from the newly established English universities, such as Oxford, since according to Vern Bullough there is enough evidence available to

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[4] Rubin, *Medieval English Medicine*, 110.

[5] Ellen Berry Pride, "Ecclesiastical Legislation on Education, A. D. 300-1200," *Church History*, vol. 12, no. 4. (1943), 250.

[6] Siraisi, *Medieval and Early Renaissance Medicine*, 11.

[7] Jonsen, *A Short History of Medical Ethics*, 17.

[8] Rubin, *Medieval English Medicine*, 180.

indicate that some form of medical education was being offered.[9] This in no way undermined the practice of St. Benedict's Rule in the English monasteries.[10] In fact, St. Benedict's Rule continued to govern medical treatment for patients in the monasteries and some of their hospitals, though the hospitals remained primarily secular establishments.[11] From the eleventh to the end of the fourteenth centuries, monasteries also trained their own physicians who provided aid to the lay community. Monasteries continued to offer physical medical care in their infirmaries and in a few of their hospitals during the twelfth and thirteenth centuries, as the number of secular physicians began to increase. These secular physicians were also affiliated, at one time or another, with a religious order.[12]

At the same time, most of the hospitals and schools fell under secular control.[13] This was due to the decline in monastic financial support and the increase in funding from the monarchy during the twelfth century.[14] While monasteries began to lose their financial hold over hospitals, many were still able to compensate for the cost of medical services with incomes from rent and donations from people who wanted to insure that they received admission to the monastic infirmaries once they reached old age. Monasteries also received funds from pilgrims and penitents and were also able to give

[9] Bullough, "Medical Study at Medieval Oxford," 601.

[10] Knowles, *The Monastic Order in England*, 518.

[11] Prescott, *The English Medieval Hospital, 1050-1640*, 1.

[12] Rubin, *Medieval English Medicine*, 180.

[13] Ibid.

[14] Kealy, *Medieval Medicus*, 17.

food from their lands to their patients.[15] This means that even though medical education and practice gradually became dominated by the secular community by the thirteenth century, the monasteries still offered physical medical care to some of the public, not just to those housed by the monasteries.[16]

In order to maintain control over the clerical practitioners, the Church established the *Fourth Lateran Council* in 1215, of which Canon twenty-two states that since sin is the cause of all illness, the physicians of the body should call the physicians of the soul for healing so that spiritual health is restored to the patient and the cause of the illness is no longer present. Once this is done, the physician of the body can then administer treatment to the patient. Canons fifty and fifty-one reinforce the earlier edicts of celibacy, which appeared in the Second and Third Lateran Councils, that forbid the clergy to marry or have mistresses. Canon fifty-three demands that the clergy refrain from receiving payment for their services since it is "cheating the church of the tithes."[17] These Canons were generally directed at the clerical practitioners during the twelfth and thirteenth centuries, and with the increase in secular practitioners many monasteries and their hospitals would hire secular physicians and practitioners. This was because secular physicians could provide educational expertise while the other secular practitioners performed the physical treatment of patients, leaving the spiritual healing to the clergy.[18]

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[15] Rubin, *Medieval English Medicine*, 180-181.

[16] Ibid.

[17] H. J. Schroeder, "Twelfth Ecumenical Council: Lateran IV 1215," *Disciplinary Decrees of the General Councils: Text, Translation and Commentary* (Internet Medieval Sourcebook: Fordham University Center for Medieval Studies, 1996). http://www.fordham.edu/halsall/basis/lateran4.html.

[18] Rubin, *Medieval English Medicine*, 183.

The secular physicians of the thirteenth century began to replace the preceding generation of physicians, who were mostly trained in herblore, remedies, charms, magic, and faith healing. They were more formally trained and to an extent still applied the classical and Anglo-Saxon traditions in their practice of medicine, although the developing scientific trends in medicine eventually led them to take a more clinical, and less magical, approach to practicing medicine. The development of clinical medicine in the thirteenth century was mostly due to the growing number and influence of universities that offered medical degrees. This new approach to medical practice focused on examining the patient in a somewhat systematic manner that became the standard for all thirteenth and fourteenth-century physicians. The clinical practice of medicine taught physicians to study the symptoms and to then prescribe the most effective treatment for the condition. This approach to medical treatment was also encouraged by the increased number of translated classical Greek texts from Arabic to Latin.[19]

The classical texts that were once again made available in the thirteenth century dramatically altered medical ideas and techniques. While some of these texts were available by the end of the twelfth century, it was not until the thirteenth century that the complexity of ideas in these works were absorbed into university medical education and practice. Most of these texts were Arabic translations of classical works, but there were also several texts that had been written by medieval Arab scholars.[20] The majority of the

[19] Rubin, *Medieval English Medicine*, 189.

[20] Siraisi, *Medieval and Early Renaissance Medicine*, 15.

new translations were of both scientific and philosophical works, but those that were translated were usually picked at random.[21]

One of the prominent translators of these new works was Gerard of Cremona, who by 1187 had translated a large number of the medical treatises that became the core of thirteenth-century medical education.[22] These texts include several previously unknown works by Galen, the *Canon of Medicine* by Avicenna, and the *Liber Continens* by Rhazes. All of these works were of pagan origin, so it makes sense that the Church targeted these new concepts. According to Grant, many of the new Latin translations from the Greco-Arabic texts caused friction between the standard concepts of reason and faith; however, Christian authorities appeared to openly accept rather than attack these new ideas.[23]

In twelfth-century England, the influence of the classical authors on medical ethics and practice had been reduced, since the application of monastic and secular medicine was influenced less by natural philosophy and more by the practical application of Anglo-Saxon remedies and the monastic regulations on lifestyle and diet.[24] The Christian acceptance of the new classical concepts, along with the rising number of universities in the thirteenth century, began to change the practice of medicine in England, especially in the secular community.[25] A dichotomy between rational and irrational medicine already existed in England, since the majority of the country,

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[21] Grant, *The Foundations of Modern Science in the Middle Ages*, 24.

[22] Ibid.

[23] Ibid, 25.

[24] Lindberg, *The Beginnings of Western Science*, 320.

[25] Getz, *Medicine in the English Middle Ages*, 17.

including the monasteries, practiced a form of supernaturalist medicine through the thirteenth century. The naturalist or rational beliefs supported by classical authors demanded that only natural causes created illness. This belief contradicted sharply with the supernaturalist belief that the forces of God, or simply, good and evil were at work.[26] The separation between these two practices existed throughout the early Middle Ages, but with the rise of classical education in medieval universities, these two systems were gradually integrated in theory and practice.[27] In fact, Joseph Ziegler argues that the monastic and academic forms of medieval medicine were not truly separate in practice as they are often described in historical accounts.[28] Overlapping traditions were common in thirteenth-century England, especially since the Church was unable to completely separate the pagan practices from Christian traditions.[29] With the development of the new clinical medicine in universities that implemented the teachings of classical authors in a non-empirical manner, religious orders felt comfortable with the new approach to medical practice.[30] This would explain why Christian authorities were so accepting of new pagan concepts during a period of Gregorian reform.

Most of the standard classical concepts taught by medical programs supported Aristotle's definition of man as composed of a body and a soul.[31] This supported the necessity of medicine in theological settings where members of religious orders suffered

[26] Lindberg, *The Beginnings of Western Science*, 320.

[27] Joseph Ziegler and Peter Biller, *Religion and Medicine in the Middle Ages* (York: The University of York, 2001), 4.

[28] Ibid.

[29] Braekman, *Studies on Alchemy, Diet, Medecine and Prognostication in Middle English*, 124.

[30] Ziegler and Biller, *Religion and Medicine in the Middle Ages*, 5.

[31] Ibid.

from mental disorders brought on by excessive thinking. This accorded with the belief that it was then natural for the body to become sick if the soul was ill or disturbed, so of course the soul would also become unwell if the body was ailing or wounded.[32] This made the practice, or at least the study, of medicine crucial to the clergy, reinforcing the practice of academic medicine as a prerequisite for theological contemplation. The new concepts of medicine and philosophy in the thirteenth century became more like a form of esoteric knowledge that was only available to a select few among the elite, especially since Aristotle argued that the layman could never attain this information on his own. This aligned the possession of a medical degree with a higher social status, thus reinforcing the class-oriented hierarchy of medical practitioners established in thirteenth-century England.[33]

The special access granted to medical students to study these new concepts also led to some disagreement over certain texts that were incompatible with religious beliefs and practices in both continental Europe and England during the thirteenth century. Scholars chose to either ignore, censure, or ban texts that contradicted standard religious concepts. If this approach was not acceptable to the rest of the academic community, then the text was altered to make it more suitable for use. The alteration of texts also led to other problems for medical students who had to learn to conceal, avoid, or reject certain opinions that were taboo in thirteenth-century medical scholarship. For instance, some scholars had to reconcile the two disparate beliefs of God, having absolute power

[32] Ziegler and Biller, *Religion and Medicine in the Middle Ages*, 6.

[33] Ibid, 7.

with the idea that nothing, not even God, could prevent death.[34] Another example of these religious and textual tensions, mentioned by Ziegler, appeared when medieval scholars tried to justify Galen's discussion of the soul. Galen's atheistic beliefs were ignored by thirteenth-century scholars and his works were continuously depaganized to make them suitable for Christian use.[35] The works of Hippocrates were also depaganized, especially the Hippocratic Oath.[36] According to Nutton, Christian scholars depaganized this Oath by combining sentences in the oath with Christian doctrine that emphasized love and charity. The words were then written in the form of the cross, though these changes were less commonly practiced.[37] Most scholars simply removed any offending words by replacing them with neutral equivalents. Once the texts were thoroughly edited, universities used them to train medical students.[38] These teachings of Galen and Hippocrates, among many others, were influential in the development of the medical profession and many individuals from the continent and England came to study them.

In fact, all of England's physicians in the twelfth and thirteenth centuries came from universities abroad. Several of them were from other countries, while many were natives of England.[39] According to the statistics extracted from the lists provided by Hammond and Talbot mentioned previously in Chapter One, the number of medical practitioners in England had nearly tripled from 117 in the twelfth century to 310 in the

[34] Ziegler and Biller, *Religion and Medicine in the Middle Ages*, 9.

[35] Ibid, 10.

[36] Vivian Nutton, "God, Galen, and the Depaganization of Ancient Medicine", *Religion and Medicine in the Middle Ages*, edited by Joseph Ziegler and Peter Biller (York: The University of York, 2001), 26-27.

[37] Ibid, 26.

[38] Ibid, 27.

[39] Ziegler and Biller, *Religion and Medicine in the Middle Ages*, 6.

thirteenth century. Out of the 310 medical practitioners listed, eighteen were monks and of these monks, seventeen were also trained physicians. The same number of clerical physicians was also available in the twelfth century, so even though academic scholarship in the universities was becoming more compatible with religious theology, monasteries in England appeared to prefer to train their own physicians.[40] The medieval university was strongly tied to monasteries where medical education had existed for centuries. The monasteries would have had the same access to manuscripts that the universities did; it was simply their employment of this knowledge that differed.[41] Many of the elite clergymen also received medical training at universities and these men then taught other clergymen, exposing them to a university education.[42] Hence, the quality of medical treatment offered by clerical practitioners would have been similar or even equal to that of the university-trained physician.

While the quality of medicine in English monasteries and their hospitals improved throughout the thirteenth century, it continued to be less available to the general public.[43] This means that the only people who received medical care from the monasteries were members of the religious orders, the few individuals housed by the monastery, occasional members of the elite, and a small number of the impoverished.[44] In the thirteenth century, domestic medicine was still very commonplace, since medical expertise was still a

[40] Hammond and Talbot, *The Medical Practitioners in Medieval England, passim.*

[41] Getz, *Medicine in the English Middle Ages,* 15.

[42] Ibid, 27.

[43] Ibid, 15.

[44] Prescott, *The English Medieval Hospital, 1050-1640,* 5.

developing field, and had found a place in the secular medical hierarchy.[45] These practitioners were the most accessible form of medical care, since folk medicine was existent in every home or at least in every town.[46] While the practice of domestic medicine was prohibited for the clergy, it was true that many of these folk practices were still used in monasteries, since each monastery housed leeches and other practitioners who were knowledgeable about herbs, Anglo-Saxon recipes, and charms.[47] A large portion of the secular practitioners in thirteenth-century England were women healers who were unable to receive a university education. Though the exact number of women healers is unknown due to a lack of documentation, it was understood that women worked as nurses, mid-wives, or simply as lay healers.[48]

These women healers became the primary caretakers of the impoverished who were unable to afford the services of the educated physicians. They practiced a form of empirical medicine which was based on the practical knowledge and application of plants and herbs.[49] In a way, this type of medicine was similar to the classical traditions taught in the universities. The difference between the two approaches was, however, quite prominent since the local healers had no way of understanding the chemistry that made their remedies effective, while classical medicine expanded on medical theory and philosophy that sought to intellectually establish order to the world by explaining how it worked. The important position these female healers held in thirteenth-century English

[45] Lindberg, *The Beginnings of Western Science*, 325.

[46] Jonsen, *A Short History of Medical Ethics*, 13.

[47] Rubin, *Medieval English Medicine*, 189.

[48] Nenno, "Between Magic and Medicine: Medieval Images of the Woman Healer", 45.

[49] Ibid, 46.

society led to academic and theological disputes over the role of women in medicine, the significance of their medical practice, and to what standards of practice these women and others like them should be held accountable.[50]

By the thirteenth century, the role of women in medicine began to change, though major changes in the status of women did not occur until the sixteenth and seventeenth centuries.[51] This change correlated with the increase in standardization and professionalization in the larger medical field. According to Nenno, most of the universities and monasteries felt ambivalent about women healers long before these changes began to occur. It was not until the thirteenth century that the social existence and practices of these women became more politicized. This change had a lot to do with how the practice of these healers was evaluated by other medical practitioners. Before the thirteenth century, the quality of medicine provided by women healers had been evaluated based on the overall intentions of the practitioner. With the new standards of the thirteenth century, these women were evaluated according to the source of their power, within a religious context, which led to further evaluation of the actual woman. These ambivalent perceptions of women healers caused successful treatments to bring the woman praise while failure brought her disdain and distrust, and possibly accusations of witchcraft.[52] The new way of appraising the practice of women healers also created friction within the religious community which began to associate the pagan practices of women healers with witchcraft.[53]

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[50] Ibid, 45.

[51] Ibid.

[52] Nenno, "Between Magic and Medicine: Medieval Images of the Woman Healer," 46.

[53] Ibid, 47.

The persecution of witches appears later during the age of inquisition from the fourteenth to the sixteenth centuries; however, in the thirteenth century, the associations between women healers and images of witchcraft were just beginning to take shape in the medical community.[54] The magical elements of folk craft did little to discourage the pagan affiliations of women healers which appeared even in the medical titles they were bestowed. Names like *saga*, wise woman, and *belladonna* were all derived from the Celtic fays of medieval literature and the dualistic qualities of these fays were then associated with women healers. The distinction between pagan and Christian associations become clearer in later centuries, but through the thirteenth century, the fields of magic, medicine, and science were deeply interwoven.[55] These pagan practices were later distinguished from monastic medicine by the fourteenth century, though they were still applied in the monastic infirmaries by secular practitioners.[56] The increasing antagonist views of women healers were also a reflection of the social and gender power struggles where women were barred from universities as medical schools sought to remove women from medical practice in general.[57] In fact, university physicians would adapt, rewrite, or add suggestions to their texts that depicted women healers, in a cultural context, as suspicious and marginal.[58]

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[54] Ibid, 47.

[55] Ibid, 46.

[56] Siraisi, *Medieval and Early Renaissance Medicine*, 11.

[57] Muriel Joy Hughs, *Women Healers in Medieval Life and Literature* (New York: Books For Libraries Press, 1968), 64.

[58] Nenno, "Between Magic and Medicine: Medieval Images of the Woman Healer", 47.

The disdainful attitude of the universities and monasteries towards women and many of the lay practitioners helped to reaffirm the growing medical hierarchy in thirteenth-century England.[59] The growing demand for formal medical instruction reduced the status of folk medicine, but it was never able to suppress it.[60] By the end of the thirteenth century, universities and their physicians claimed the right to evaluate and issue medical licenses to every valid medical practitioner. It was also during this time that several previous works by female medical authors began to gain attention in the medical community. For instance, Trotula of Salerno wrote a medical treatise *On the Diseases of Women Before, During, and After Childbirth* and other shorter works on cosmetics.[61] The work now titled with her own name, called *The Trotula: An English Translation of the Medieval Compendium of Women's Medicine,* is also among the documents she published.[62] Her work has been dated between the eleventh and thirteenth centuries, so women by the thirteenth century in England would have heard of these texts from local physicians.[63]

Hildegard of Bingen, a twelfth-century Benedictine abbess from the Rhineland, was also a familiar female author to university trained physicians and many women healers in England. Her works, both medical and religious, was produced during the late twelfth century, so by the thirteenth century knowledge of her work would have spread to

[59] Hughs, *Women Healers in Medieval Life and Literature,* 64.

[60] David Herlihy, *Opera Muliebria: Women and Work in Medieval Europe* (Philadelphia: Temple University Press, 1990), 103.

[61] Ibid, 104.

[62] Green, *The Trotula*.

[63] Herlihy, *Opera Muliebria*, 105.

England and throughout the universities.[64] Several of her medical works include her treatise on medicine[65], the *Physica*[66], *Scivias,* and *Causae et Curae*. Many of her medical and physiological works also influenced her religious works, such as the *Liber divinorum operum simplicis hominis*.[67] While her religious works gained her the most fame, her medical works were acknowledged for their quality and expertise.[68] Her work revealed a thorough understanding of folk traditions and would become an important resource in many of the English monasteries and hospitals.[69]

Medical texts, like the works of Hildegard of Bingen or the works of classical authors, in the thirteenth and early fourteenth centuries had a profound impact on medical education and practice through the new concepts they contained.[70] The political reforms of the Church and the professionalizing standards of the medical establishment led to the marginalization of certain ideas and groups, such Jews and women, while reinforcing the medical hierarchy established by the elite and their supportive reforms regarding textual information, concepts, and the overall social behavior of the clergy and secular medical practitioners.[71] The marginalization of these groups and ideas had a large affect on the

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[64] Ibid, 107.

[65] Dr. Wighard Strehlow and Gottfried Herzka, M.D., *Hildegard of Bingen's Medicine* (Santa Fe: Bear and Company, 1988).

[66] Priscilla Throop, *Hildegard von Bingen's Physica: The Complete English Translation of Her Classic Work on Health and Healing* (Rochester: Healing Arts Press, 1998).

[67] Ibid, 2.

[68] Hughs, *Women Healers in Medieval Life and Literature*, 121.

[69] Herlihy, *Opera Muliebria*, 107.

[70] Siraisi, *Medieval and Early Renaissance Medicine*, 14

[71] Vern L. Bullough, "Education and Professionalization: An Historical Example," 162.

quality of thirteenth and early fourteenth-century medicine. Such groups were limited in their ability to rise within the medical hierarchy so their exposure to medical education was limited.

Medical education in the thirteenth century was predominantly available in four places: the monasteries, which had the same access to manuscripts that the universities did, the universities, civil authorities, and trade guilds.[72] The difference in medical practice in each of these locations was entirely based on their employment of medical knowledge.[73] Most female and Jewish practitioners were excluded from these educational channels, though women did find a nitch working for the monasteries and were able to acquire licenses as nurses, while Jews were able to receive licenses from the civil authorities and occasionally a university.[74] The majority of university trained physicians were of the elite, some of whom were clerical officials, while other secular practitioners were generally from the lower classes.[75] Many of the elite clergymen received medical training at universities. These men would then teach other clergymen, exposing them to a university education.[76] This means that the quality of medical treatment offered by clerical practitioners would have been similar or even equal to that of the university trained physician.

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[72] Getz, *Medicine in the English Middle Ages*, 19.

[73] Ibid.

[74] Conrad, *et al., The Western Medical Tradition,* 147.

[75] Bullough, "Status and Medieval Medicine", 206.

[76] Getz, *Medicine in the English Middle Ages*, 27.

The quality of medicine offered by clerical and secular physicians may have been similar, but domestic medicine was still very commonplace.[77] The developing social and religious reforms could not completely abolish domestic medicine, because separating the traditions was impossible, and these secular practitioners continued to be the most accessible form of medical care into the fourteenth century, since folk medicine was existent in every home or at least in every town.[78] While practice of domestic medicine was prohibited for the clergy, it was true that many of these folk practices were still used in monasteries, since each monastery housed leeches and other practitioners who were knowledgeable about herbs, Anglo-Saxon recipes, and charms.[79] This means that the quality of medicine in the thirteenth century would have improved somewhat as medicine remained widely available while continuing to develop stricter ethical standards of practice, as well as, provide traditional Anglo-Saxon treatments that were continuously employed over centuries with some level of effectiveness or success.[80] In order to understand how the characteristics of medicine continued to change at the turn of the fourteenth century, the fourth chapter will focus on the inter-relations between the various medical traditions and how the transition from monastic to professionalized secular medicine, in the twelfth and thirteenth-centuries, affected the quality of practiced medicine in late-thirteenth and early fourteenth-century England when the Church reforms became completely established

[77] Lindberg, *The Beginnings of Western Science*, 325.

[78] Jonsen, *A Short History of Medical Ethics*, 13.

[79] Rubin, *Medieval English Medicine*, 110.

[80] Braekman, *Studies on Alchemy, Diet, Medecine and Prognostication in Middle English*, 113.

CHAPTER FOUR:

MEDICINE AFTER THE GREGORIAN REFORMS TO THE BLACK DEATH

The intent of this chapter is to observe the relations among the various medical traditions and how the transition from monastic to professionalized secular medicine, during the Gregorian reforms, affected practiced medicine in England through the Black Death of 1348. To address this issue, this chapter will evaluate the state of late thirteenth and early fourteenth-century medicine, who profited, what medical standards and ethics took priority within the monastic and secular communities, how medical treatment and its availability in hospitals throughout England changed by the thirteenth and fourteenth centuries, who the main practitioners in the hospitals were, and how all of these characteristics affected the quality of practiced medicine in late medieval England.

Prior to the arrival of the Black Death in 1348, the state of medical practice in England had become a developing profession; however, it cannot be assumed that financial gain was the primary force driving this trade at this time, since most practitioners did not become wealthy. Only a select number of privileged physicians and surgeons were able to secure noble patronage for their medical practice. Those who established noble patronage received payment in the form of annual salaries, land grants, sinecures, gifts, and access to other important patrons.[1] The financial prosperity of physicians and surgeons reinforced their high social status within the medical hierarchy that had begun to take shape during the Gregorian reforms as medicine became professionalized and secularized.[2] Surgeons, after this period of social and religious

[1] Siraisi, *Medieval and Early Renaissance Medicine*, 21.

[2] Nenno, "Between Magic and Medicine: Medieval Images of the Woman Healer", 46.

reform, had achieved a status nearly equal to and just as profitable as that of the university educated physician.[3]

The fourteenth century also saw a slight decrease in the number of clerical medical practitioners, since Talbot and Hammond only mention fifteen known clerical practitioners, of which ten were physicians, one was a medical advisor, and one was a student of medicine. Two were friars, but one was a combination of a friar, physician and surgeon.[4] Each field of medicine was slowly becoming more regulated by the universities and trade guilds in the thirteenth century and by the next century the establishment of medical ethics had become secure, enforcing the concept of self-regulation in an occupational group that reaffirmed the importance of general public welfare. These changes reinforced the status of the various levels of medical expertise, since other clerical and secular practitioners were required to justify the ethics of their own practices and were evaluated on the level of their expertise and ethical standards.[5] The new establishment of medical standards and ethics also improved the quality of available medicine in both the secular communities and the monasteries. The distinction between the various ethical traditions, including university standards, other secular traditions and the regulations of St. Benedict in the monasteries, appeared to be the most pronounced when divided within the medical hierarchy.

The number of medical practitioners available in fourteenth-century England also had an affect on the availability of medicine and the reinforcement of medical ethics and

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[3] Siraisi, *Medieval and Early Renaissance Medicine*, 21.

[4] Hammond and Talbot, *The Medical Practitioners in Medieval England*, *passim.*

[5] Vern L. Bullough, *Universities, Medicine and Science in the Medieval West* (Aldershot: Ashgate Publishing Ltd. and Variorum Collected Studies Series, 2004), 606.

standards. The medical hierarchy, at this time, placed physicians and surgeons at the top of the professional pyramid, followed by barber-surgeons, leeches, apothecaries, the general *medicus*, and other less recognized and educated secular practitioners.[6] Each of these various fields was dominated by men, except for the lower ranking secular healers and nurses who were generally women. According to the biographical lists of practitioners provided by Talbot and Hammond, the number of known physicians had increased from 310 practitioners available in the thirteenth century to 350 practitioners in the fourteenth century, only three of which were women. Out of the 310 medical practitioners listed in the thirteenth century, eighteen were monks and of these monks seventeen were also trained physicians. The same number of clerical physicians was also available in the twelfth century, so even though academic scholarship in the universities was becoming more compatible with religious theology, monasteries in England continued to prefer training their own physicians from the twelfth into the fourteenth centuries.[7] Many of these physicians worked within the monastic infirmaries and hospitals alongside physicians and other secular practitioners.[8]

By the end of the thirteenth century, according to Prescott, there were over 500 hospitals in England,[9] while Hughs argues that there were as many as 750 documented. The accuracy of these numbers is debatable, but it is true that the overall number of hospitals in thirteenth-century England had increased significantly since the twelfth

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[6] Siraisi, *Medieval and Early Renaissance Medicine*, 22.

[7] Hammond and Talbot, *The Medical Practitioners in Medieval England*, *passim*.

[8] Barbara Harvey, *Living and Dying in England, 1100-1540* (Oxford: Clarendon Press, 1995), 81-82.

[9] Prescott, *The English Medieval Hospital, 1050-1640*, 1.

century.[10] These hospitals were mainly secular establishments, with a few run by monasteries.[11] Of the hospitals run by the monasteries, the number of hospitals that offered medical treatment would have remained nearly the same as it was in the twelfth century. This would place the number of monastic hospitals that provided medical care at 112, since most of the new hospitals were secular.[12]

In each of the monastic hospitals, the staff generally consisted of a master or warden, clergymen, and nurses.[13] The master or warden was usually a priest, but was sometimes a member of the lay community. There are also few accounts that describe the warden as a physician.[14] Every member of the staff had some level of medical training that was either provided by the monastery or by a university.[15] This included the nurses who were often nuns. The role of nuns as medical caretakers appears to be more easily accepted than the existence of secular women healers. This is ironic since many of these nun nurses were knowledgeable of the same domestic medicine practiced by secular women healers. These women seemed to have escaped the criticism that secular female healers received from the monasteries and universities. The lack of criticism was because they were taught and regulated by the religious orders that also housed university trained physicians, who would often provide educational opportunities to both the male and female clerical practitioners. Secular women healers were not so offensive that English

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[10] Hughs, *Women Healers in Medieval Life and Literature*, 115.

[11] Kealy, *Medieval Medicus*, 83.

[12] Carlin, "Medieval English Hospitals," 24.

[13] Hughs, *Women Healers in Medieval Life and Literature*, 115.

[14] Rotha Mary Clay, *The Medieval Hospitals of England*, 149.

[15] Hughs, *Women Healers in Medieval Life and Literature*, 115.

society did not demand their aid during times of endemic disease, which led many of the secular women healers to join these religious orders in order to care for the sick in the monastic hospitals.[16] In fact, English religious orders regularly gave medical licenses to the secular women and men who joined the ranks of the monastic hospitals during an epidemic.[17] The monastic distribution of medical licenses to secular practitioners was the most apparent during the Black Death of 1348.[18] This means that the quality of medicine practiced in monastic hospitals was similar to the domestic medical traditions the religious orders sought to diminish.

According to Siraisi, many of the medical practitioners in England during the late thirteenth and early fourteenth centuries had received formal training from hospitals, monasteries, guilds, or public authorities. While the credentials of each of these institutions were valid, the university continued to hold the highest status.[19] Siraisi does argue that it is equally possible that many practitioners did not acquire the standard qualifications for medical practice, since most of them lived in rural communities and among the poor who were less affected by any form of regulation.[20] However, with higher status and regulations came financial prosperity. Physicians profited from the medical profession far more than the lay practitioners, but the practice of medicine was only really profitable for elite physicians and no more than a small number of them

[16] Ibid, 117.

[17] Siraisi, *Medieval and Early Renaissance Medicine*, 18.

[18] Getz, *Medicine in the English Middle Ages*, 15.

[19] Siraisi, *Medieval and Early Renaissance Medicine*, 19.

[20] Ibid, 20.

became rich by the end of their careers.[21] There were, however, some lower ranking practitioners who also profited from a wealthy clientele, though this only occurred if the individual practitioner possessed a good reputation and a high standard of success.[22]

Regardless of status and profit, it is the quality of medical ethics practiced by both university trained physicians, clerical practitioners, and various lay practitioners that needs to be called into question in order to understand how the quality of medicine changed during the transition between the twelfth and thirteenth centuries in England. The ethical philosophies and practices followed by university trained physicians naturally derived from the Greek traditions, but they were also heavily influenced by the ethical writings of Arabic scholars.[23] Three Arabic physicians were particularly influential in western medical practice. Their names were Rhazes, Ahwazi (Haly Abbas), and Ibn Sina (Avicenna). All three of these authors published medical treatises that focused on Hippocratic ethics, as well as, two distinctly Arabic beliefs that support the idea that God has the power over life, death, sickness, and healing and that good Christians are obligated to care for the poor and ailing. An example of this appears in the work called *Canon of Medicine*, where Avicenna discourses on the place medicine should hold within society.[24]

Avicenna bases his conclusions on three concepts: that medicine can be pursued as a practical field for economic gain, that it can be performed as an act of devotion to

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[21] Ibid, 21.

[22] Ibid, 22

[23] Ibid, 3.

[24] O. C. Gruner, *A Treatise on the Canon of Medicine of Avicenna: Incorporating a Translation of the First Book* (London: Luzac & Co., 1930).

one's fellow man, and also out of devotion to God.[25] Another influential Arabic scholar and physician during the thirteenth century was Al-Ruwahi who had written *Practical Ethics of the Physician (Abad al-Tib)* during the ninth century. This work was potentially the first medical treatise that focused strictly on the theory and practice of medical ethics.[26] With reservations, the universities did accept the teachings of a few of these Arab scholars and what they did not agree with they ignored, removed or altered, making it more compatible with developing western medical traditions.[27]

The university-trained physicians relied primarily on Greek ethical traditions that were evident in works by Hippocrates, Galen, and Aristotle.[28] These physicians were divided into four schools of thought: the Dogmatists, the Empirics, the Methodists, and the Pneumatists. The Dogmatists followed the logic of Hippocrates, who sought to change medicine through the application of logic or reason as a way to explain medical ailments and solutions, while the Empirics denounced the theories of the Dogmatists and the Alexandrian concepts of anatomy. The Empirics claimed to have been the first to apply clinical observation to medical practice by analyzing theories, testing them, and putting them into practice.[29]

The Methodists were disliked by the supporters of Galen since they argued that there were two causes of disease, those that were caused by open ducts and those that were caused by closed ducts. They treated each disease by reversing the condition of it,

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[25] Jonsen, *A Short History of Medical Ethics*, 20.

[26] Ibid, 19.

[27] Ziegler and Biller, *Religion and Medicine in the Middle Ages*, 9.

[28] Siraisi, *Medieval and Early Renaissance Medicine*, 3.

[29] Bullough, *Universities, Medicine, and Science in the Medieval West*, 2.

which means that if a disease is caused by closed ducts, then the ducts must be opened and vice versa. The Pneumatists were influenced by Stoic philosophy, which was based on the belief that there were two forms of *pneuma*. These *pneuma* would be distributed throughout the nervous system by the heart, which altered air into a type of "vital spirit." The two *pneuma* also regulated the health of the individual through a pneumonic pulse or *tonus*. These different traditions, according to Bullough, cataloged medicine, making it easier for lay practitioners to gain knowledge of the practices acquired through a university education.[30]

The secular practitioners of thirteenth-century England continued to rely upon the Anglo-Saxon traditions for practical medical treatments, but in regards to medical ethics, they were influenced by the classical theories of the universities, as well as, religious medical practices.[31] The access secular healers had to a monastic medical education increased during times of epidemics when monastic hospitals needed to hire more medical caretakers. This exposed them to the teachings of St. Benedict, as well as, the classical practices the clerical practitioners applied to medical treatment.[32] Secular practitioners were also brought into monasteries to perform surgeries that were being separated from the monastic medical system.[33]

This separation occurred both in monasteries and in universities. The reason was that many classical works glorified the role of the physician to the status of an intellectual, which established manual practice as something that was performed by lay

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[30] Ibid.

[31] Bullough, *Universities, Medicine and Science in the Medieval West*, 609.

[32] Getz, *Medicine in the English Middle Ages*), 15

[33] C. H. Talbot, *Medicine in Medieval England* (London: Oldbourne Book Co., Ltd., 1967), 54.

practitioners who were of lower status. The physician became more of a medical consultant while manual treatment was left to other practitioners. These changes affected the quality of medical treatment because once again the majority of medical care came from clerical practitioners who only treated a small minority of the population, and the lay practitioners, who had always treated the vast majority of England's population.[34]

Among the lay practitioners were women healers and other practitioners who were trained by guilds, the monasteries, and sometimes the civil authorities.[35] The women healers were used a great deal in the monasteries as nurses, but because they were barred from both the universities and the guilds, they were unable to attain any status higher than a nurse, except in a few rare cases.[36] According to Siraisi, the textual existence of these women practitioners is limited and from what evidence is available, women are only estimated to make up 1.2 percent of the total number of medical practitioners in England from the thirteenth to the fifteenth centuries. She does argue that this number is most likely incorrect since many women would have become mid-wives, nurses, or healers without leaving any evidence of their existence on record. This implies that women must have been employed in the poorer areas of the country and that they were part-time or even temporary healers.[37] The other lay practitioners, who were generally men, were trained by guilds and became barbers, surgeons, barber-surgeons or other types of medical providers.[38] These lay practitioners and women healers were

[34] Ibid.

[35] Getz, *Medicine in the English Middle Ages*, 6.

[36] Rubin, *Medieval English Medicine*, 183.

[37] Siraisi, *Medieval and Early Renaissance Medicine*, 27.

[38] Ibid, 26.

considered medical tradespeople since during the thirteenth century in England, the field of medicine had expanded into a form of commercial industry.

That these lay practitioners were the main source of medical treatment for the general population did not mean that they were driven by profits, since only a small number became wealthy over the course of the century. The lay practitioners who profited from medical care the most were the surgeons whose services nearly rivaled the physicians in status.[39] Physicians, like clerical practitioners, were separating the physical practices of medicine from their fields of expertise.[40] The demand for surgical treatment was a vacuum that was filled by the surgeon who would rival the status of the physician by the fourteenth century.[41] According to the list of names assembled in the biographical register by Talbot and Hammond, the number of known surgeons in England nearly tripled from thirty-two surgeons in the thirteenth century to eighty-eight surgeons in the fourteenth century. There is only one account of a Jewish surgeon, whose name is Sampson, and he appears in the thirteenth century, which means that by the fourteenth century Jewish surgeons were possibly non-existent in England.[42] Women also practiced surgery; moreover, their practice was not confined to gynecological cases.[43] However, there is only one known female *surgiene* or surgeon listed by Talbot and Hammond from England in the thirteenth century and none listed in the fourteenth century. Her name

[39] Ibid, 21.

[40] Bullough, "Education and Professionalization: An Historical Example," 161-162.

[41] Bullough, "Status and Medieval Medicine", 206-207.

[42] Hammond and Talbot, *The Medical Practitioners in Medieval England*, 317.

[43] Siraisi, *Medieval and Early Renaissance Medicine*, 27.

was Katherine and she appears in 1286.[44] This means that, while women could become surgeons, there were not many women who were known to have achieved this status, especially in late medieval England.

The need for lay practitioners, like leeches, nurses, and surgeons, also led to many of them being housed or employed by monasteries alongside the physicians. For example, on July 13, 1232 the *Patent Rolls* states that at Westminster Abbey, Master Peter le Leche was granted 100 shillings for life at the Exchequer of Michealmas.[45] On May 25, 1242 in Pons, the same Master Peter appears to receive a fee of £40 and 10ℓ. sterlings for his services.[46] Then on November 29, 1240, he was referred to as a *physicus* when he was granted placement at the church of Chypping by the king.[47] His status as a physician is later reaffirmed on the entry dated September 6, 1241, where he was mentioned as the queen's physician.[48] Master Peter is a good example of a wealthy clerical leech who became a physician, since the earlier references refer to him as a leech while later he is referred to as a physician.

Other examples of leeches being housed by monasteries appear in the *Patent Rolls*, where on October 10, 1254 in Bordeaux the bishop of Hereford promises Cantorinus the leech that he will provide him with a benefice of fifty marks for his

[44] Hammond and Talbot, *The Medical Practitioners in Medieval England*, 200.

[45] Great Britain Public Records Office. *Calendar of Patent Rolls of Henry III, vol.III* (Nendeln, Liechtenstein: Kraus Reprint, 1972), 113.

[46] Ibid, 306.

[47] Ibid, 239.

[48] Ibid, 258.

services.[49] While being employed or housed by these monasteries was profitable for a select few, most of the secular practitioners received lower wages than the surgeons and physicians. These variations were based on the social value placed on education, status, and tradition.

The vast majority of medical treatment in thirteenth-century England was provided through herbal medicines, charms, and remedies. These medicines consisted of herbs, animal parts, and sometimes minerals. Every type of medical practitioner relied on herbals and medical handbooks that described and illustrated the various applications of medicine and other effective *materia medica*. For example, information about classical medicine and treatments were found in texts such as Theophrastus' *Medical Botany* and the *Materia Medica* by Dioscorides.[50] Other classical works that were made available include the *Old English Herbarium*, the *Medicina de Quadrupedibus,* and Pliny's *Naturalis Historia.*[51]

The first two of these three texts were translated from the Latin to Middle English, making their materials more comprehensible to practitioners who were not familiar with Latin. These two books also included information from the *Naturalis Historia* on the medicinal use of plants and animals; however, the translations of these texts also led to a large number of mistakes and inaccuracies.[52] Gilbertus Anglicus' pharmaceutical writings were also translated into Middle English from Latin. It provided

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[49] Great Britain Public Records Office. *Calendar of Patent Rolls of Henry III, vol. IV* (Nendeln, Liechtenstein: Kraus Reprint, 1972), 343.

[50] MacKinney, *Medical Illustrations in Medieval Manuscripts,* 24.

[51] De Vriend, *The Old English Herbarium and Medicina De Quadrupedibus,* v.

[52] Ibid.

categorized medicinal recipes that were grouped according to the disease or ailment they treated.[53] This text shared recipes with other Middle English compendiums, not all of which had a classical origin.[54] One medical tract in particular was known throughout Europe and that was the *Regimen Sanitatis Salernitanum* of the School of Salerno. According to Dolan and Smith, this tract was circulated more than any other medical document during the Middle Ages and was translated into every European language. It included sections on hygiene, *materia medica*, anatomy and physiology, etiology, ectology, pathology, disease classification, and medical practice.[55] All of these texts were widely used by every literate practitioner in thirteenth-century England, but the majority of the translations were hard to access unless you were a certified medical practitioner.[56]

These works and most of the others were also too expensive for the majority of England's medical practitioners. The solution to this problem came in the form of abbreviated and illustrated handbooks that usually only provided rough sketches of procedures, herbs, animals, and minerals.[57] A good example of a text that was widely published in this manner is the translated work by Pseudo-Albertus Magnus called *De Secretis Mulierum*, which dates from the thirteenth to the fifteenth centuries.[58] The author of this text is unknown, but was probably Albertus, Thomas of Brabant, or Henry of

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[53] Faye Marie Getz, *Healing and Society in Medieval England: A Middle English Translation of the Pharmaceutical Writings of Gilbertus Anglicus* (Madison: The University of Wisconsin Press, 1991), xv.

[54] Ibid, xv-xvi.

[55] John P. Dolan and William N. Adams-Smith, *Health and Society: A Documentary History of Medicine* (New York: The Seabury Press, 1978), 73.

[56] Vriend, *The Old English Herbarium and Medicina De Quadrupedibus*, v.

[57] Ibid.

[58] Helen Rodnite LeMay, *Women's Secrets: A Translation of Psuedo-Albertus Magnus's 'De Secretis Mulierum' with Commentaries* (New York: State University of New York Press, 1992).

Saxony. According to Margaret Schleissner's dissertation in 1987, thirteen additional manuscript copies of this text have been found, bringing the total of known copies to eighty-three. The original version of this manuscript is no longer in existence so an archetype has been constructed from the various translations.[59]

The *De Secretis* was also heavily influenced by the classical form of natural philosophy that did more than simply treat the body. Instead, it sought to understand human nature, astrological influences on a developing fetus, spontaneous generation, monsters in nature, and the generation of sperm in men and women. The author does distinguish between natural philosophy and medicine, but the majority of his work is more philosophical in nature, relying on works by Avicenna and Averroes.[60] Unfortunately, this text produced several anatomical errors, so practitioners who used this source would have needed enough skill to be able to spot flaws and avoid making errors when applying information from this work to medical practice. If they were unable to identify and correct these textual inaccuracies, then these practitioners would have continued to be misguided in their knowledge of anatomy and how to treat various conditions of the body. Many of these errors were centered on female anatomy and the function of the female body. In fact, a proper medical text from this period would have been far more useful than the chapter in *De Secretis* called "On a Defect of the Womb" where, instead of locating the womb, Galen argues that it actually becomes displaced. Clearly no medical practitioner could effectively treat the female body if they could not

[59] Ibid, 1.

[60] Ibid, 3.

even identify the location of female anatomy.[61] What is reassuring is that Albertus' ignorance of basic medical facts was not reflective of the entire medical community, including that of England.[62]

Another well known medical treatise that was translated into commonly used handbooks was the pharmaceutical writings of Gilbertus Anglicus. These manuscripts were written in Middle English and were generally possessed by less educated medical practitioners in thirteenth-century England.[63] This does not mean that university trained physicians did not use this text or others like it, there just is not enough evidence at present to answer the question regarding who and how many people owned or used this text.[64] This text also provided more medical treatments of a better quality than those provided by Pseudo-Albertus Magnus in his *De Secretis*. Its understanding of how to treat the body was more detailed and practical. Secular practitioners would have found using this text as a medical reference far more convenient and helpful.

The quality of medical treatment in monasteries, hospitals, and within the secular community would have been strongly affected by the texts that were used. Too much theory in a medical handbook decreases the quality of medical practice because the text does not provide sufficient descriptions or knowledge of medical recipes or other manual treatments. The text that provides the best quality of thirteenth-century medicine would be one that combined the theoretical and the practical forms of medicine by using theory to justify or denounce medical practices while including other optional treatments as

[61] Ibid, 5.

[62] Ibid, 4.

[63] Getz, *Healing and Society in Medieval England*, xvii.

[64] Ibid.

alternative remedies. It has already been established that *De Secretis* was lacking in every area but theory; however, Gilbertus Anglicus' works appear to provide many if not all of these prescribed elements.

In Gilbertus Anglicus' writings, the theory that nothing in nature was without power laid the foundation for the rest of his work which was strongly reflective of the standard for pharmaceutical practice.[65] His writings provided nearly four thousand therapeutic substances in Middle English and his Latin exemplar provided many more.[66] An example of these therapeutic substances can be found in Chapter IX, Part 3 on "The Cough", where he discusses the potential causes of the cough, the types of cough, and what methods of treatment are the most effective for each kind of cough. One cause of the cough "*is Þe wiynde Þat a man breÞiÞ to delyuere him of sum corrupcion Þat is withyn him.…OÞirwhiles it is a sekenes by himself; oÞirwhiles it followiÞ anoÞir sekenes*."[67] If the cough is caused by himself, then "*it comeÞ of humours Þat fallen down fro Þe heed into Þe breest and into Þe li3t, eiÞir of fumes, eiÞir of humours Þat comen into Þe breast from Þe stomake, or from Þe liver, or fro sum oÞir place Þat byneÞe Þe mydrif*."[68] The treatment that he prescribes for this appears later as a joint treatment from a cough with blood and the coughs of other sicknesses. It states that "*wheÞir it be of blood or of colre, let him be purged with a colog[og]e, for Þe same Þat purgeÞ coler purgiÞ blood*." The colog[og]e that he prescribes in this passage calls for "*the juice of licorice, of draggantum, of gum arabic, ana, dr. x, dr. xx, dr. v, dr. iii, and the seed of*

[65] Ibid, xviii.

[66] Ibid, xviii-xix.

[67] Ibid, 112.

[68] Ibid, 113.

gourdis, of melons, of lettuce, and of hockis and ana". The herbs referred to as 'dr.' appear to be specific combinations of herbs and his remedy goes on for another page.[69] His knowledge of these different therapeutic substances and his prescribed use was backed up with theoretical justifications that included the empirical and the symbolic; however, it is often impossible to differentiate between which theory is being applied. This does not interfere with the use of the handbook or the quality of its medicine; it simply makes the reasoning behind why treatments are used more ambiguous. This handbook and others like it continued to be the standard reference materials for all thirteenth-century practitioners in England.[70]

For surgeons, the anatomy texts were the most important reference guides. Currently, there are no anatomical manuscripts that pre-date the fifteenth century; however, one manuscript was found in the *Bibliothèque Publique de Chartes* in M.S. No. 284, *Galieni Opuscula*.[71] The manuscript was later dated between 1250 and 1300 by Dr. Charles Singer and Professor C. H. Haskins. The entire text is a collection of smaller books on Galen, with some other unknown sources, and translations from Arabic compilations that were labeled generally under the works of Galen through the twelfth century.[72] The section of the text that focuses on anatomy extends from folia 139 verso to 149 verso and the text is said to be almost exactly like the *Anatomia Vivorum*, with only three or four differences evident between the two texts. This means that the manuscript

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[69] Ibid, 114.

[70] Ibid, xix.

[71] George W. Corner, M. D., *Anatomical Texts of the Earlier Middle Ages: A Study in the Transmission of Culture with a Revised Latin Text of Anatomia Cophonis and Translation of Four Texts* (Washington: Carnegie Institution of Washington, 1927), 35.

[72] Ibid, 36.

found in Chartres was an earlier version of what would later be known as the *Anatomia Vivorum*. The sources of these two texts would have been available to surgeons during the twelfth and thirteenth centuries, which helps explain what knowledge surgeons applied in their procedures. These sources consisted of works by classical authors like Aristotle, Galen, and Hippocrates and Arabic works by Avicenna and Rhazes.[73]

Of these various authors, the work by Rhazes was the most influential since it became one of the most important texts of medieval medicine. It was titled *Khitaab-al-Mansuri* in Arabic and *Liber ad Almansorem* in Latin. It was one of many texts that was preserved and published many times.[74] During the twelfth and thirteenth centuries, the translation of surgical texts was at its height. At this time, surgeons rivaled physicians in their claims of expertise while also trying to avoid extreme work conditions.[75] In fact, the field of surgery was beginning to develop hierarchies of practitioners within the field.[76] As the field grew, so did the standards of medical practice and surgeons soon found themselves being evaluated according to their performance and medical ethics like all of the other medical practitioners in thirteenth-century England.[77]

The new standards of medical practice began to delimit the scale of surgery and define what treatments were successful and which had failed. These new standards did not necessarily improve the quality of surgical care, since the limited range of surgery led many of its practitioners to protect their own reputations by inflicting more pain during

[73] Ibid, 37.

[74] Ibid.

[75] Siraisi, *Medieval and Early Renaissance Medicine*, 153.

[76] Ibid, 154.

[77] Ibid, 155.

procedures and by raising the hopes of the patients and their families.[78] This was a way of bolstering their own importance as a medical practitioner, but it did more harm to their patients than was necessary.[79] In the twelfth century, there were no known surgeons available so other practitioners would have been responsible for any form of surgical care. By the thirteenth century, there were twenty-six known surgeons, one of whom was known as both a surgeon and a physician. The one surgeon who was also a physician was a member of a marginalized group since he was Jewish.[80] The dramatic increase in available surgeons would have given the public more access to a specialized practitioner and surgical care; however, this did not greatly improve the quality of medicine, since surgeons were too expensive for the impoverished to afford and when a patient was treated they were inflicted with more pain than was necessary.[81] Very little evidence has survived the Middle Ages that helps scholars portray how surgical procedures were performed and what the standard work conditions were. The few source materials that are available are found within other medical texts in small sections and even in some non-medical literature, but none of these sources provide enough information for a clear picture of these practices to be established.[82]

By the end of the thirteenth and fourteenth centuries, the increase in surgeons did little to improve the quality of medicine, since their practice was limited and the patient's well-being was often disregarded to the extent that, by today's medical standards, is

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[78] Ibid.

[79] Ibid, 154.

[80] Hammond and Talbot, *The Medical Practitioners in Medieval England, passim*.

[81] Siraisi, *Medieval and Early Renaissance Medicine*, 155.

[82] Rubin, *Medieval English Medicine*, 129.

considered malpractice.[83] The role of the physician became more intellectual and instructional while the other secular practitioners were left to provide the manual forms of medicine as they had already done throughout the Middle Ages.[84] The clerical practitioners became more theological and intellectual like the physicians and worked to heal the soul before healing the flesh.[85] The practice of medicine in thirteenth and early fourteenth-century England had become better organized than it had been in previous centuries and this improved the availability of medicine to the population. The categorization of information and the translation of many new classical and Arabic works led to an increase in medical information for university-trained physicians, clerical practitioners, as well as, other secular practitioners and this improved the overall quality of medical education and medical standards.[86]

The increase in sources could, however, have led to confusion regarding which texts were of the highest quality and the most applicable. It also would have made distinguishing between useful texts, which provided information that worked, difficult unless the individual was trained or simply able to identify what information could be employed in medical application and what could not.[87] The thirteenth century saw the decline of monastic medicine and its availability to the public, but the rising number of secular hospitals continued to supply the population with medical care.[88] In the end, the

[83] Siraisi, *Medieval and Early Renaissance Medicine*, 155.

[84] Bullough, "Status and Medieval Medicine", 206- 207.

[85] Jonsen, *A Short History of Medical Ethics*, 17.

[86] Grant, *The Foundations of Modern Science in the Middle Ages*, 24.

[87] Cameron, *Anglo-Saxon Medicine*, 19.

[88] Prescott, *The English Medieval Hospital, 1050-1640*, 1.

people who provided the most medical care, and thus had the greatest affect on the actual quality of thirteenth and early fourteenth century medicine, were the lay practitioners, such as leeches and women healers who provided the manual treatment of medicine inside and outside of the monasteries and hospitals.[89]

[89] Jonsen, *A Short History of Medical Ethics*, 13.

CONCLUSION

The advancement of medical knowledge during the twelfth century increased with the number of universities throughout Europe.[1] The increasing availability of a variety of medical sources led to the translation and application of many classical texts and traditions that continued to gain authority as the practice of monastic medicine declined throughout England.[2] The decline of monastic medicine was due entirely to the Gregorian reforms of the first four Lateran councils.[3] However, these reforms did not take root in England until the end of the twelfth and the beginning of the thirteenth century.[4] Prior to the decline of monastic medicine, the quality of medical care was best in cathedral monasteries and their hospitals, since the level of expertise available in these locations utilized the monastic, classical, and Anglo-Saxon practices in their treatment of ailments.[5] The combination of these traditions offered the patient a wider variety of medical treatments, improving the quality of their medical care. The quality of medicine did not change dramatically as twelfth-century monastic medicine declined and secular medicine advanced. It was only the location of medicine, its availability to the public, the type of medical practitioner, and the standards of medical ethics and practice that altered over the course of these three centuries. These changes did not take away from the public's ability to receive medical treatment; it merely increased the demand for secular medicine and

[1] Lindberg, *The Beginnings of Western Science*, 206.

[2] Ibid., 325.

[3] Knowles, *The Monastic Order in England*, 485.

[4] Getz, *Medicine in the English Middle Ages*, 15.

[5] Jonsen, *A Short History of Medical Ethics*, 15.

practitioners.[6] This made medicine more available to the public, at the same time standards and ethical practice became more professional.

Despite the decreasing availability of monastic medicine, towards the end of the twelfth century, monasteries during the late medieval period continued to train their own physicians or send their clerical practitioners to a university to receive a medical education.[7] These monasteries also housed all of the known physicians in England throughout the Middle Ages. This exposed the physicians, and the secular practitioners they employed, to higher levels of medical education.[8] The thirteenth and fourteenth centuries also witnessed a sharp increase in the number of physicians, surgeons, and other practitioners due to the growing population and the increasing development of universities.[9] The number of hospitals also grew, with the financial backing of the monarchy, during the twelfth century, and by the thirteenth century, England had anywhere from 500 to 1,103 hospitals, though, only 112 of these hospitals supplied medical treatment to the poor and the sick.[10] The hierarchy of the medical profession became more distinguished by the thirteenth century and was established completely by the fourteenth century, that had an affect on the social status of the practitioners, since the difference between folk and academic medicine was barely evident during the Middle Ages.[11] In fact, folk remedies were continuously employed over centuries with some

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[6] Ibid, 17.

[7] Getz, *Medicine in the English Middle Ages*, 27.

[8] Rubin, *Medieval English Medicine*, 180.

[9] Hammond and Talbot, *The Medical Practitioners in Medieval England*, *passim*.

[10] Carlin, "Medieval English Hospitals," 22-24.

[11] Braekman, *Studies on Alchemy, Diet, Medecine and Prognostication in Middle English*, 113.

level of effectiveness or success.[12] The consistent presence of domestic medicine and its application in other medical traditions throughout the Middle Ages suggests that the poor could have received better, if not the same quality of medical treatment, as the wealthy. Within the medical hierarchy, the preparation of remedies, charms, and surgical procedures was practiced mostly by the lower ranking secular practitioners, so the quality of medical care would have been somewhat consistent regardless of where it was practiced. The transition from monastic medicine to secular medicine did not greatly affect the quality of medical remedies and charms in late medieval England. Instead, it was the quality of medical care that both improved through the development of clinical medicine and ethical standards and suffered due to the emphasis of spiritual healing over physical treatment. The practice of medicine in thirteenth and early fourteenth-century England became more organized and this improved the availability of medicine to the population. The categorization of information and the translation of many new classical and Arab works led to an increase in medical information for university-trained physicians, clerical, and other secular practitioners, which improved the overall quality of medical education and medical standards.[13]

The establishment of clinical medicine in the universities reformed the standards of medical practice, which helped shape medical ethics in the thirteenth and early fourteenth centuries.[14] The establishment of new standards was possible due to the abundance of translated medical manuscripts and treatises that began to appear in the

[12] Ibid.

[13] Grant, *The Foundations of Modern Science in the Middle Ages*, 24.

[14] Bullough, *Universities, Medicine, and Science in the Medieval West*, 2.

twelfth and thirteenth centuries. These treatises dramatically altered medical concepts and techniques with a revolution of new ideas.[15] These new ideas led to the reform and standardization of medical practice and the establishment of a medical hierarchy that placed educated physicians and clerical practitioners at the top, while relegating the lower ranking secular practitioners to the bottom.[16]

The social and religious reforms may have established new standards of practice and medical ethics, but the clerical and secular physicians became more like overseers in the field of medical practice, prescribing medical treatments for other secular practitioners to use, while refraining from the actual physical practice of medicine since they preferred to adopt a more consultative role.[17] In the end, the people who provided the most medical care, and thus had the greatest affect on the actual quality of medicine before and after the Gregorian reforms, were the lay practitioners and women healers who provided physical medical treatment to the monasteries and hospitals.[18] In fact, the secular practitioners continued to be the dominant source of medical care both inside and outside the monasteries, as well as, the hospitals, during the Black Death of 1348 as the numbers of physicians declined.[19]

The Gregorian reforms of the Church redirected monastic medicine toward spiritual rather than physical healing. The university medicine of the thirteenth and fourteenth centuries established medical hierarchies, ethical standards of practice, an

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[15] Siraisi, *Medieval and Early Renaissance Medicine*, 15.

[16] Ziegler and Biller, *Religion and Medicine in the Middle Ages*, 6.

[17] Jonsen, *A Short History of Medical Ethics*, 17.

[18] Rubin, *Medieval English Medicine*, 183.

[19] Getz, *Medicine in the English Middle Ages*, 15.

increased specialization of medical practice, and an increased availability in the number of trained medical practitioners. The changes that occurred during this medical revolution did not greatly alter the domestic practices and remedies that were utilized by the majority of the population.[20] Instead, these domestic practices continued to be the dominant form of medicine, though socially it was relegated to a lower status, since it was not until the Scientific Revolution of the sixteenth and seventeenth centuries that the establishment of clinical medicine truly took control of medical treatment.[21]

The transition from monastic to secular professionalized medicine that began with the Gregorian reforms of the twelfth and thirteenth centuries culminated with the introduction of the Black Death, since the medical establishment during the plague became scattered and unorganized. The arrival of the plague in 1348 also inhibited public access to what remained of monastic medicine, while those housed by the monasteries continued to have access to medical care.[22] However, during the Black Death, many of the Benedictine monasteries were hit by the plague. England and Continental Europe each suffered a loss of a third of their populations,[23] while the wealthier Benedictine monasteries of England suffered a loss somewhere between a fifth (17.8 %) and a fourth (28.5%) of their abbots, priors, and bishops. This estimate shows that a smaller number of higher ranking clergymen died in comparison to the approximate mortality rate of the

[20] Jonsen, *A Short History of Medical Ethics*, 13.

[21] Lindberg, *The Beginnings of Western Science*, 358-9.

[22] Rubin, 180-181.

[23] J. M. W. Bean, "Plague, Population, and Economic Decline in England in the Later Middle Ages," *The Economic Review*, New Series, vol. 15, no. 3 (1963), 424.

entire clergy, which peaked at a loss of forty percent.[24] The exact number of Benedictine abbots and priors killed by the Black Death is vague, since only eight deaths can be linked directly with the plague, while the other deaths from 1349 to 1361 are unclearly defined. According to Sir William Dugdale's *Monasticon Anglicanum*[25] and the *Literae Cantuarensis*,[26] the eight abbots whose deaths can be directly attributed to the plague were from Westminster Abbey,[27] St. Alban's,[28] Ramsey,[29] Ely,[30] and Christ Church Canterbury.[31]

The lower death rates of the abbots and priors of the wealthier Benedictine monasteries, in comparison to the higher death rate of the whole population, suggests that medical care was more available within these monasteries and was an effective tool for reducing the spread of the plague or treating it. Previously noted, it is now understood that during the fourteenth century monasteries housed physicians. What is less known is

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[24] Susan Scott and Christopher Duncan, *Biology of Plagues: Evidence from Historical Populations* (Cambridge: Cambridge University Press, 2001), 91.

[25] Dugdale, *Monasticon Anglicanum, vol. I-IV*.

[26] Christ Church Priory Canterbury, *Literae Cantuarienses, the Letter Books of the Monastery of Christ Church, Canterbury, RS, 85, vol.II*. Ed. by J. B. Sheppard (London: England, 1887-89), xxii-xxiii.

[27] Sir William Dugdale, *Monasticon Anglicanum, vol. I* (Westmede, England: Gregg International Publishers, 1970) 274.

[28] David Knowles, *The Religious Orders in England, vol. II: The End of the Middle Ages* (London: Cambridge University Press, 1979), 39-61.

[29] Sir William Dugdale, *Monasticon Anglicanum, vol. II* (Westmede, England: Gregg International Publishers, 1970), 550.

[30] Ibid., vol. I, 465

[31] Ibid., vol. I, 85-86.

how many physicians or other practitioners were located in the wealthier monasteries from 1348 to 1351.[32]

According to the biographical register provided by Talbot and Hammond, of the 350 known practitioners located in fourteenth-century England only thirty can be affiliated with the twenty-seven wealthier Benedictine monasteries just prior to or during the Black Death. Out of these thirty practitioners, seven belonged to Durham, six to Westminster Abbey, four to Norwich, three to Worcester and Winchester, two to Abingdon and Gloucester, and Christ Church Canterbury, Croyland, Malmesbury, Ramsey, and Ely had one each.[33]

The medical care provided in these wealthier Benedictine monasteries differed from the care that was available in hospitals.[34] Monastic infirmaries could not pick and choose who within their community received medical care, since every member of the monastery was entitled to medical care.[35] This was a very difficult policy to adhere to during the Black Death since monks, physicians, and lay practitioners were all dying in record numbers between 1348 and 1351. The infirmaries were only capable of containing a limited number of the sick, so many of these monasteries would have been, to some extent, stretched in their capacity to either house or treat the infirm.[36] Treatment of the

[32] Ibid.

[33] Ibid.

[34] Barbara F. Harvey, "Before and After the Black Death: A Monastic Infirmary in Fourteenth Century England," *Death, Sickness and Health in Medieval Society and Culture* edited by Susan J. Ridyard (Sewanee, TN: University of the South Press, 2000), 6.

[35] Ibid.

[36] Ibid.

sick within monasteries was less physical and more spiritual.[37] The infirmarians and other medical practitioners housed or hired by the wealthier monasteries were limited in the kind of care they could provide since people tended to die within days or hours after contracting the plague.[38] The monasteries relied on preventative or curative medicine based on the edicts of St. Benedict who prescribed changes in diet and lifestyle.[39] Prior to the Black Death, these monasteries also hired outside medical practitioners who applied other forms of medical care based on either clinical medical treatments or herbal remedies and charms.[40] While it is not evident how long this practice was applied it can be assumed that since medical practice in both hospitals and monasteries did not change until after the Black Death that this practice was still applied during the Black Death.[41] Regardless of what form of medicine was applied in these monasteries, there was no known cure for the plague and survival was based on either luck, isolation, or even possibly the standards of living.[42] Little is known about the Black Death's impact on the secular and monastic medical establishments. Further research on the affect the Black Death had on the availability and quality of monastic and secular medicine is still necessary in order to determine when and how the medical establishment began to change after the onslaught of the plague. The impact that the plague had on the number of available practitioners, both secular and clerical, also needs to be addressed.

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[37] Jonsen, *A Short History of Medical Ethics*, 17.

[38] Philip Ziegler, *The Black Death* (New York: Harper & Row, Publishers, 1969), 19.

[39] Knowles, *The Monastic Order in England,* 518.

[40] Harvey, "Before and After the Black Death: A Monastic Infirmary in Fourteenth Century England," 6.

[41] Ibid.

[42] Ibid, 10

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