# Chapter 1
# Theorizing Medical Vigilance between the 16th and 18th Centuries

## 1 Vigilance as a defining virtue of the *optimus medicus*

Since ancient times, a "culture of vigilance" has been both theorized and practiced as an integral component of medical theory and practice. Physicians have long been expected to demonstrate vigilance, particularly in relation to the signs and symptoms of illness observed or reported by patients. During the early modern period, a more formal ethical and deontological reflection on the concept of vigilance (*vigilantia, prudentia, cautela* and related concepts) emerged, reinforcing its significance within medical discourse and clinical practice. A clearly defined ethical profile became a crucial tool for asserting the professionalism and social status of physicians and surgeons, grounded in the assumption that a competent doctor was, in every sense, a vigilant one: the *optimus medicus.*

The notion that the ideal physician was one who made the fewest mistakes was already established in antiquity, notably in the teachings of Hippocrates and Galen.[1] Fallibility has always been an intrinsic feature of both medicine and human nature in general. The awareness of navigating a field marked by a higher degree of uncertainty than other disciplines undergirded the development of a series of reflections within the medical world on how to minimize errors. The emergence of a *methodus* would not only have recognized the legitimacy of medicine's claim to the status of science, but also have guaranteed a technical superiority, manifesting as a distinct professional identity and exclusivity. Early modern physicians understood that in order to secure a monopoly in the health market and to assert a central position within society, they needed to equip themselves with every possible means to avoid making mistakes. Despite the extreme degree of uncertainty inherent in the humoral theory, its logical structure and repetitiveness still allowed doctors to operate with a certain degree of predictability.

1 Gadebusch Bondio, *Avoidable Mistakes*, p. 1.

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## 1.1 Medicine between theory and practice

The teachings of Hippocrates and Galen conveyed the idea that man should be considered a microcosm integrated into the cosmological macrocosm, and thus subject to the four cardinal physical laws of heat, cold, dryness, and humidity. The human body was thought to consist of a certain "temperament," the result of different combinations of the four elements—fire, air, earth and water—and four visible fluids known as the "humors": blood, phlegm, black bile, and yellow bile. Each humor was believed to correspond to one of the four principal organs of the human body—heart, brain, liver, and spleen.[2] Equilibrium between these four humors was considered indispensable for maintaining health. Bile and phlegm were identified as the primary humors responsible for disease. In addition to their natural presence in the body, their production was linked to specific seasons. Winter colds were associated with phlegm, while summer dysentery and vomiting were linked to bile. These two bodily fluids only became visible when expelled during a bout of illness and their appearance was almost universally considered dangerous. Blood, on the other hand, occupied a more ambiguous status. While it was associated with life, the fact that it was naturally expelled from the body at particular times—such as during nosebleeds or menstruation—was considered suspicious. Indeed, the human body was expected to regulate itself to some extent to keep these humors in balance and to expel them when in excess. The body's occasional need to rid itself of blood reinforced the idea that it could be the cause of disease.[3]

Scholars recognized that significant differences existed between individual temperaments and humor balances, often influenced by climate and habitat. People were identified as "sanguine"—corresponding to air on a macrocosmic level, being hot and humid; "choleric"—corresponding to fire, being hot and dry; "phlegmatic"—corresponding to water, being cold and humid; or "melancholic"—corresponding to earth, being cold and dry. Age and sex were also seen as determining factors in an individual's humoral balance, and personal temperament not only shaped one's personality but also one's susceptibility to certain diseases. For example, women were considered colder and wetter than men, leading to the belief that their blood was thicker.[4]

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**2** Siraisi, *Medieval Renaissance Medicine*, pp. 104–106.

**3** Nutton, Medicine in the Greek World, p. 24f.

**4** Ibid., p. 102. The idea that women were seen as anatomically and physiologically imperfect versions of men seems to find support in Galen in *On the Use of Parts*, as argued, among others, by Laqueur, *Making Sex*, p. 124f. However, many historians have criticized this version, arguing that a strong dichotomous model of gender differences has existed since antiquity. For an

Disease was not perceived as an independent entity that could afflict the human body, but rather as an excess of one of these four humors, resulting in a state of "dyscracy." Healing, consequently, was only possible by restoring equilibrium, either through a particular "diet"[5] or through the expulsion of the corrupted humor from the body, primarily by the evacuation of blood.[6]

The conception of the human body as divided into an inner and an outer dimension, the former being of greater importance and concern due to its association with the soul and the exercise of the intellectual faculties, formed the basis of a theoretical distinction within the "official" medical world into three hierarchical categories of professionals.[7] At the top of this pyramid stood physicians—those doctors who attended university or another recognized medical school, completed their studies, passed their final examination, and obtained the doctorate. Below them came pharmacists, followed by surgeons, who, in theory, were the only professionals permitted to use their hands and were restricted to dealing with external diseases. Conversely, internal diseases were the sole domain of physicians, who were the only ones who could prescribe medicines to be ingested.

This tripartite image of medieval and early modern medicine, however, represents a conjectural framework, predicated on the hierarchical distinction within universities between theoretical and practical medicine. The reality was clearly more complex. This was particularly true on the Italian peninsula, where, between the 12th and 15th centuries, a category of "learned" surgeons emerged—those who had had studied at university and obtained a degree in surgery. Given that they were recognized as belonging to a professional category with established academic skills and credentials, their relations with physicians were certainly more equal.[8]

The traditional image of the absolute distinction and antagonism between physicians and surgeons—or rather of the perceived inferiority of the latter—is further challenged by the fact that, by the early 17th century, hospitals were increasingly configured as spaces where surgeons exercised autonomy and initiative, often independent of the authority of physicians.[9] Moreover, given that a basic knowledge of the principles of anatomy and physiology was indispensable

effective summary of the criticisms of the concept of the one-sex body paradigm, see Park, "One sex" Body, pp. 150–175, and, in particular, the bibliography cited on p. 153f.

**5** A diet not only in the sense of a nutritional regime, but in the broader sense of a set of rules for life—nourishment, physical activity, rest, and more—designed to maintain good health.

**6** Brockliss/Jones, *Medical World*, pp. 108–114.

**7** Pomata, *La promessa*, p. 134f.

**8** Siraisi, *Medieval Renaissance Medicine*, pp. 175–180.

**9** Conforti/De Renzi, Sapere anatomico, p. 444.

for the successful practice of surgery, a number of surgical manuals began to be published from the 16th century onward, most written in the vernacular in order to make them accessible to a wider audience. Drawing more from everyday experience than from classical medical texts, these treatises elevated the role of the surgeon over that of the physician, indirectly accusing the latter of blindly accepting a bookish medical culture.[10]

It is important to note that, although the statutes established by various medical colleges prohibited doctors from using knives, scissors, or any other surgical instruments, they still needed a basic understanding of surgery and anatomy to effectively supervise the work of surgeons. In theory, surgeons could not practice without the permission and instruction of physicians. In his treatise *De Optimo Medico* (1551), Antonio Siccus used the analogy of a ship, as well as that of an army in battle: for a captain, a king, or an emperor to succeed in their endeavors, they had to command from above, directing subordinates conscientiously and diligently.[11] Furthermore, many physicians were also qualified as surgeons, thus becoming *doctor utriusque medicinae*—doctors of both branches of medicine.[12] In contrast, the differentiation between theoretical and practical medicine was more pronounced outside the Italian peninsula, especially in northern Europe, where surgery was theoretically excluded from university curricula until the 18th century. In such contexts, the low esteem in which surgeons were held was exacerbated by the presence of such hybrid figures as the "barber-surgeon"—simple craftsmen who, though adept with a razor-blade often lacked formal training in medicine.[13]

This insistence on the superiority of the *theorica* over practice can be explained by the deeper concern about the fundamental nature of medicine—whether it was *ars* or *scientia.* This question delved deeper than it might at first appear; it touched upon the discipline's status, its social utility and, crucially, its relationship to truth. Avicenna, in the incipit of his *Canon* (1025), defined medicine as "the science by which we learn the various conditions of the body; in health, when not in health; the means by which health is likely to be lost; and, when lost, is likely to be restored. In other words, it is the art whereby health

**10** Ibid., p. 454.

**11** Siccus, *De optimo medico*, p. 8v : "medicus [...] similis est gubernatori navis, qui remigare sciat, & mlum scandere_ nec vero solu scit, sed ipse etiam haec faciat, & alia similia, quae ad nautas pertinet. Similiter etiam reges, & imperatores exercituum non paucos invenies, scire ea, & facere, quae militum sunt munera."

**12** Robison, *Healers in the Making*, pp. 18–20; Savoia, Early Modern Italian Surgeon, p. 32; Stolberg, *Learned Physicians*, pp. 73–75.

**13** Brockliss/Jones, *The Medical*, pp. 93–96.

is concerned and the art by which it is restored after being lost."[14] By the 13th century, however, it was widely accepted in the medical sphere that only specific aspects of medicine could provide the certainty required for *scientia*, in the Aristotelian sense of the term.[15] The particularity and extreme variety of patients and diseases, and the consequent difficulty of postulating universal criteria and treatments, led to the recognition that medicine was a *scientia coniecturalis*—conjectural science.[16] As Ian MacLean has rightly noted, recognizing the conjectural nature of medicine did not necessarily mean that the precepts of doctrine were as uncertain as its practice. Indeed, medical theory was not—and never has been—entirely abstract or self-referential: theoretical knowledge always aimed at concrete cases just as logical skills were intended to solve practical problems.[17]

## 1.2 A methodological approach to treatment

Therapeutic activity primarily involved the careful monitoring of the state of equilibrium—or disequilibrium—between the humors, with the ultimate goal of maintaining their balance. The Hippocratic-inspired diagnostic approach was essentially based on examining the patient in all their complexity and individuality, adopting what has been described as a "patient-oriented rather than nosographic-oriented form of inquiry."[18] In other words, before deciding on the optimal treatment for a patient, it was essential to conduct a thorough analysis not only of the disease's trajectory but also of the patient's habitual lifestyle. Therapeutic prescription in humoral medicine unfolded in three stages: anamnesis—collating information about a patient's medical history; diagnosis—identifying the disease; and prognosis—predicting the disease's course and outcome.[19] In a medical system where both diagnosis and treatment options were often fraught with uncertainty, the importance of a correct prognosis had consequences not only for the success of the therapy proposed but, more significantly, for the physi-

**14** Ibid., p. 78.

**15** Gilly, *Theodor Zwinger*, p. 139 f. For Aristotle, the sciences were divided into theoretical (*physica, mathematica, prima philosophica*), productive (arts and techniques), and practical (*ethica, oeconomica, politica*). In the strict sense of the word, "science" only referred to the theoretical sciences, grounded in the deductive method, and not the practical and productive sciences, which are based on contingent objects.

**16** Agrimi/Crisciani, *Edocere Medicos*, pp. 139–150; Siraisi, Bresadola, Segni evidenti, p. 733 f.

**17** Maclean, *Logic, Signs and Nature*, pp. 68–73.

**18** Nicolson, The Art of Diagnosis, p. 802.

**19** Siraisi, *Medieval Renaissance Medicine*, pp. 123–136.

cian's credibility. The two principal diagnostic methods employed were urine and pulse tests, as explained by Galen in his treatise *De pulsis et urinis.*[20] The examination of urine was considered particularly useful. Being naturally excreted by the body, the study of its color, quantity, and presence of sediment would allow the physician to observe, by means of visible characteristics, what was otherwise invisible within the body: the humors and their fluctuations.[21]

Despite attempts to establish medicine with a proper methodology, similar to other sciences like logic—aiming to generate unquestionable and definitive results—the inherently unique nature of each disease as a disorder of humors that always differed from one individual to the next and, by extension, of the administrated therapy, kept medicine in the early modern period in a state of persistent uncertainty, making prognosis difficult to predict. Furthermore, it was believed that the optimal therapy was rooted in the principle of opposites—an excess of cold and wet humors should be countered with warm and dry remedies—and that the patient's own input was essential for the treatment's success. Indeed, it was up to the patient to know their own temperament and clinical state better than anyone else, enabling the physician to prescribe the most appropriate remedy for their specific case.[22] Moreover, the inability to clearly define the difference between cause, symptom, and disease only aggravated this state of confusion, thus amplifying the perplexity surrounding the field. While medicine continued to claim its scientific nature, it lacked the degree of certainty typical of the theoretical sciences.[23] To avoid errors during these critical moments in therapy, physicians had to rely on their own experience, both theoretical—rooted in the teachings of the ancient authors, and practical, predicated on sensory and personal experience.[24]

According to the Roman protophysician Paolo Zacchia (1584–1659), a doctor could commit three types of error: ignorance, negligence, and willful misconduct [*ignorantia*, *negligentia*, *et dolus*]. From a purely legal standpoint, willful misconduct was the only type of error punishable by law, given that it entailed an intentional criminal act. For Zacchia, however, the most serious errors a medical

**20** Ibid., p. 134.

**21** Moulinier Brogi, *L'uroscopie*, pp. 7–9.

**22** Brockliss/Jones, *Medical World*, p. 299.

**23** Maclean, *Logic, Signs and Nature*, p. 261.

**24** The term "experience" referred to any kind of knowledge the physician acquired during his career and which contributed to the increase of his knowledge and skills. The ideal product of the Renaissance educational system was thus personified in the figure of the "rational doctor." He had to be equipped with adequate knowledge, based on his own experience, derived both from the study of books and from sensory knowledge of the particular.

practitioner could commit were the "sins" of *ignorantia*, and even more so, of *negligentia.* Both, in part, stemmed from poor or non-existent vigilance on the part of the medical practitioner. Indeed, physicians could sin not only *in committendo* [through positive action], but also *in omittendo* [through omission]. While ignorance could be partly excused due to the vastness of medical knowledge—or a physician's lack of experience when young—it became unforgivable when it led to negligence. In such cases medical practitioners failed to recognize the limits of their knowledge or abilities; or chose not to act appropriately due to recklessness or carelessness.[25] To protect themselves from accusations of negligence, physicians needed to align themselves with an ideal model of physician—one they could aspire to and embody in practice. Drawing on medieval precedents, a series of treatises were published from the late 15th century onward, stipulating the behavior and practices that medical practitioners were expected to follow.

Let us begin by examining the knowledge considered essential for any physician to be deemed "good." Their education should commence at an early age, when the mind is more malleable. Theory—defined as the possession of a general understanding of basic physiological principles—was seen as the starting point for medical practice. Without an in-depth understanding of the human body and its workings, it would, practically speaking, be impossible to treat a patient. Therefore, the basic requirement for a physician to avoid errors was a thorough theoretical knowledge of medicine, knowledge which could be acquired both through a rigorous study of the subject, within a defined academic path, and through the mastery of a *methodus:* a codified and regulated procedure designed to acquire correct theoretical knowledge [*scientia*] that could then be applied in practice.[26]

Theoretical knowledge was anchored in the ancient authors' teachings, beginning, of course, with the works of Hippocrates and Galen. Any young physician had to be well-versed in the rules of natural philosophy. As Galen had observed, a good physician was, first and foremost, a philosopher. Alongside philosophy, other sciences were seen as complementary to medicine. According to influential physicians such as Pietro d'Abano (1250–1316), a physician should have mastered the *artes liberales*, especially dialectics. Ever since the Middle Ages, the liberal arts had constituted the two foundational groups of academic teaching: the *trivium* which included grammar, rhetoric, and dialectics, and the *quadrivium*, which encompassed arithmetic, geometry, music, and astronomy.[27] As disciplines, astrology

**25** Marchisello, La responsabilità del medico, pp. 221–248.
**26** See Zwinger's reflections on the Hippocratic method in Gilly, *Theodor Zwinger*, pp. 54, 119.
**27** Gadebusch Bondio, *Avoidable Mistakes*, p.7.

and music were particularly relevant to medical practice. Both astrology and medicine were considered conjectural arts reliant upon predicting future events through signs incomprehensible to non-specialists.[28] Astrology, in particular, was believed to play a key role in a doctor's prognosis, notably in relation to the theory of critical days, a branch of medical astrology. This field involved the application of astrological techniques for medical purposes, such as calculating the position of the planets on any given day in order to decide whether a particular medical procedure should be carried out. It was also believed that the position of the planets at the time of birth could influence a person's temperament.[29] The study of music, too, was viewed as decisive, as it was thought to aid in properly interpreting and analyzing the rhythm of the human pulse.[30]

Some physicians, however, believed this educational system was flawed, as it was overly grounded in accumulating abstract concepts that had little practical value for therapeutic practice. This was the case, for example, with the Turin physician Leonardo Botallo (1519–1558), who, in his *De medici et de aegri munere* [the duty of the doctor and the patient] (1565), did not reject the centrality of the liberal arts, but rather argued that they were essentially barren when studied in isolation. Specifically, Botallo accused his colleagues of overly concentrating on the definition of things, losing sight of their essence and thus depriving themselves of the possibility of acquiring genuine knowledge about them.[31]

For Botallo, a thorough knowledge of diseases and the human anatomy was of paramount importance. The practice of human dissection for academic purposes was first documented in 1315, when the anatomist Mondino de' Liuzzi conducted a dissection on the body of a criminal in Bologna. Over time, this practice spread to other European centers and gradually became an official part of the university curriculum.[32] At the University of Florence, for example, the 1388 statute of the *Studium* mandated that two dissections be conducted each year—one on a male corpse and the other on a female. Based on the assumption that "no one can be a good or fully trained doctor unless he is familiar with the anatomy of the human body,"[33] participation in both dissections was compulsory for graduation.[34]

**28** Siraisi, *Medieval Renaissance Medicine*, p. 69.
**29** Ibid., p. 135 f.
**30** Siccus, *De optimo medico*, p. 7r.
**31** Botallo, D*e medici munere*, p. 62.
**32** Nutton, Medieval Western, p. 177.
**33** Park, Criminal and Saintly Body, p. 14.
**34** Park, *Doctors*, p. 59 f.

The burgeoning significance of autopsies—specifically the *anatomia medica*—can be traced back to attempts to unite the two branches of medicine (*theorica* and *practica*) in order to overcome the probabilistic nature of medical knowledge.[35] Academic dissections had an exemplary purpose: to provide students with visual aids that would help them better grasp the teachings in their texts.[36] Dissecting a corpse had the merit of eliminating the obstacle of fragmented medical knowledge, thereby allowing universal conclusions to be formulated on the basis of specific results, in keeping with an inductive approach to investigation.[37]

Similarly, a physician was expected to possess a thorough understanding of both the natural and supernatural causes of disease, as well as be familiar with the "six non-naturals" [*sex res non naturales*]. These factors, while belonging to the realm of nature, did not directly relate to the body's constitution, but nonetheless influenced how it functioned. These "six non-naturals" encompassed air, food and drink, sleep and wakefulness, movement and rest, evacuation and satiety, and finally the *passiones animi*, which included sexual activity.[38]

Furthermore, physicians were required to have a solid grasp of both surgery and pharmacology in order to effectively supervise their subordinates. A good physician needed a method rooted in Aristotelian logic—one that would enable him to avoid errors in judgment. The idea of logic as fundamental to the medical profession had been firmly established since the Middle Ages. Pietro d'Abano, for instance, believed logic had to take precedence over philosophy and must adhere to the principles laid down by Aristotle.[39] Only through the rigorous application of logical rules could medicine be transformed from a conjectural science into an exact one, enabling physicians to identify signs of disease without the risk of erroneous diagnosis or prognosis. This involved adapting the variability of individual cases to the universal framework of logic. The ultimate goal was to equip medicine, once and for all, with the necessary means to become an exact science, through the use of analytical logic and systematic quantification.[40]

As Hippocrates taught, "experience"—in the broadest sense, encompassing both particular cases derived from practice and universal cases arising from theory—played a central role in training doctors and in medical practice.[41] Despite

**35** Liboni, Humanist Post-Mortem, p. 23.
**36** Siraisi, *Medieval Renaissance Medicine*, p. 89.
**37** Siraisi, Bresadola, Segni evidenti, p. 723.
**38** Maclean, *Logic, Signs and Nature*, p. 252.
**39** Siraisi, *Medieval Renaissance Medicine*, p. 67.
**40** Ibid., p. 164 f.
**41** Gilly, *Theodor Zwinger*, pp. 52–57.

the highly theoretical nature of the curriculum, the works selected for study in university classrooms were primarily aimed at equipping future physicians with the skills and knowledge necessary to treat their patients in the most practical and effective manner. Being both *ars* and *scientia*, medicine "was at once a system of explanation and a set of techniques; the acquisition of medical expertise was both an intellectual enterprise and a process of gaining skills."[42] As such, a period of apprenticeship with a more experienced practitioner was required, along with attending autopsies and anatomy lessons at least once a year, as these were considered essential for acquiring knowledge about the "hidden parts" of the human organism. Thus, theory and practice—which traditional medical historiography had for centuries presented as dramatically opposed—were, even within the academic realm, far more interconnected than previously thought. This is not to deny that, within universities, theoretical teaching took precedence over practical training.

With the growing focus on practice and experience in the medical field, a range of literary genres with explicitly practical objectives and character proliferated from the 16th century onward. This renewed attention to practical experience can be traced primarily to the humanist physicians' direct engagement with the works of Hippocrates. In particular, Books I and III of the *Epidemics* served as a key reference model for employing anecdotal narration [*per historiae*] as a guide for medical treatment. In the *Epidemics*, the narrative unfolds by means of presenting specific cases—through a description of how symptoms of the disease progressed in specific individuals, as observed firsthand by the physician from Kos.[43]

From the latter half of the 16th century, and increasingly in the 17th century, *per historiae* descriptions became a highly successful literary genre throughout the European medical world. By discussing individual medical cases, physicians —especially surgeons—were able to identify paradigmatic cases on which to optimally base their therapies.[44] In 17th-century medical treatises, the term *historia* explicitly referred to knowledge derived primarily from direct observation, often accompanied by bibliographical references, yet never subordinated to them.[45] The exemplary nature of history as *magistra vitae* [teacher of life] was thus adopted within the medical practice, with the narrative *per historiae* solidifying as an expression of *sensata cognitio*—practical, non-abstract knowledge rooted in sensory perception and direct observation.[46] To this end, collaboration among

**42** Nutton, Medicine in the Greek World, p. 49.
**43** Pomata, Praxis Historialis, p. 112.
**44** Ibid.
**45** Pomata,/Siraisi, *Historia*, p. 28.
**46** Pomata, Praxis Historialis, p. 106.

experts was of paramount importance, especially in the form of the *consilium*—a collective consultation or advisory process in which physicians would come together to provide guidance in uncertain situations. As Chiara Crisciani noted, the act of "giving *consilia*" was not merely a competence exercised by the physician; it was, in many ways, central to defining their identity. The *consilium* served as an expert assessment of *what to do* in situations of uncertainty.[47] In the face of doubt, physicians had to skillfully navigate the challenges confronting them, carefully considering the nuances of each case, where variability was the norm. As a metaphor from the early modern period aptly put it: "The profession of doctor is akin to the profession of seafarer." Like navigators at sea, medical professionals had to be prepared for all eventualities, never allowing themselves be taken off guard by complications.[48]

Medical advice encompassed three spheres of action: the physician's direct instructions to the patient; collective decisions made by multiple healers about a single patient; and offering "opinions" to a colleague who explicitly sought help with a particularly difficult case. In the latter context, the specific case afforded an opportunity for broader reflection, allowing physicians to hypothesize from the illness at hand. This marked a departure from the traditional approach in early modern medicine, which had, for centuries, aimed to apply general and universal concepts to particular contexts. While the *consilia* were still designed with practical intent, they increasingly took on a distinctly theoretical and doctrinaire character. This shift was further influenced by the fact that those doctors offering advice often did so at a distance: the patient was not directly in front of them. Instead, they would read a letter from a colleague who had carefully summarized the clinical case and sought counsel. As a result, direct engagement with the patient—a hallmark of earlier medical case studies—gradually diminished. The *consilia* evolved in such a way as to assume the appearance, scope, and argumentative structure of the scholastic *tractatus*, eventually becoming an integral part of the academic education system.[49]

**47** Crisciani, Consilia, p. 260.

**48** Da Villanova, *Explicatio super Canonem*, quoted in Crisciani, Consilia, p. 260: "Officium medici est simile officio nautae." The metaphor is also found in Siccus, *De optimo medico*, p. 15r: "Nec vero male mihi videntur sentire, qui medicos impitos comparant mali navirum gubernatoribus: sicut enim minime percipiuntur, istorum errore tranquillorum pelago et pacato, in magni vero & adversis tempestibus perspicui sunt, ac tunc cuiuis liquet per imperitiam gubernatoris naugragium contingere, ita imperitorum medicorum errores, in levibus morbis latent vulgarem quemquae & inexercitatum, quem non eveniunt ex illis magne offesiones."

**49** Crisciani, Consilia, pp. 266–268.

In the medical field, the literary genre of *Observationes*, which emerged in the second half of the 16th century, epitomized the focus on experience and individual cases. Initially, *Observationes* served as a means of self-promotion for physicians, highlighting their previous successes to demonstrate professional competence. However, the *Observationes* genre was not confined to medicine. As early as the 1630s, compilations of *Observationes Legales* or *Forenses* began to be published in the legal realm, featuring collections of solutions to hypothetical court cases based on jurists' common opinions. Reports of authentic cases, discussed and resolved in court, were also collected during this time.[50] In parallel, *Observationes* in medicine evolved as collections of real-life cases, with a focus on therapeutic success. Unlike the medieval *consilia*—which sought to abstract diseases and formulate general theories and doctrines—these cases were presented within their specific contexts, thereby offering future therapeutic models. Over time, however, the emphasis shifted to a more descriptive knowledge of the disease, derived from direct, first-hand observation.[51] Ultimately, *Observationes* were intended for publication and, above all, for circulation among colleagues. The goal was to contribute —by dint of the detailed description of therapeutic cases—to the creation of a shared and effective body of knowledge within the community of medical scholars and professionals—the *respublica medicorum*.[52]

This focus on the particular nature of therapeutic practice reminds us that therapy involves more than just the interaction between the doctor and the disease, or between colleagues. In fact, there is a third, and perhaps more crucial, component: the patient. The importance of the doctor-patient relationship, emphasized since ancient medicine, and notably reflected in the Hippocratic Oath,[53] is central to effective treatment. For treatment to succeed, the physician needed not only a deep understanding of the disease and the human body, but also the skill to conduct tests to detect and interpret signs of disease practically and correctly. Equally essential was gaining the patient's trust—an element always deemed vital for the success of any treatment. With the twin objectives of avoiding errors and establishing clear standards of practice, early modern physicians had to rethink the nature of their chosen profession, carefully crafting a model of practice to guide their interactions with patients at the bedside.

**50** Pomata, Sharing Cases, p. 201f.
**51** Ibid., p. 205.
**52** Ibid., p. 197.
**53** Rigato, Medico divino e razionale, p. 40.

## 2 *Optimus medicus* as *medicus cautus:* the evolution of ethical and deontological inquiry

To explore how a physician could embody the ideal of the attentive physician [*medicus cautus*] in practice—and thus how this ideal could be realized—treatises were published from the late 16th century that sought to offer behavioral models for physicians to follow in practice. The *cautelae* genre was seen as most fitting for this purpose, bridging the gap between the ideal model of a physician and its practical application.[54] As the medical profession consolidated in the early modern period and as medical knowledge was increasingly scrutinized, there arose a growing need to codify ethical and deontological standards, with the ultimate goal of safeguarding medicine's social standing.[55] In this context, the ethical profile of a conscientious physician began to reflect not just technical expertise, but also an evolving framework that sought to position medicine more strategically within society. Adherence to these standards allowed good physicians to distinguish themselves not only by their skill and knowledge but also by their ethical conduct from their adversaries.

### 2.1 A competitive marketplace

In early modern society—where reputation was closely linked to fame and honor—a bad reputation could result in outright exclusion from political and social life. The importance of a good reputation in medicine was particularly relevant, in a field with an uncertain and irregular clientele, where no guaranteed remuneration existed for any services rendered. Patients often selected the healer to whom they would turn based on purely "word-of-mouth" recommendations. As Gianna Polmata highlighted, a patient's judgment of a healer's ability, in practical terms, carried more weight than that of professional colleagues. Recognition from the authorities "above"—in the form of a degree or a license to practice[56]—was

**54** Linden, Gabriele Zerbi, p. 20 f.

**55** Münster, Deontologia medica, pp. 60 – 83.

**56** The need to bring order to the vast and varied world of healers led the political authorities to make several attempts to regulate them, both politically and socially. Institutions such as guilds and medical colleges were created to exercise greater control over this profession, which, despite numerous criticisms, was recognized as essential to the upkeep of a resource that the authorities considered increasingly important—public health. Following the example of the medieval *arti*—secular associations of individuals practicing the same profession—guilds of physicians were established. One of their key functions was to keep special registers to identify those members

insufficient without what might be called "legitimation from below."[57] Physicians, however, faced widespread skepticism toward the medical profession, largely driven by the inherent uncertainties of medical practice and theory. This general suspicion and mistrust of medicine's capabilities were compounded by many notorious polemics against medical professionals, leading to accusations to which they had to respond in order to save their profession's social standing and good repute.

The primary accusation levelled at doctors—next to incompetence—was that of greed. It was widely believed during the early modern period that physicians and apothecaries intentionally mislead their patients with incorrect or inappropriate treatments, aiming to prolong the course of the disease and thereby enrich themselves.[58] This accusation became particularly intense during times of plague, with physicians and apothecaries sometimes accused of deliberately infecting the population to boost their earnings. Cardinal Sforza Pallavicino's chronicle of the 1656 outbreak of plague in Rome recalls how, at the onset of the epidemic, numerous rumors circulated suggesting that doctors—in league with the city's magistrates—were intentionally spreading the disease. The contagion was described as a fully-fledged "artifice of secret politics," a tool of political control set in motion by the authorities in cahoots with the medical sect. It involved machinations of covert politics, with doctors and political leaders colluding to control the population.[59]

Accusations that doctors endangered their patients due to ignorance, arrogance, and recklessness, clearly greater carried weight when voiced by fellow medical professionals. This criticism is particularly evident in *De medici et de aegri munere* by the Turin anatomist Leonardo Botallo, who explicitly criticized academic medicine for being overly reliant on book learning. He advocated a more pragmatic approach, arguing that for the good of the patient, medical knowledge had to be rooted in direct knowledge of the subject rather than in

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who were registered, and therefore, were authorized to practice and enjoy certain rights and obligations. The guild itself was responsible for examining its members and granting them a license to practice, as well as ensuring that they met the professional and moral standards required for the profession. In Italian cities such as Venice, as early as 1316, guild-like organizations were set up in which only medical professors and graduate physicians could be admitted as members: these were the "colleges of physicians." These colleges presented themselves as genuine judicial bodies, responsible for examining and licensing all those who wished to practice medicine in a given territory. See Gelfand, Medical Profession, p. 1124; Gentilcore, I Protomedicati; Andretta, *Roma medica.*

**57** Pomata, *La promessa.*

**58** Siraisi, *Medieval Renaissance Medicine,* p. 85.

**59** Pallavicino, *Descrizione del contagio,* p. 30.

abstract definitions.[60] Botallo contended that the conjectural nature of medicine rendered certainty impossible and that claiming to have all the solutions based solely on book knowledge was a clear sign of ignorance and hubris.[61]

During the early modern period, lacking a good reputation posed an enormous obstacle for any physician seeking to practice medicine. Medicine was viewed as a commodity in a competitive "medical marketplace," structured according to similar rules employed in commercial exchanges,[62] where supply often far outstripped demand. Unlike the traditional tripartite model of medicine that assumed the monopoly of academic medicine, many healers—both official and unofficial—were active throughout this time.[63] Patients were free to choose their healer, often basing their decision on the expectation that their needs would be met effectively and swiftly. To achieve this, patients did not hesitate to turn to all sectors of medical practice, whether licensed or not. As Gianna Polmata noted, the hope of finding relief from their illness drove patients to engage in what she called "therapeutic experimentalism," trying every available option. In the patient's eyes, the two universes of medicine—the official and the unofficial—were not separate entities but rather part of a unified world from which they could select different cures.[64] Furthermore, the recurrent failures of official medicine—often demonstrating its impotence—made the use of pseudo-medicine and other non-institutionalized channels more acceptable to the general population. For official medicine to retain patients and convince them of the superior quality of care it offered, it needed to overcome mistrust while establishing an outright monopoly on the practice of healing.

Throughout the early modern age, physicians had to compete with a wide array of healers. It should not be overlooked that at that time there was a marked presence of "folk" healers, practicing a form of medicine rooted in empirical knowledge of the animal and plant kingdoms, passed down orally over generations. More often than not the boundaries between learned and popular medicine were blurred. Even physicians did not hesitate to use remedies of popular origin, particularly those validated by tradition as effective. At the same time, numerous concepts from academic medicine were made accessible and translated into vernacular knowledge.[65] Many physicians published treatises called *secreta* in everyday Italian as spoken by a layman, explaining how to obtain effective remedies

**60** Botallo, *De medici munere.*
**61** Gadebusch Bondio, *Avoidable Mistakes*, p. 11 f.
**62** Fissell, *The Medical Marketplace*, p. 533.
**63** Robison, *Healers in the Making*, p. 8.
**64** Pomata, *La promessa*, p. 249 f.
**65** Wear, Medicine Early Modern, p. 238.

for everyday ailments such as headaches or constipation—using a few simple ingredients that could typically be found in any well-stocked kitchen.[66] Paradoxically, the sheer simplicity of the treatments on offer was the key factor leading to a preference of domestic medicine over learned medicine. The use of technical language, particularly in Latin, only further alienated the largely illiterate population and increased the distrust patients harbored toward university-trained physicians. Folk medicine frequently appeared the optimal solution for patients seeking a relationship with the healer grounded, as far as possible, in a sense of "equality."

Alongside domestic medicine—unrecognized by the authorities' official licensing system—existed a distinct realm of practitioners linked to healing practices collectively known as *medici*, including barbers, midwives and others.[67] In *Quaestiones medico-legales* (1621-1635), Zacchia dedicates the entire first section of the sixth book to errors committed by doctors punishable by law [*De medicorum erroribus a lege punibilis*].[68] While eight of the thirteen *quaestiones* address errors committed by physicians, the remaining five consider those by other health practitioners, including, in order of importance, surgeons; pharmacists and apothecaries; empirics (i. e., quacks) and chemists; midwives; and finally, nurses and assistants. Zacchia, whose goal was to cover the subject as exhaustively as possible, adheres to the medical world's traditional tripartite hierarchy, yet also acknowledges those figures who, despite lacking official recognition—either due to the absence of a specialized corporation or formal academic training—were socially recognized as health professionals. Although indirectly recognized, Zacchia is particularly hostile to these healers who, despite possessing rudimentary curative skills, "abuse the title of doctor"[69] and were accused of doing more harm than good to their patients because of their extreme ignorance and lack of formal training. "Empirics" were harshly criticized for making mistakes every time they sought to treat a patient, as they acted without the slightest understanding of the disease they were supposed to treat or its causes, thus committing a "mortal sin."[70] The overriding reproach against them was their lack of a rationale.

Zacchia acknowledged that theoretical teaching was essentially incomplete without practical experience, for not only was practice without theory insufficient for the medical profession but was perilously so. Consequently, empirics were un-

**66** Park, *Doctors*, p. 48 f.
**67** Ibid., p. 136.
**68** Zacchia, *Quaestiones*, pp. 371 – 406.
**69** Ibid., p. 371: "omnes enim hi abusive Medici nomine veniunt."
**70** Ivi p. 402: "toties peccato mortali subijciuntur, quia medentur non cognito morbo, nec causa inquisita."

equivocally defined as "enemies of men." The animosity toward them was so pronounced that the Roman protophysician did not hesitate to liken them to those figures regarded with even greater hostility by the academic medical world: charlatans.[71] The Portuguese physician Rodrigo de Castro (1550–1627) critically viewed empirics, devoting an entire chapter in his influential treatise *Medicus Politicus* (1614) on how to distinguish between true and false physicians [*De veri et falsi medici agnitione*], thereby warning his readers—particularly the easily impressionable women [*mulierculae*]—about the deceptive nature and inherent danger of those remedies offered by these "pseudo-medics."[72] While the practice of buying remedies from peddlers dates back to antiquity, as David Gentilcore noted in his study *Medical Charlatanism* (2006), early modern charlatanism emerged as a distinct socio-historical phenomenon. The very fact that charlatans were required to hold a license from the mid-16th century onward exemplifies the reality and novelty of the development. Also known as "empirics," charlatans were considered by the Italian *protomedicati* as a legitimate medical category with specific functions and characteristics, practicing medicine without any official qualifications—lacking formal training in medicine, enrollment in college, or membership to a guild.[73] To obtain a license, the charlatans had to convince the authorities of the novelty of their remedies, which had to align with pharmacopoeia and official medical theories, and prove effective by curing a large number of people. Obviously, the remedy had to be external, as ingestible or "internal" medicines were reserved for physicians.[74] According to Gentilcore, several factors contributed to the rise of early modern charlatanism. First, the progressive medicalization of Italian society in the 15th and 16th centuries, and the consequent organization of health professionals within faculties and colleges, transforming medical treatment into a service for which payment was required.[75] Alongside this, increased literacy, the rise of a mainly mercantile economy and the decline of the traditional craft economy all played a role. Many charlatans, being literate, could not only access medical and pharmacopoeia texts, but also engage on a more equal footing with medical and institutional authorities.[76]

**71** Ibid.: "sed empirici, a ratione ita sunt alieni, ut ei sint inimici manifesti."
**72** De Castro, *Medicus Politicus*, pp. 200–205.
**73** Brockliss/Jones, *Medical World*, p. 230.
**74** Gentilcore, *Negoziare rimedi*, p. 76 f.
**75** Gentilcore, *Medical Charlatanism*, pp. 91–98.
**76** Ibid., pp. 99–106.

## 2.2 Ethical and deontological inquiry

To provide a positive code of practice, the authors of treatises on the *optimus medicus* felt it necessary to present a negative model by identifying and exposing the deceit and fraudulent practices committed by bad doctors. In his prologue to *Opus perutile de cautelis medicorum* (1495), the Paduan professor Gabriele Zerbi—while also defining the concept of *cautela*—argued that his primary goal was to provide his medical colleagues with the necessary means to avoid making errors. Zerbi offered physicians a code of conduct for use in all practical situations where errors could occur: "to make as few mistakes as possible [*peccare*], to err as seldom as possible [*errare*], and accordingly not be liable, or hardly ever, for legal prosecution [*delinquere*]."[77] Even more explicit was Giovanni Antonio Sicco, who, with his treatise *De Optimo Medico* (1551), strove to offer young aspiring physicians a model of excellence, contrasting it with the typical defects of his contemporaries. The ideal profile of the *optimus medicus* was personified by Sicco's professor at the University of Padua, Vittore Trincavelli, to whom his treatise was dedicated, as can be seen from the work's first page.[78] Unlike other contemporary physicians—accused of being arrogant and reckless, or timid and reticent [*multi enim praecipites sunt, ac audaciores; non pauci vero timidi & segnes*]—Trincavelli always acted diligently and prudently thus avoiding serious mistakes and invariably finding a concrete and most appropriate solution for each particular case.[79] Traditional medicine's strongly polemical nature is evident in Botallo's *De medici et de aegri munere,* where physicians who made mistakes were labelled "bad" and "false" practitioners, and often compared to actors on stage. In his treatise *De optimo medico*, published in Messina in 1637, the physician Pietro Castelli reformulated a traditional analogy: "such [bad] physicians resemble characters introduced in tragedies, for just as they share the appearance, attire, and persona of those they portray, yet are not truly those individuals, so too, many doctors exist only in reputation and in name, yet very few are so in reality."[80]

The desire to correct errors committed by contemporary physicians was expressed through the writing and publication of numerous treatises, not just in the form of *cautelae.* A notable example is the work by Sicilian protophysician

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**77** Gadebusch Bondio, *Avoidable Mistakes*, p. 5.

**78** Siccus, *De optimo medico.*

**79** Ibid., pp. 2r–4 l.

**80** Castelli, *De Optimo medico*, p. 15: "Simillimi enim huiusmodi Medici sunt personis, quae tragoediis introducuntur; quemadmodum enim illi figuram quidem, et habitum, ac personam eorum quos referunt habent, illi ipsi autem vere non sunt: sic et Medici fama quidem et nomine multi, re autem, et opere valde pauci."

Giovanni Filippo Ingrassia: *Iatropologia liber quo multa adversus barbaros medicos disputantur* (1547).[81] While not a *cautela*, the *Iatropologia* represented a strongly polemical attack on Sicilian medical practitioners, whom Ingrassia considered barbaric [*barbaros medicos*] due to their outdated and completely ineffective, if not downright dangerous, medical practices. He also accused his peers of excessive presumptuousness and arrogance. Aimed at warning younger physicians against repeating the mistakes of their elders, Ingrassia's work tackled methodological issues, notably the need to unify medical theory and practice and the importance of subordinating medicine to philosophy, as Galen had taught. Recognizing the primarily philosophical nature of medicine, Ingrassia argued, would restore its erstwhile prestige, distinguishing and defending it from accusations of being a merely lucrative exercise.[82]

Ethical reflection in medicine has ancient origins, with references to the ideal qualities in a doctor's training, qualifications, and behavior dating back to ancient Greece. A key reference is unquestionably the Hippocratic Oath, which examines the healer's behavior in their relationship with their patient and their relatives—the *adstantes* as they were called, those surrounding the patient during illness. During the Middle Ages, these ideals were revived and adapted to align with Christian moral values.[83]

The earliest known work that grapples with such issues is *Arsenio's Letter to Nepoziano*, a manuscript likely written between the 5$^{th}$ and 8$^{th}$ centuries as a series of paternal recommendations to a son, a doctor. While obviously fictional, it allows for a broader ethical reflection on the medical profession. The text can be divided into four parts. In the first, the author dwells on the doctor's essential attributes: in addition to being sober and modest, he ought, above all, to be vigilant, compassionate, and skillful in all circumstances.[84] Following a similar model, a whole series of prescriptions was written between the 9$^{th}$ and 14$^{th}$ centuries on the qualities of a good physician, detailing the subjects he should master along with practical instructions—on procedures like checking someone's pulse and examining urine—as well as on how medical practitioners should interact with patients. These texts also highlight medical etiquette, stressing moderation. As in the earlier texts, the "good" doctor had to be sober and modest, eager to learn, humble and benevolent, able to control himself and avoid all excesses, especially those arising from the "passions of the soul." His approach should be discreet, primarily

**81** Ingrassia, *Liber adversus barbaros*.
**82** Gadebusch Bondio, *Avoidable Mistakes*, p. 8 f.
**83** MacKinney, Medical Ethics, pp. 2–5.
**84** Minois, *Il prete e il medico*, (translation) p. 46.

aimed at not frightening the patient while fostering trust and cooperation.[85] From the 14th century onward, this genre of writing became more practical, with greater attention paid to how physicians should present themselves at the bedside. While medieval medical writing primarily sought to secure respect and obedience for the profession, a wider range of motivations emerged, with the patient becoming a co-protagonist in therapeutic practice. Acknowledging the predominately conflictual nature of the doctor-patient relationship, the physician had to find ways to earn his patient's trust and ensure his obedience for therapeutic purposes.[86]

Alberto de' Zancari's (1280–1348) *Libellus de cautelis seu documentis medicorum habendis*, likely written between 1301 and 1325, is an example of such a treatise. Concerned with preserving the reputation of his peers, Zancari stressed the need to avoid rushed or superficial diagnoses. Only a thorough study of the patient's medical history and signs of disease could enable a physician to correctly pronounce on the disease's progression and its future evolution.[87] This marked the beginning of medical examinations as detailed investigations, where physicians were called upon to examine both the symptoms and the patient in order to identify the true causes of illness and prescribe the most appropriate treatment.[88]

Another notable treatise, *De cautelis medicorum*, attributed to the Catalan physician Arnaldo da Villanova (1235–1311), insisted that honesty and meticulousness were essential qualities for a physician's competence and professionalism. This treatise is divided into four parts, offering general reflections on prudent conduct, rules for examining patients, health regimes, and a section entirely devoted to precautions regarding urine analysis [*cautelae circa urinas*].[89]

The content of these medieval texts does not substantially differ from that found in treatises on the characteristics of the *optimus medicus* published during the early modern period. The key differences are essentially twofold: first, the later treatises marked a growing departure from Christian sources, embracing a more secular and materialistic approach to medical practice; and second, they introduced a clearer formulation of the medical profession's deontological framework. While ethical reflection was already present in classical and medieval medicine, it was limited to the expression of ideals for conduct that medical practitioners were expected to keep in mind and endeavor to follow in practice. In contrast, the growing professionalization and regulation of the medical class

**85** MacKinney, Medical Ethics, p. 18.
**86** Duranti, Confidentia, p. 64 f.
**87** Linden, Gabriele Zerbi, pp. 31–33.
**88** MacKinney, Medical Ethics, p. 24.
**89** Linden, Gabriele Zerbi, p. 32.

in the sixteenth and seventeenth centuries transformed these ideals into an actual code of practice, essential for full recognition as a member of the medical profession. Consequently, these codes of conduct—which were essentially ethical in nature—assumed a deontological character. Adherence to certain moral standards became a reflection of proven technical superiority, which had the merit of upholding the reputation and dignity of doctors and their profession.

### 2.3 *"With diligent attention": the medical examination*

The moment when a doctor's vigilance should have been at its sharpest was during the medical examination. Loren MacKinney discovered five manuscripts, dating from the 10th century to the 15th century, outlining how doctors were expected to examine patients.[90] These works emphasized that each patient was unique and therefore required a tailored approach. The primary objective of the examination was to "know everything" about the patient and their state of health. The process began by questioning the patient about the nature and intensity of their symptoms, followed by an assessment of their pulse and urine. The doctor would then inquire about the smallest details of the patient's illness—whether the pain was severe, whether they had difficulty sleeping or breathing, and additional complaints. After a thorough analysis of any symptoms revealed by the physical examination and the patient's responses to questions, the skilled doctor would be able to identify the causes of the illness and prescribe an appropriate treatment.[91] Since the Middle Ages, the acts of inspecting and inquiring have remained at the heart of the physician's role during the medical examination. This approach stemmed from the recognition that, in order to formulate a correct prognosis, doctors had to approach the patient's bedside in what MacLean called a "Sherlock Holmesian" manner—with a sharp eye for detail.[92] Therapy could succeed only if the doctor applied an investigative method, uncovering every possible clue to extract the truth. The level of attention required, then, had to be exceptionally high, turning the act into a genuine appraisal.

Though not exceptionally successful at the time, Zerbi's work surely remains the best example of this type of treatise. Zerbi, an anatomist and professor of medicine and logic, initially lectured at the University of Bologna (1475–1483) and later at the University of Padua, where he taught theoretical medicine from 1495 to

**90** MacKinney, Medical Ethics, p. 23.
**91** Ibid., p. 24f.
**92** Maclean, *Logic, Signs and Nature*, p. 98.

1505. In the intervening years, he settled in Rome, where he lectured medicine at the university and served as Papal *Archiatra*—the pope's personal physician—at the courts of Pope Sixtus IV (1471–1484) and Pope Innocent VIII (1484–1492). Although historians have traditionally viewed Zerbi's work as the earliest and most comprehensive systematic work on medical ethics written during the early modern period, recent scholarship has shown that Zerbi was, in fact, reformulating long-standing ideas, referring not only to authoritative physicians and philosophers such as Galen and Hippocrates, but also to Pietro d'Abano and Alberto de' Zancari.[93] Katharine Park further emphasized Zerbi's great indebtedness to his Florentine colleague Niccolò Falcucci, author of the well-known *Sermones Medicinales* (also known as *Practica*), a compendium of contemporary medical knowledge on various diseases, their causes, symptoms, and treatments.[94] The primary goal of this work was to systematize medical knowledge and render it more accessible to a wider public. In the first *sermo*, Falcucci outlined the figure of the ideal doctor, for whom personal and ethical virtues were considered pivotal attributes in earning the patient's trust and, by extension, ensuring the treatment's success.[95] As Linden has argued, Zerbi's outstanding innovation lay in revitalizing the medieval *cautelae* genre by dedicating an entire work to ethical and deontological reflections—rather than limiting such material to a chapter or section within a general medical textbook. In doing so, he acknowledged their pivotal importance to the medical profession.[96]

Zerbi devoted the entire fourth chapter of his book to the subject of the medical examination and the physician's conduct toward patients during this process, titled *De modo se habendi medici erga patientes et maxime erga egrotantes* [On the manner in which the physician should behave toward the patient, and especially toward the sick]. For a prognosis to be successful, Zerbi advised that physicians maintain vigilance before, during, and after the examination. Under normal circumstances, the doctor was expected to visit the patient twice daily—morning and evening. In exceptionally grave cases, however, the doctor was not to leave the patient's bedside at all.[97] While overseeing the course of the treatment, the doctor was not to act alone but in close collaboration with the patient's family and friends. Their role was particularly important during the anamnesis phase, which involved collating information about the patient's medical history, temperament, symptoms, and the trajectory of the illness. Given the critical importance

**93** Gadebusch Bondio, *Avoidable Mistakes*, p. 3.
**94** Park, *Doctors*, pp. 110–112.
**95** Duranti, Confidentia, p. 67.
**96** Linden, Zerbi, p. 34.
**97** Zerbi, *De cautelis medicorum*, p. 92.

of gathering information to ensure a proper understanding of the symptoms of the disease, it was necessary to obtain as much detail as possible. Interviewing those who knew the patient and had cared for them during their illness was therefore indispensable. As Zerbi wrote: "Listening to the patient and to those around them; studying all the changes that have affected the patient in their life—and those that will affect them in the future, not only the major ones but also the smallest details—in order to consciously avoid all deceptions and mistakes."[98]

Once the physician entered the patient's room, he was expected to carefully observe the surroundings, looking for any fruits, herbs, or prepared palliatives from which he could deduce the patient's illness.[99] This preliminary phase was followed by the examination proper, which included close inspection of the patient's face—pallor, for instance, being considered a good indicator of the patient's overall health—followed by an evaluation of the pulse, palpation of various body parts, and, finally, a urine examination. After completing the examination, the doctor was to gather the patient's friends and family to inform them of the real causes and nature of the illness, and possibly provide a prognosis. Given the sensitivity of this final step, Zerbi advised that the physician proceed with the utmost caution, as a premature or inaccurate prognosis could not only harm the patient but also the doctor's professional reputation.[100] With this investigative phase concluded, the curative part of treatment—prescribing the necessary therapy—could begin.

### 2.4 Controlling gestures and words: medical etiquette

Another important precaution that doctors had to observe during the medical examination concerned their own conduct. As Zerbi noted, the physician was expected to present himself as praiseworthy to the public not only in his behavior and manners, but also in his attire. According to what might be termed a "medical eti-

**98** Ibid., p. 104 f. "Audiens ab infirmo, et ab astantibus omnia que possunt, investigans de omnibus mutationibus egro supervenientibus, et que supervenerunt, et ita in posterum que supervenient in processu vite non solum magnis, sed etiam qua<n>tumcunque parvis, ut certior factus deceptiones, et fallacias quascunque evitet."

**99** Ibid., p. 98. "Utatur preterea medicus altera cautela dum locum ubi residet infirmus ingressus est si forte viderit fructus, herbas, aut fomenta aliqua parata per que coniecturari possit super egri infirmitate."

**100** Ibid., p. 110.

quette," the physician had to be extraordinarily attentive, diligent, and courteous toward both the patient and any bystanders.[101]

As previously noted, the way the doctor presented himself to the patient was considered important, especially in the Middle Ages, when moderation was viewed as a defining quality of a good physician. The doctor's sobriety had to be evident in every aspect of his presence: in his gestures, speech, and appearance. From the medieval period onward, medical authors consistently emphasized the need for a highly careful and measured approach to the patient—one that would inspire confidence, foster trust and thereby contribute to the success of the proposed treatment.[102]

In this context, Sicco's moral portrait of the excellent physician is exemplary. He begins by emphasizing the doctor's training, which, according to tradition, should begin at an early age and be grounded primarily in the study of dialectics. This discipline was intended to continue throughout the doctor's life, instilling in him a habit of self-questioning and guarding against arrogance. The good medical practitioner was to be modest, sincere, and prudent, devoid of vices—especially those of gluttony, wine, and luxury. Finally, as Zerbi noted, a physician had to be God-fearing, recognizing that nothing could occur without the intercession of divine will.[103]

In addition to general rules, a distinct code of conduct was expected at the patient's bedside. Above all, the doctor was to remain calm and display good manners. He was expected to be friendly and courteous with the patient and his family, without being overly talkative. To ensure clarity and avoid arousing suspicion, doctors were advised to minimize the use of Latin and refrain from excessive courtly formalities. Beyond his behavior, the physician was also to be mindful of his appearance—neither negligent nor overly fastidious. Particular attention was paid to personal hygiene: doctors were expected to wash and apply perfume before seeing patients, though they were cautioned not to overdo the scent. These various expectations can be summarized by the maxim: *refrain from excess and follow moderation.*[104] The purpose of such medical etiquette was not only to distinguish the true doctor from his rivals, but also to win favor with the sick and, in turn, secure their compliance with treatment.

The physician's self-vigilance is similarly highlighted in the treatise of the Portuguese *converso* Rodrigo de Castro, written in the early 17th century as he left Lisbon

**101** Ibid., pp. 102 f.

**102** MacKinney, Medical Ethics, p. 18.

**103** Siccus, *De optimo medico*, p. 6r: "Verus autem, bonusque medicus Deum semper in animo habet, unum illim contemplatur, illi omnia refert accepta in sanandis morbis."

**104** Ibid., p. 10r: "sed ab omni excessu declinare, & mediocritatem sequi."

for Hamburg.[105] In the third book of his *Medicus Politicus*, de Castro argued that the physician's "prudence" should be twofold: the first type, defined as *militarem* [military] or *oeconomicam* [economic], was to be applied to others—particularly to patients and assistants—and resembled the prudence of generals with their troops or masters with their household servants. The second type, described as *eremiticam* [hermit-like], was to be turned inward, toward the physician himself. Once again, the aim was to provide doctors with a code of conduct by which to live prudently, cultivating a careful and self-restrained disposition.

De Castro also portrayed the good physician as a man of moderation, stressing that abstinence from vices and excesses was not only essential to maintain focus on one's work, but also for establishing the physician as a moral exemplar within society. Doctors were particularly advised to abstain from lust—a vice that, according to de Castro, could drive a man insane and reduce even the most capable to a beastly state "*quae nomine reddit belvinos ac bruti similes, & animum stupidum & ad sapientiam inertem*"—rendering the mind dull and inert in relation to wisdom. Above all, however, they were urged to refrain from melancholy.[106]

In line with contemporary polemical literature against the medical class, de Castro also identified avarice, pride, and envy as the most widespread vices among his fellow physicians. So pervasive were these flaws that physicians had to remain particularly vigilant against them. He reserved particular criticism for overly proud doctors who, in claiming the success of their treatments, failed to recognize that the therapeutic success and healing ultimately came from God acting through man.[107] Building on what his predecessors had written, de Castro further emphasized that modesty should never be mistaken for mediocrity.[108]

The impression the doctor aimed to convey was that of a competent yet humble professional; affable, but never inappropriate. Central to this perception was the physician's outward appearance. Although, as de Castro reminds us, "clothes don't make the man,"[109] it remained important to present oneself in a way that created a favorable impression. Once again, the guiding principle was "moderation": a doctor had to be polished, though not excessively so, and impeccably hygienic. Equally important was how doctors approached their patients. Their gestures were never to be rash or abrupt; instead, their conduct had to be adapted to the temperament of each individual. In this way, a doctor needed not only to be a reassuring presence, but also to project authority. This made the performative

**105** Arrizabalaga, Medical Ideals, p. 108 f.
**106** De Castro, *Medicus Politicus*, pp. 110 – 112.
**107** Ibid., pp. 113 – 121.
**108** Ibid.
**109** Ibid., p. 124: "vestis monachum non facit."

dimension of medical practice crucial—carefully staging diagnostic gestures, such as pulse-taking and urine inspections.[110] Particular care was required when treating patients prone to melancholy, as the wrong words or mannerisms could deepen their despair and accelerate the progression of the illness.[111] Prognoses, especially in cases marked by uncertainty, had to be delivered with the utmost caution. While doctors were encouraged to instill hope, they were strictly warned against guaranteeing recovery—for the final outcome, ultimately, rested with Divine Will.[112]

The treatises dedicated to describing an excellent doctor were fully integrated into the contemporary cultural climate. In fact, medical etiquette appears to have absorbed and, in some ways, adopted the principles of all those court etiquettes published from the 16th century onward, the prototype for which is undoubtedly Baldesar Castiglione's *Il libro del Cortegiano.* Published in Venice in 1528 from the press of Aldo Manuzio, *Il Cortegiano* set out to provide a manual of conduct for those living at court. As in the medical treatises, Castiglione's analysis integrates both ethical and aesthetic considerations, ultimately culminating in the ideal of moderation. As Cicero declared in *De officiis* [*mediocritatem illam tenebit, quae est inter nimium et parum*], one should pursue the ideal of moderation. Castiglione, in turn, applied this principle to the figure of the courtier who "through study and effort [should] treat and largely correct [their] natural defects."[113] This was the art known as *sprezzatura* [effortless grace], the antithesis of *affettazione* [mannerism].

Whereas *affettazione,* Castiglione noted, referred to an overtly forced and contrived behavior aimed at earning approval from others, *sprezzatura* can be defined as a form of "nonchalance." It was not a natural and spontaneous attitude, but rather one so controlled and refined as to appear so. For the courtier, *sprezzatura* came to represent a *regola generalissima*—a very general rule—that required continuous exercise and relentless self-surveillance. Such meticulous control over the smallest gestures and movements had the merit of perfecting them through practice, thus concealing the learning involved and lending the impression that everything was done with ease.[114] To this end, the courtesan had to be endowed with the virtues of caution and prudence, equipping themselves with

**110** Malatesta, *Fiducia, fiducie*, p. 13.
**111** De Castro, *Medicus Politicus*, p. 126 f.
**112** Ibid., p. 135 f.
**113** Castiglione, *Cortegiano*, p. 40 f: "e con studio e fatica liminare e correggere in gran parte i difetti naturali."
**114** Ibid., p. 59.

true inner discipline in a bid to govern their outward appearance.[115] They had to resort to the art of *sprezzatura* to achieve grace, and, consequently, harmony. Similarly, a doctor was expected to maintain constant vigilance over himself, striving to uphold all those ethical-deontological rules of behavior—internalizing them and transforming them into genuine habit.

Alongside descriptions of the ideal physician, some deontological reflections on the professional identity of the "good surgeon" were also published by graduate surgeons. This is evident, for example, in Giovanni Andrea Della Croce's *Cirugia universale e perfetta* (1583), and Giovanni Battista Cortesi's *In Universam Chirurgiam Absolutam Institutio* (1633). The attributes of the ideal surgeon scarcely differ from those of the ideal physician, and are similarly rooted in the teachings of medical authorities such as Celsus (c. 143–37 BC) and Galen.[116] Like the good physician, the good surgeon had to be vigilant, temperate, and God-fearing. He also needed to be healthy, as no one would trust their wellbeing to an unhealthy person. Furthermore, he had to be sober in judgment and modest in conduct. As with physicians, the ideal surgeon was expected to be well-versed in theory and practice, especially in how to conduct himself at the patient's bedside. The key difference was that a surgeon needed to have "learned hands"—confident in what he was doing and never trembling,[117] while being fully equipped with all the tools necessary for exercising his profession. He should not move too briskly, make fewer incisions than are necessary, and not be put off by his patients' cries. Irrespective of the circumstances, the surgeon had to remain calm, with his senses fully alert, paying close attention to any visual inputs.

The surgeon's sense of moderation had to be expressed aesthetically: never overly groomed, but not unkempt either. A surgeon had to be familiar with his patients and yet maintain a certain distance, for otherwise his instructions would not be taken seriously. His words had to be clear and concise. He should neither diagnose nor operate without first being thoroughly aware of the ailment's true nature, nor should he promise recovery or make predictions of death in doubtful situations.[118] Surgeons embraced the Galenic definition of surgery as a "manual art," thereby stripping the practice of its negative connotation. As Dalla Croce wrote, surgery—being performed by hand—was not only the most intricate branch of medicine but also the most reliable, as it directly engaged with the physical body: a tangible, material entity. It also represented the oldest tradition within

**115** Ibid., p.128.
**116** Savoia, Early Modern Italian Surgeon, pp. 33–35.
**117** Celsus, *De Medicina*, p. 296 f.
**118** Dalla Croce, *Cirugia Universale*, p. 6v (HAB: M: MK4° 6).

medical practice.[119] Given that surgery required the utmost precision, a good surgeon had to be experienced, thus he could not be too young. Nor could he be too old, for that matter, for age—generally a sign of experience and authority—often brought with it a weakening of the senses.[120]

## 3 The complex nature of the doctor-patient relationship

The doctor-patient relationship throughout the early modern period was much more intricate than generally assumed. A simplistic, and quite superficial interpretation, would suggest that the doctor-patient dynamic, from the time of Hippocratic medicine until the 1970s, took the form of "medical paternalism." This view posits an unequal and highly asymmetrical relationship, a genuine power imbalance which favored the doctor—who held technical-scientific knowledge—to the detriment of the patient. While a key component in any therapeutic process, the patient was completely passive, and was expected to accept the doctor's decision without expressing an opinion.[121] As we have seen, however, the situation was much more complicated. Winning the patient's trust was not just an essential goal, but also a strategic one, crucial not only for the success of the therapy undertaken, but also for navigating the highly competitive medical market.[122] While trust was considered an essential element in any therapeutic relationship between doctor and patient, it was, nonetheless, a historically constructed and asymmetrical concept. The resulting imbalance in this relationship stems from the fact that trust presupposes, above all, that the patient is in a state of discomfort or distress, necessitating their reliance on the doctor's care. Trust, therefore, was a hetero-driven sentiment, a concept which, in medieval legal terms, referred to a binding relationship that was inherently asymmetrical.[123]

The indispensability of the patient's trust in healing has been theorized since ancient times. In the aforementioned *sermones* by Niccolò Falcucci, the lack of a patient's trust was identified as one of the greatest obstacles to successful treatment.[124] Zerbi and Sicco, likewise, stress the paramount importance of trust and goodwill for effective therapy. The patient's cooperation was seen as a funda-

**119** Ibid., p. 1r.
**120** Celsus, *De Medicina*, p. 297.
**121** De, Paternalism in Medicine; Kaba, Soorakumarian, Doctor patient relationship; Sisk, Frankel, Isaacson, Truth-telling; Viafora/Furlan/Tusino, *Questioni di vita.*
**122** In this respect see Pomata, *La promessa.*
**123** Duranti, Confidentia, p. 61.
**124** Malatesta, *Fiducia*, p. 14.

mental resource. Zerbi asserts that: "the confidence a patient places in [his] doctor does more for his recovery than all of his [the doctor's] instruments."[125] Sicco, too, describes medicine as an art based on three elements: the doctor, the patient, and the disease. To explain how these three elements interrelate, he draws an analogy to war: as in a battle, the patient's body becomes the battleground, the disease the enemy, and the doctor the commander—yet even the most skilled commander is powerless without the cooperation of his ally, namely the patient. The patient was never merely perceived as a passive party, but was positioned as a key player. Botallo, echoing this perspective, offers a vivid analogy: "the disease is the enemy, the sick person is the ally, therapies are the weapons and strongholds, the doctor is the artificer."[126] In this view, not only was cooperation vital—but so too was obedience. The patient's role was not merely to trust but also to follow the physician's instructions, as their collaboration was essential for therapeutic success.

The doctor-patient relationship exhibits an inherent asymmetry, though this did not imply that the doctor's opinion takes precedence over the patient's wishes and consent. Quite the opposite, in fact. Rather, their relationship was complex for a number of reasons. While honesty and transparency were expected between doctor and patient, and it was understood that the patient should never lie about their true state of health, there are instances when the doctor was exempt from the obligation of fully telling the truth. Situations did arise when the doctor's omission—not telling the truth—was considered therapeutic. Mindful of the suggestive power of the imagination, Sicco warns doctors to be prudent with their words, so as not to upset or annoy patients.[127] Zerbi similarly cautions doctors never to rush to answer their patients' questions, but to carefully consider them first before speaking.[128] Finally, while patients should never lie, doctors were well aware of the risk of being deceived by the patients themselves. When faced with a patient's dishonesty, vigilance no longer served a therapeutic purpose but instead transformed into a defensive mechanism.

**125** Zerbi, *De Cautelis*, p. 64. "Confidentia autem quam habet infirmus de medico plus valet ad sanitatem, quam medicus cum omnibus suis instrumentis."

**126** Botallo, *De medici munere*, p. 108. "La malattia è il nemico, il malato è l'alleato, le terapie sono le armi e le roccaforti, il medico è l'artefice."

**127** Siccus, *De optimo medico*, p. 12v.

**128** Zerbi, *De Cautelis*, p. 116.

### 3.1 The physician's right to lie

As noted, physicians were expected to be vigilant about how they expressed themselves verbally, especially when delivering a dire prognosis, or addressing patients who were easily impressionable or prone to despair. In such cases, doctors needed to exercise self-censorship, carefully choosing their words and delivery. The potential for omitting and concealing information from patients became a subject of ethical reflection within the medical world, encapsulated by the question: "Is it permissible for a doctor to lie?"

In the *Medicus Politicus*, Rodrigo de Castro devotes the whole chapter IX of Book III to this issue of whether is it permissible for a doctor to deceive a patient for the sake of their health [*Liceatne Medico Aegrum Fallere Valetudinis Gratia*].[129] This theoretical question, equally explored by other authors, takes on greater complexity here in view of de Castro's religious status. De Castro was in fact a Jewish convert who, after arriving in Germany, made it increasingly clear that his conversion to Catholicism was a professional necessity rather than a true personal conviction.[130] The Lusitanian doctor's position was that for therapeutic purposes, the doctor was authorized—even on moral grounds—to lie to the patient. De Castro based his position on a passage from Plato's *Republic* in which the Greek philosopher argued that, if done for a good cause, a lie by doctors and jurists should not be considered intrinsically evil, but rather as a form of medicine [*φαρμακός*]. The idea that physicians could deceive their patients has been theorized and accepted in medical circles since ancient times, as evidenced in Hippocrates' treatise *In Epidemiis,* and Galen's commentaries on that work. Ancient medical practitioners accepted the use of a lie to induce a placebo effect in their attempts to have patients believe that they had been given one substance instead of another. For example, in *Epidemiis* (VI, 5–7) there is an episode in which a sick man complains of an earache. To cure him, the doctor pretended to remove a foreign body from the patient's ear, which was nothing more than a wool ball he had concealed in his hand and which he quickly threw into the fire after its supposed removal.

While Galen was skeptical about physicians' use of deception, he distinguished between two types of patients: courageous ones—whom the physician should always inform about their current state of health—and timid ones, for whose recovery it was necessary to awaken hope, and for whom deception was not only acceptable but even recommended.[131] De Castro also observed that

**129** De Castro, *Medicus Politicus*, pp. 142–146.
**130** Arrizabalaga, Medical Ideals, p. 22f.
**131** Gadebusch Bondio, Verità e menzogna, p. 73.

patients were often distrustful of doctors, trying to catch every little word they uttered, carefully scrutinizing their faces for the slightest clue that might reveal something about their true state of health. This required physicians to be alert with their words, trying not to reveal what they knew. This became essential when dealing with anxious patients, where the doctor had to dissimulate and adopt an impassive and inscrutable expression in their presence, maintaining neutrality and objectivity, for therapeutic reasons. De Castro recalled that Celsus and Damascenus (c. 650–750) supported lying to keep the patient's hopes alive and prevent despair, but he always advised informing the family of the true state of the patient's health. The legitimacy of lying is further reinforced by a biblical example from the First Book of Samuel, in which David escapes from Achish, king of Gath, through cunning and by feigning madness.[132]

However, de Castro also notes—alongside the views of those thinkers who accepted lying if it was for the patient's good—the opposing views of those who totally condemned lying, particularly those positions formulated by Aristotle in the *Nicomachean Ethics*, where he argued that simulation was contrary to the divine order of nature, and thus inherently evil. To defend his stance, de Castro distinguished between three types of lies. The first, he noted, consisted not so much of a false statement as an omission of the truth,[133] referencing the subtle distinction that had existed in early modern times between *dissimulatio* [pretending not to be what one is] and *simulatio* [pretending to be what one is not ."[134] The second, de Castro emphasized, was the abominable difference between a harmful lie [*mendacium nocivum*] and a benevolent lie [*mendacium officiosum*].[135] While the former should always be avoided and condemned, the latter could have positive effects depending on the context, as with a placebo. He further supported the recourse to a lie for a good purpose by invoking the concept of *dolus* which, following Winfried Schleiner's suggestion, can be translated as "ruse," or "cunning."[136] Returning to the war analogy, a *dolus* against an enemy took on a positive

**132** Samuel 21:13–15. "13 And he changed his behavior before them and pretended to be insane in their hands and made marks on the doors of the gate and let his spittle run down his beard.

14 Then Achish said to his servants, "Behold, you see the man is mad. Why then have you brought him to me?

15 Do I lack madmen, that you have brought this fellow to behave as a madman in my presence? Shall this fellow come into my house?"

**133** De Castro, *Medicus Politicus*, p. 142 f.

**134** Zagorin, *Ways of Lying*, pp. 2–3. See Zacchia, *Quaestiones medico-legales*, p. 169: "simulator enim id quod non est, vel alio modo quam sit, dissimulatur vero id quod est."

**135** De Castro, *Medicus politicus*, p. 144.

**136** Litterally, *dolus* means "fraud, deceit."

value in view of its outcome.[137] In my view, this military analogy is particularly thought-provoking because it sheds further light on just how multifaceted the doctor-patient relationship was. If disease was considered the enemy, it's important to recognize that it was not seen as separate from the patient. As a result, any deception used to combat illness—though intended to benefit the patient—was still directed at them. This approach was justified through the metaphor *dolus ad bonum* [good deceit], likening it to strategic deceit in warfare.

While the doctor's simulation was accepted and even encouraged in certain circumstances, the patient's condemnation of deception was unequivocal. Despite patients' total rejection of doctors lying—especially in view of the therapeutic success achieved—physicians were, in reality, aware that patients might resort to deception for a variety of reasons. For instance, patients might lie about their condition out of shame or fear—typical examples being women lying about their virginity, or men feigning to suffer from colic to avoid attending court—or they might fabricate details simply to test the doctor's competence. Zerbi argued that physicians, much like athletes, must consistently exhibit determination and maintain an alert mind [*animo semper prompto*] to avoid falling victim to deception. Caution, in this context, is not simply a matter of habitual response, but rather involves proactive, vigilant action. This concept underscores the necessity of constant vigilance, ensuring both the avoidance of dangers and the safeguarding of daily security amidst unforeseen challenges in professional practice.[138] The likelihood that a patient might resort to deception during a medical examination was considered particularly high, not only during the oral questioning about their symptoms, but also during other sensitive moments, such as urine examinations.

As previously noted, the urine examination was a central yet much-contested element of medical therapy practice. While deemed the only bodily excretion capable of furnishing detailed information about the internal state of the "humors," the urine test itself was fraught with ambiguity and easily prone to error. The emphasis on doctors being vigilant during urine analysis was primarily justified by the complex nature of the test itself, which could be influenced by a formidable array of external contingencies that might distort its interpretation. Doctors were advised, inter alia, to use containers of a specific color, to analyze the contents only under certain lighting conditions, and to do so at a set time of day.[139]

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**137** Schleiner, *Medical Ethics*, p. 12.

**138** Zerbi, *De cautelis*, p. 44: "Describitur autem cautela per actum, et non per habitus cum dicitur invitatio cum diligenti attentione ut denotetur medium ad pericula assicura ac free quotidie capiti suo emergentia in actu operativo vitanda debere esse animo semper pronto, atque intento non minus qual athlete."

**139** Moulinier Brogi, *L'uroscopie*, pp. 84–88.

It should also be noted that many medical practitioners were highly critical of such methods and of those who claimed to offer safe and accurate diagnoses based solely on urine without physically examining the patient. In fact, the examination was often carried out at a distance, an approach that was often met with hostility and regarded as inadequate. Beyond this purely technical concern, a second kind of fear demanded the physician's utmost caution: the likelihood of being deliberately deceived by the patient. Several publications were devoted to the precautions doctors needed to take when examining urine—the *cautelae urinarum*. The earliest examples of this type of work date back to the late Middle Ages, attributed to the Catalan doctor Arnaldo de Villanova. Its enduring authority is evident later centuries, as it cited in several posthumous treatises, including de Castro's *Medicus Politicus*.[140] The most noteworthy aspect of Villanova's *cautelae* is that he begins his reflections with a warning to doctors of the need to equip themselves with the means to guard themselves against those determined to deceive them. He framed the patient-doctor interaction as a veritable contest, urging physicians to carefully scrutinize and analyze the patient's demeanor, gestures, and words.

The second precaution advised the doctor to observe the patient's face during the urine examination. If the patient intended to deceive, de Villanova noted, they might soon burst out laughing, or their face might change color. Other precautions involved gathering information about the patient whose urine was being collected and their symptoms.[141] The doctor's line of questioning assumed an inquisitorial tone, as they not only had to pay attention to assess the symptoms, but also ensure the truthfulness of the patient's responses. The physician had to be meticulous in their practice: nothing about the patient should go unnoticed, and even the slightest nod of the head could conceal a deeper meaning. Urine could be tampered with in multiple ways. Numerous reports describe patients substituting someone else's urine, or adding ingredients such as wine or vinegar in a bid to alter its color, consistency, and odor.[142] These manipulations could lead to misdiagnoses, such diagnosing pregnancy in male patients. The doctor's constant vigilance was crucial to avoid deception and safeguard their reputation.

The ramifications of patient fraud could be more severe, even politically and socially. This is evident when considering another fraudulent practice that required careful attention: feigning illness. Simulating diseases [*De morborum simulatione*] was a significant concern for both the medical and legal professions

**140** De Castro, *Medicus Politicus*, p. 150.
**141** Da Villanova, De Cautelis Medicorum, p. 751.
**142** De Castro, *Medicus Politicus*, p. 153 f.

of the time, so much so that between the 16th and 17th centuries a number of treatises were published on how to detect false illnesses. The methods for simulating disease were numerous and inventive—for instance, holding a bar of soap in one's mouth to simulate foaming—as documented in numerous medical treatises, from Galen to Hippocrates. These included techniques for inducing ulcers, dropsy, madness, and more, along with ways to alter skin color, raise body temperature, and speed up or slow down pulse rate.[143] By the late 16th century, feigning illness had become the subject of a branch of forensic medicine; it was viewed as equivalent to fraud and, therefore, punishable by law. These treatises outlined how to induce fever, feign pallor and facial deformities, and falsify urine, and even produce lesions similar to those displayed by lepers, often using herbs such as Thapsia mixed with ointments and then applied to the supposedly injured areas. To simulate madness, mandrake roots were boiled in wine, which, if swallowed, caused one to lose one's mind for a whole day. Of particular interest were the methods used to simulate tumors, such as vigorously rubbing dried powder made from wasp and hornet decoctions, known as *raspiolae pulvis,* onto the body near a source of heat.[144]

The topic of disease simulation is pivotal because it allows us to further explore the multifaceted nature of the doctor-patient relationship, and to focus attention on a second type of medical vigilance—the "negative" kind, seen as a tool with which to investigate individuals suspected of criminal actions or behavior. Under normal circumstances, vigilance against patient deception was considered necessary to preserve the doctor's reputation and prevent his competence from being ridiculed. However, in extraordinary contexts, such as criminal proceedings, it took on another meaning. Here, the doctor's role was not only to safeguard the reputation of the medical profession, but also to determine whether an individual—who was allegedly guilty of wrongdoing—ought to be prosecuted. Despite the multiple ways in which illness could be faked, physicians agreed that the motives for simulating disease were invariably the same: "namely out of fear, out of shame, or out of profit."[145] In these contexts, the doctor's expertise became crucial, for only they could uncover the truth on account of their knowledge and

**143** Pastore, *Le regole dei corpi,* pp. 73–77.

**144** The methods for simulating diseases were essentially always the same, given that the authors, when they did not refer to each other, relied on readings from works such as those of Galen. See, for example, Selvatico, *De ijs qui morbum simulant*, pp. 7–10; Pastore, *Le regole dei corpi,* pp. 63–73; Maladies vraies et simulées, pp. 11–26.

**145** Selvatico, *De ijs qui morbum simulant,* p. 6. " ad timorem scilicet, vel ad verecundiam, vel ad lucrum."

skills. Thus, simulating diseases offers a new lens to examine medical vigilance, particularly within the more confined context of the criminal court.

## 4 The social and political utility of medical expertise

In the pre-modern-era, judges commonly relied on expert opinion [*consilium sapientis*] in their decision-making[146]—a practice rooted legal system's demand for evidence, which underpinned the entire criminal process. Circumstantial evidence and mere suspicion were considered insufficient: what was needed were certainties, actual evidence such as the testimony of at least one witness, but more importantly, a confession by the alleged offender.[147] Throughout the early modern era, in contrast to the Anglo-American system based on English common law—where testimony from non-direct witnesses was not considered admissible—the Italian system followed the inquisitorial model typical of Roman and canon law, whereby evidence was decisive.[148] As Paolo Zacchia, the Roman physician considered the father of modern forensic medicine, wrote in support of jurisprudence, medicine offered its services in the belief that: "The truth is always a safeguard of justice; therefore, it is always a good thing, and never evil, never harmful, never a defender of crime, but always useful and always praiseworthy; and therefore the truth must be sought, lies banished."[149]

The self-generated claims that medicine could offer those certainties and absolute truths in court may seem to contradict what has been argued in the previous pages about the inherent uncertainty of medical knowledge, especially regarding the humoral theory. As previously explained, Galenic medicine struggled to establish itself as a *scientia* across Europe due to the unpredictable results it produced when applying general and universal theories to highly individualized cases. Despite numerous efforts to confer upon it greater epistemological authority, academic medicine had to accept its status as *scientia coniecturalis*—an inferior science compared with others that could offer infallible and unquestionable truths through the use of a theoretical, logical *methodus*. The recognition of med-

**146** For more information on this issue, see Ascheri, Consilium sapientis, pp. 533–579.

**147** Di Renzo Villata, Paolo Zacchia, pp. 17–24.

**148** Watson, *Forensic Medicine*, p. 9. On the difference between the Continental and Anglo-American systems of collecting evidence, see Clark/Crawford, *Legal Medicine*; Crawford, Medicine and the Law.

**149** Zacchia, *Quaestiones medico-legales*, p. 570: "veritatis tutela semper pro iustitia est, ergo semper bona, numquam mala, numquam perniciosa, numquam crimini patrocinans, sed semper utilis, semperque laudabilis; et idcirco semper veritas quaerenda, mendacia repellenda."

icine as a *scientia*, rather than merely an *ars*, gained its first decisive impulse with the rise of what might anachronistically be described as "forensic medicine."

Although expert advice to assist a judge on technical matters was widespread practice in areas where Roman canonical procedure was used, doubts arose as to the binding nature of such an opinion, particularly medical ones. Jurists, while recognizing the need for doctors to intervene in certain circumstances, questioned the reliability of medical expertise, given that it was based on suppositions and not infallible and proven truths—ignoring the fact that jurists themselves rarely dealt with *proba plena* [conclusive proof], but only with traces and clues. Yet physicians asserted their authority by insisting on the particular and individual nature of medical knowledge, making their contributions indispensable in legal proceedings. While their inability to produce universal knowledge was considered a major deficiency, it became an asset in the courtroom. Given the diversity of the human physique, only a physician's expert eye, accustomed to dealing with the specifics of human physiology on a daily basis, could offer true knowledge.[150] To again quote Zacchia: "The nature, however, of particular individuals, which must be taken into account when rendering a judgment, can never be fully grasped by a judge, who must rely on a physician's expertise with extensive experience."[151]

Attempts to reconcile the specifics of individual cases with a broader framework of general causes capable of providing true explanations led to the creation of *consilia* in the Middle Ages. From the 16th century onward, procedural advice became the primary means for affirming the "scientific" nature of medicine, thereby asserting the importance of its practitioners for society. The rise of forensic medicine was symptomatic of a broader process of "medicalization" in early modern society—a growing expansion of medicine's authority.[152] It is noteworthy that the aspect of medicine that most elevated its prestige was applied in situations where the therapeutic goal—typically the key objective of medical practice—was entirely absent. Instead, the focus was on ascertaining truth through the study of signs of illness.

For medicine's indispensable role to be recognized, the doctor's vigilance during legal proceedings had to be of the highest caliber. Above all, he had to closely monitor symptoms, whether palpable or reported by the defendant, in order to transform these "conjectural signs" into "obvious signs" and thereby construct a

**150** De Renzi, La natura in tribunale, p. 808 f.

**151** Zacchia, *Quaestiones*, p. 341: "natura tamen particularium individuorum, cuius respectus habendus in sententia ferenda, numquam ut medicus callere poterit, qui etiam in hoc casu requiritur, ut si magnae experientiae ."

**152** de Ceglia, *Corpses, Evidence*, p. 16 f; Watson, *Forensic Medicine*, p. 43 f.

truth, even in the absence of absolute certainty. This was undoubtedly most evident in cases involving the substantiation of pain, such as a headache, which could only be verified through the patient's own testimony. Since pain is a completely subjective experience that does not manifest through any objective signs, the only way to assess its presence was through the patient's description of how they were feeling. In light of the fact that a patient might lie about their state of health, the doctor needed specific diagnostic techniques to interpret these signs accurately and determine whether the reported pain was real or not.[153]

## 4.1 Autopsies

Available records show that physicians were appointed to public functions since the 13th century, when they were called upon to assess the severity of wounds or to perform autopsies. Although post-mortems were a traditional task dating back to ancient Greece, the practice was only institutionalized toward the end of the Middle Ages.[154] Physicians searched for "obvious signs" inside the body that could reveal the truth when external indications were lacking. In his commentary on Hippocrates' *Prognosticon*, the physician Girolamo Cardano 1501–1576 expressed confidence in the infallible ability of autopsies to determine the cause of death. He distinguished three kinds of medical signs: diagnostic, prognostic, and cadaveric dissection [*dissectio cadaveris*]. Diagnosis and prognosis were fraught with uncertainties, and cadaveric dissection was seen as the only method capable of producing empirical evidence.[155]

While the practice of opening corpses has been substantiated as early as the mid-12th century—primarily as a funerary practice for the elites—the first known autopsy commissioned by civic authorities occurred in 1286. As historian Katharine Park notes, the decision to dissect a corpse was driven by the goal of uncovering the cause of the high rate of sudden mortality affecting both men and chickens in the cities of Cremona, Piacenza, and Reggio. To this end, a doctor from Cremona examined the carcasses of several chickens and the corpse of a recently deceased man, discovering an *aposteme*—an abscess or pustular swelling—in the hearts of both. This finding prompted a Venetian doctor to issue a bulletin advising against the consumption of chicken and eggs. Originally a public health investigation, the

**153** De Renzi, Witnesses of the Body.
**154** Crawford, Medicine and the Law, p. 1621; Watson, *Forensic Medicine*, pp. 27–35.
**155** Siraisi, Bresadola, Segni evidenti, p. 719.

autopsy in cases of death from unknown causes quickly evolved into a full-fledged forensic practice in Bologna. Doctors were called upon only to give an opinion based on an external examination of the body in cases of violent injuries or suspected murder. By the 14th century, the practice of performing autopsies on victims of unexplained deaths became increasingly common. The earliest known judicial autopsy occurred in 1302, when two physicians and two surgeons were tasked with examining the body of Azzolino degli Onesti, who was suspected of having been poisoned. Their findings, however, contradicted the poisoning hypothesis.[156]

While the practice of requesting an autopsy in cases of suspected murder has much older origins, scholars generally agree that it was only with the promulgation of the *Constitutio Criminalis Carolina* by Emperor Charles V (1519–1555) in 1532 that autopsy was finally enshrined as an integral part of criminal law practice.[157] Although the *Constitutio* was specifically designed for the territories of the Holy Roman Empire, it was to become the model for all territories where Roman law was in force.[158] Local precedents, such as those in Venice, required autopsies in all homicide cases, as well as in cases of sudden death from unknown causes.[159] For example, in Lorenzo Priori's *Prattica criminale* (1663), the chapter dedicated to "vision of corpses" emphasizes the necessity of adequately observing and describing the cadaver. Given that judges and notaries often lacked the expertise to determine whether a wound should be considered fatal, expert opinions from professionals "intelligent in the art" were not only indispensable, but also not be questioned.[160]

The criminal statutes in force in numerous cities generally stipulated that in murder cases, the criminal notary should be dispatched to the crime scene, accompanied by a doctor—and in more complex cases, by two doctors. Typically, one was a physician while the other was a surgeon, thereby combining both aspects of medicine—*theorica* and *practica*—to produce a report as accurately as possible.[161] The surgeon was the only authorized figure permitted to operate manually and directly on the body, whether dead or alive. However, in theory, such

**156** Park, Criminal and Saintly Body, p. 5.

**157** Watson, *Forensic Medicine,* p. 21 f. Out of 219 articles, only four (Art. 35, 36, 147, 149) explicitly call for the intervention of medical professsionas or midwives in cases of suspected abortion, infanticide, wounds, or uncertain death. A further twelve articles merely imply that a medical assessment was necessary.

**158** Wear, Medicine Early Modern, p. 237.

**159** Ruggiero, The Physicians and the State, pp. 156–166.

**160** Priori, *Prattica criminale*, p. 17 f: "descriver diligentemente tutte le ferite con le sue qualità."

**161** Pastore, *Il medico in tribunale*, p. 86.

operations could only take place under the watchful eye of the physician whose task was to guide the surgeon's hands by means of verbal instructions.

Dissecting a corpse was viewed as paramount in cases of sudden death, especially when poisoning was suspected yet no external signs were visible. The threat of poisoning was both a pervasive and disturbing everyday phenomenon, particularly for members of the wealthier classes. Notable examples include the suspected poisoning of Popes Julius II (1503–1513), Leo X (1513–1521), and Clement VII (1523–1534). Similarly, the scandal of the Palermo poisoners Teofania d'Adamo and Giulia Tofàna (possibly her daughter), who concocted the *aquetta* or—*acqua Tofàna*,[162] a lethal poison primarily used by women who wanted rid of their husbands, led to over 600 deaths.[163]

Suspected poisoning cases challenged physicians, putting their skill and knowledge to the test. They had to contend with widespread lack of understanding about poisons, many of which were of mineral origin, and played only a marginal role in official galenic pharmacology, which focused primarily on plant or animal substances.[164] Documentation shows that autopsies were routinely performed in cases of "sudden deaths," particularly at the onset of epidemics, dating back to the Black Death of the 14th century.[165]

With the advent of forensic autopsies, early modern physicians transitioned from being experts in examining the living to becoming examiners of the dead. Giovanni Maria Lancisi highlighted this shift in 1707 in his *De subitaneis mortibus:* "Nothing teaches us more clearly than the dissection of cadavers, which brings to light the hidden causes—unknown to us—to the light of the sun."[166]

## 4.2 Controlling social deviance: the obligation to denounce

In a bid to control and reduce violence in urban areas, political authorities soon began requiring doctors to report any violent injuries they encountered during their examinations. One of the earliest instances of this practice is the Venice decree of 30 April 1281, which mandated that doctors report all injuries caused by acts of violence. For non-serious injuries, doctors were obliged to report them within a maximum of two days to the *Cinque Savi e Anziani alla Pace*—

**162** See Feci, *L'acquetta di Giulia.*
**163** Pastore, *Il medico in tribunale*, p. 363 f.
**164** Pomata, *La promessa*, p. 146 f.
**165** Park, Criminal and Saintly Body, p. 8.
**166** Cited by de Ceglia, *Corpses*, p. 7: "Nihil est, quod nos doceat apertius, quam ipsam cadaverum sectionem, quae occultas nescis causas ad solis lucem evidenter exponit."

a magistracy responsible for overseeing non-fatal disputes among commoners. Injuries deemed potentially fatal [*in periculo mortis*] had to be reported immediately to the *Signori di Notte.*[167]

In Tuscany, the obligation for doctors and surgeons to report injuries was first formalized in a proclamation issued on 2 January 1551. Physicians who did not comply could be punished at the presiding judge's discretion. The importance of punishing doctors who failed to notify the authorities in a timely manner is emphasized in major criminal treatises of the period—most notably in *Praxis et Theoricae Criminalis* (1594–1614) by the jurist Prospero Farinacci.[168]

This requirement to alert the authorities was an attempt to align medical knowledge with political power, aiming for a broader and more effective invasive control of public order. It clearly reveals the ambivalence inherent in a doctor's vigilance toward visible and invisible symptoms. Whenever issues of social order were at stake, the same attentiveness required for treatment could, paradoxically, work against the patient's best interests.

This ambivalence regarding medical vigilance is particularly evident in relation to sodomy. Throughout the early modern period, sodomy was harshly condemned—legally, as a crime, and morally, as a sin. Political and ecclesiastical authorities' extreme aversion to sodomy stemmed from the belief that it was considered an "act against nature," its purpose not being procreation but rather the quest for sheer sexual pleasure. To use Priori's definition:

> Sodomy is a nefarious vice, which occurs when intercourse is performed against nature, and it is committed in three ways [...]. The first is through touching [...]. The second is when engaging in carnal acts with a male, or also with a female in a way that is against nature [...] The third is when a man engages sexually with a beast, a dead body, a Jew, or an infidel.[169]

Along with blasphemy, sodomy was thus strictly condemned as an offense against God. Ultimately, fear of divine retribution being unleashed on a particular city—

**167** ASVe, Maggior Consiglio, Liber Comunis Secundus, f. 103r: "et teneantur isti medici dicere et manifestare quinque de pace percussem quem habuerit in cura infra duos dies et si esi videbitur quod predictus percussum staret pro illa percussion in periculo mortis, teneatur manifestare dominis de nocte quam cicius poterunt bona fide." Cited in Ruggiero, The Physicians and the State, p. 159.

**168** Savelli, *Pratica Universale*, p. 203.

**169** Priori, *Prattica criminale*, p. 165 f: "Sodomia è un vizio nefando, ch'è quando il coito si fa contro natura il quale si commette in tre modi [...]. Il primo è quando si usa col toccamento [...]. Il secondo è quando s'usa carnalmente col maschio, ed anco con la donna contro natura. [...] La terza è quella quando l'uomo usa con un animal brutto, con un corpo morto, con un ebreo o un infedele."

such as the outbreak of an epidemic—led Italian political authorities to enact a series of extremely punitive laws against these practices. A central aspect of these laws was the requirement for doctors to report patients believed to have sustained anal injuries from sodomy. The desire to effectively control the moral order of citizens made it necessary to issue a series of directives against doctors who failed to comply. For instance, on 12 October 1578, a decree—later reissued in 1623—imposed a fine of 100 *ducats* and banishment from Venice on surgeons who failed to report violent injuries.[170] This obligation to notify the authorities became particularly crucial during plague epidemics, as the preventive function of medicine took precedence over the curative. The gradual segregation of those infected was largely based on reports submitted by doctors themselves. Given the severity and danger that pestilence posed to public health, physicians who violated this duty were subject to corporal punishment, as mandated by local health authorities. [171]

## 5 Medicine and jurisprudence: a complicated relationship

While the physician's role in court constituted an integral part of early modern criminal procedure, the relationship between physicians and jurists was not without conflict. Even within academia, a long-standing rivalry persisted between these two professions, each asserting its epistemological superiority. De Castro explores this contentious debate in Chapter XII of Book I of the *Medicus Politicus*, where he compares law and medicine [*Iurisprudentiae et Medicinae Comparatio*].[172] Advocates for the primacy of jurisprudence, according to de Castro, argued that its superiority stemmed, above all, from its function in administering justice. Unlike medicine, which focused on the health of the individual, jurisprudence concerned itself with public affairs. Medicine was criticized as a purely technical and manual art, concerned only with material matters [*de terra*] while jurisprudence's raison d'être was regarded as more noble—even divine [*de caelo*].[173] Faced with such accusations, physicians countered that their discipline was a rational science, while jurisprudence, they claimed, was in a state of servitude. Whereas medicine adhered to the universal rules of reason, jurisprudence could only respond to civil laws—historical constructs devised by the simple will of men. Medicine, they argued, addressed divine matters, since nothing was more sacred than keeping the

**170** Pastore, *Il medico in tribunale*, p. 151.
**171** Cipolla, *Contro un nemico invisibile*, pp. 21–24.
**172** De Castro, *Medicus Politicus*, pp. 42–53.
**173** Ibid., p. 42f.

body healthy and free of disease. Furthermore, it should be regarded as a science: to acquire insight and cure any ailment, one had to investigate invisible and deeper causes, for which the study of logic and philosophy was indispensable. By contrast, lawyers were said to rely on "grammar" to practice their profession; their knowledge was aimed at regulating practical events and they did not engage in speculative inquiry.

Medicine alone could be recognized as a science capable of providing certainty. In response to claims that they were nothing more than "mechanics," physicians conceded that although surgery had a mechanical aspect to it, it was both practically and epistemologically distinct from the broader field of medical knowledge and therefore held a lower rank.[174] The relationship between the macrocosm (the universe) and the microcosm (the human body) endowed medicine with almost religious significance. The nobility of the human body reflected the honor bestowed on those charged with monitoring and diagnosing its health or illness, thereby elevating the physician's art within the intellectual hierarchy of the time.[175]

Similar arguments were presented in Paolo Zacchia's *Quaestiones medico-legales*, particularly in the third title of the sixth book [*De Praecedentia inter Medicum, & Iurisperitum*].[176] Zacchia acknowledged that critics rightly targeted false doctors who were nevertheless officially recognized as members of the medical profession. The Roman protophysician echoed common stereotypes about physicians, who were often accused of avarice, arrogance, and ignorance. Medicine was criticized as an impious practice, as it disregarded religious dictates—such as allowing patients exemptions from fasting during Lent. Above all, it was denounced as a mechanical art in which experience often outweighed reason.[177]

Critics of jurisprudence similarly contended that any law created by humans was not natural, but historically constructed. They pointed to the multiplicity of laws and constitutions across Western Europe as evidence that laws were born not of Divine Will, but from unsuccessful attempts to curb human transgressions. Given that jurisprudence did not teach anything about the natural world or require manual practice, they contended that it was neither an art nor a science.[178] While acknowledging the importance of jurisprudence in regulating human society—since humans are, by nature, social animals—advocates for the healing arts made it clear that medicine should be ranked higher than jurisprudence

**174** Ibid., pp. 4345.
**175** Ibid., p. 34.
**176** Zacchia, *Quaestiones*, pp. 431–461.
**177** Ibid., p. 436.
**178** Ibid., p. 440.

[*medicina iurisperitiae anteponenda*]. They argued that the health of the human body—and by extension, the soul—was derived from medicine. For this reason, the practice of healing was considered noble in itself, requiring no external justification—such as mediating conflicts between litigating parties.[179]

Thus, the relationship between doctors and lawyers fluctuated between mutual complementarity and professional rivalry. Despite their clear differences, some theorists proposed a correlation between the two fields. For example, the 14th-century jurist Baldo degli Ubaldi (1327–1400) identified a series of procedures common to both fields, even asserting: "a judge is just like a doctor." Both, he claimed, had to proceed by means of "conjectures" and gradual approximations to achieve any degree of certainty in their investigations.[180]

As Alessandro Pastore notes, early modern academic medicine occasionally attempted to appropriate jurisprudence's probabilistic framework, endeavoring to combine "possible arguments and accredited doctrines."[181] Yet the idea persisted that medicine, unlike law, could never reach "truth," only "verisimilitude."[182] Both disciplines remained subject to social criticisms, particularly accusations of avarice and arrogance.[183]

Rather than resolving their bitter rivalry, physicians and lawyers were often compelled to collaborate in court. While the role of the medical expert was generally recognized and accepted—particularly in cases of serious injuries leading to permanent disability—this collaboration often led to friction between the two professions. Lawyers struggled to acknowledge that doctors had their own independent sphere of expertise in areas traditionally dominated by the legal profession. As a result, when physicians sought a more prominent role in court, aiming for greater social recognition and professional status, their efforts were met with hostility. Lawyers view such ambitions as an encroachment on judicial authority.

These objections reflected a broader desire to maintain a clear separation between the two professions—one rooted in the era's strict social hierarchies. To maintain this distinction, it was deemed necessary to establish a well-defined division of competencies to prevent overlap between their roles. In contrast, some Italian doctors argued that the medical expert should no longer be seen just as an adviser to be consulted, but rather as a professional with real prerogatives and technical knowledge, even within the legal sphere. This gave rise to intense debates over whether expert opinion should be binding on judicial decisions.

**179** Ibid., p. 457.
**180** Pastore, *Il medico in tribunale*, p. 16: "iudex est sicut medicus."
**181** Pastore, *Le regole dei corpi*, p. 98.
**182** De Renzi, Witnesses of the Body, p. 223.
**183** Siraisi, *Medieval Renaissance Medicine*, pp. 20–25.

### 5.1 Medical expertise as *consilium sapientis*

In Western Europe, the custom of seeking expert opinion has been common since the Middle Ages, particularly when judges faced uncertainty in cases requiring technical expertise. This procedure, known as *consilium sapientis*, involved presenting expert testimony in court at the formal request of the judge, or of one or both parties. As Mario Ascheri notes, the earliest theoretical foundation for this tendency to consider expert depositions as highly reliable can be traced to a decretal by Pope Gregory VIII (1187), later inserted in *De probationibus* under the title *Liber Extra* (X 219 c.4). In this text, it was argued that the testimony of seven midwives [*matronae*], who agreed with the woman under investigation, held greater evidentiary weight in canon law than the husband's oath to the contrary in proving a woman's virginity in a matrimonial case.[184]

Although expert testimony was generally accepted as reliable, a fierce debate among jurists raged from the 14th century onward about whether a judgment based on medical expertise could be overturned in light of fresh expert testimony. While no consensus prevailed, the majority of jurists still believed it could be. The non-binding nature of doctors' opinions was justified by the belief that, due to the partiality of their knowledge, they testified not *de veritate* [based on truth] but only *de credulitate* [based on belief or assumption].

As a result—contrary to the arguments put forth by physicians from the 16th century onward—their opinion could not, legally speaking, be considered sufficient to establish *proba plena,* the standard required to determine truth. Instead, their depositions were seen instead as merely probable.[185] The debate over the relationship between expertise and testimony also remained unresolved. The prevailing view tended to be that the two roles should not be conflated, arguing, for example, that if a doctor certified that a patient had died of apoplexy, they should then not be called upon to testify on the definition of apoplexy.[186]

### 5.2 Antonio Maria Cospi's *Il Giudice criminalista*

In his treatise *Il Giudice criminalista* (1643), the Florentine jurist Antonio Maria Cospi explicitly denounced the growing role of the medical expert in criminal courts. Written during Cospi's tenure as a judge at Bologna's *Torrone* criminal

**184** Ascheri, Conslium sapientis, p. 534.
**185** Ibid., p. 536 f.
**186** Pastore, *Le regole dei corpi*, p. 94.

court and later as secretary to Otto di Balia in Florence, the work was published posthumously by his nephew Ottaviano Carlo Cospi, a knight of the Knights of St Stephen.[187] Much like the medical treatises on the "good doctor," Cospi's treatise is essentially a programmatic work outlining the attributes of a "good" criminal judge. Its primary objective was to equip judges not only with a model of behavior but, more importantly, with enough foundational knowledge to enable them to critically evaluate expert opinions—particularly those of physicians—so that they would not accept such testimony uncritically. The underlying conviction was that judges should command an encyclopedic knowledge, allowing them to function as partial experts in any given subject over which they might be required to arbitrate in court. This, in turn, would shield them from being overwhelmed by technically-derived expert opinions.[188] According to Cospi, the remit of such experts was—as belonging to a specific category of witnesses—confined to explaining certain complex issues and performing technical tasks such as collecting and presenting data and information for the judge. Ultimately, it was the judge's responsibility to draw conclusions based on their own judgment. In addition to advocating for a clear distinction between the roles, functions, and prerogatives of judges and experts, Cospi directly accused experts of dishonesty, noting that some, motivated by the prospect of profit, had often made false statements in court.[189]

Cospi's treatise, written in the vernacular, is divided into three parts. The first is devoted to the ethical and deontological qualities of a good judge. The second examines a wide range of crimes, with close attention to those falling under both civil and ecclesiastical jurisdiction such as heresy and witchcraft. The third part—alongside discussing subjects like forgery and *simulatio*, particularly in relation to alchemy and necromancy—delves into key aspects of criminal procedure. Notably, the final section contains no fewer than 36 chapters devoted to subjects that could be classified as "forensic medicine."[190] This level of attention reflects Cospi's desire to equip criminal judges with a breadth of expertise beyond the legal sphere, so that they would not be at the mercy of medical experts. It also sought to enable judges to assess the competence of these experts and the reliability of their reports and evidence. For instance, Cospi shows marked skepticism toward medical opinion, particularly in the chapter on poisons. He emphasized that the judge needed to understand the nature, characteristics, and effects of the var-

**187** Ibid., p. 85.
**188** De Renzi, Witnesses of the Body, p. 225.
**189** Cospi, *Il giudice Criminalista*, p. 5.
**190** Ibid., pp. 359–469.

ious poisons available given that poisoning was often difficult to prove and considered an "occult crime." Physicians, he argued, were prone to attribute death to "natural causes" rather than poisoning. To prevent the crime from going unpunished, the judge, Cospi insisted, had to be capable of determining whether poisoning was the true cause of death—"leaving Doctors, Physicians, and Surgeons to the curative part."[191]

Medicine's merely secondary role vis-à-vis jurisprudence is perhaps most evident in the sections devoted to corpse dissection. Only surgeons were authorized to perform autopsies, supervised by physicians. Paradoxically, this official recognition of medical expertise only served to reinforce medicine's disrepute by reaffirming its status as a manual practice at the service of the law. Even when a medical expert performed the autopsy and identified potential signs of death, the responsibility for formulating the final judgment on the findings rested entirely with the presiding judge who, armed with the requisite knowledge, had to interpret independently the relevant evidence. Cospi further argued that inquiries into the victim's lifestyle and the questioning of relatives—tasks typically within the doctor's purview in the therapeutic field—should fall under the authority of the judge and his notary at the trial, particularly during the identification of the of corpse.[192] Cospi portrays the judge's careful engagement with expert knowledge as a hallmark of honor and nobility. Expertise, when used judiciously, helped prevent deception by specialists and facilitated a quicker confession from suspects —thus sparing the need for torture.[193]

## 6 A new self-awareness: the publication of the *Methodus Testificandi*

In contrast to the hostility of jurists and the overall neglect to the crucial role played by medical practitioners in court, some Italian physicians in the 16th century started publishing medical treatises aimed at establishing diagnostic criteria to be applied in legal investigations of the accused's presumed pathological conditions. While medical expertise had become an indispensable element in the judicial process, no scientific concepts or methodologies had yet been developed for the medico-legal practice. As a result, expert opinions were often rushed and superficial. To address this shortcoming, they produced works that systematically ex-

**191** Ibid., p. 375.
**192** Ibid., pp. 406–409.
**193** Pastore, *Le regole dei corpi*, p. 89.

amined matters of "forensic medicine," grouped under the general heading *Methodus testificandi* [Methods of Testifying].

The authors' overriding objective was to underscore the paramount importance of the medical expert, and to propose a model of exemplary professional conduct. The treatises served as a series of evolving perspectives and solutions to various and often challenging medico-legal problems. Their purpose was not only to assist doctors in delivering expert opinions but also to guide lawyers and judges, who required at least a general understanding of medicine to perform their duties effectively. These works did not seek to replace the jurist's authority but to support it by offering technical insights into matters beyond legal expertise. For instance, the 1602 treatise published by the Sicilian physician Fortunato Fedeli served as a practical manual for doctors summoned to testify in court, including suggestions and templates for drafting expert reports to be submitted to judicial officers. While Fedeli outlined the many domains in which medical competence was essential, he also acknowledged the inherent objective limits of the field—for example, the difficulty of offering conclusive opinions in cases of suspected poisoning or in interpreting certain autopsy findings.[194]

Regarding the figure of the *optimus medicus*, Fedeli emphasized that the technical expertise of the *optimus peritus* should be grounded in the triad of prudence, circumspection, and attention, and must be accompanied by strong moral integrity. Far from competing with magistrates, he insisted that physicians should seek to collaborate with them, using clear, evidence-based reasoning and language. For this reason, medical reports were to be written in Latin—or in the vernacular, if requested by the judge for the sake of greater clarity—while avoiding overly technical jargon, and steering clear of digressions and irrelevant issues.[195]

In addition to expressing a desire for reconciliation with jurists, these treatises were clearly crafted in response to a growing ambition to redefine the role of medicine in early modern European society. The call for a more active and central presence of the physician in court was rooted in the assumption that it was up to the physician himself to investigate and determine the facts in any suspicious case —thereby allowing him to "grasp the truth."

The earliest treatise on forensic medicine appears to be *Methodus dandi relationes pro mutilatis, torquendis aut a tortura excusandis*, written by the Sicilian protophysician Giovanni Filippo Ingrassia. The work remained in manuscript form and was likely unknown until it was published posthumously in 1914,

**194** Fidelis, *De Relationibus*, p. 333 f.
**195** Ibid., pp. 349 – 352.

after a handwritten copy dated 1632 was discovered in Palermo's municipal library by Francesco Garsia, an heir of the author.[196] Although long overlooked, this treatise is notable as an early indication of a wider social and cultural shift toward recognizing forensic medicine as an autonomous field.[197]

Ingrassia's work is considerably shorter than the other *Methodus Testificandi* published in the 17th century, both in length and scope. What it shares, however, with the other treatises is that it outlines the methodology to be followed when writing reports for the criminal magistrates and addresses the medico-legal aspects surrounding mutilations resulting from injuries and judicial torture. Central to Ingrassia's approach is his belief that doctors—particularly when testifying in court—must exercise great caution to avoid error. To do so, a solid understanding of medical theory, especially in human anatomy, was essential. Echoing the treatises on the *optimus medicus*, Ingrassia devotes a few pages to portraying the ideal medical expert as a professional rigorously trained in his art, always vigilant against acting recklessly or without reflection.[198]

The second significant work is *Methodus Testificandi* by the physician Giovanni Battista Codronchi, likely written in 1595 and published in a single edition in Frankfurt am Main in 1597.[199] Codronchi's text is often regarded as the world's first treatise on forensic medicine—as its author himself qualifies, "as far as I know."[200] It was intended to offer explanations and solutions to new and challenging medico-legal questions of interest not only to doctors engaged in drafting expert reports—whether young physicians still in training or older ones often caught unprepared—but also to lawyers and judges required to adjudicate such matters. Codronchi's objective was to establish medical expertise in legal proceedings as a discipline anchored in written doctrine and characterized by scientific coherence.

The preface opens with a robust defense of the role and status of medicine, noting that not even emperors and pontiffs would shy away from submitting certain cases to the physician's judgment, aware that judicial decisions in forensic contexts often hinged on medical opinion.[201] Codronchi denounced the careless and hasty way in which medical expertise was generally carried out, often entrust-

**196** Perrando, *Prefazione*, p. VI.
**197** di Renzo Villata, Paolo Zacchia, pp. 42–44.
**198** Ingrassia, *Methodus dandi relationes*, p. 27 f.
**199** Puccini, *Il Methodus Testificandi*, p. 87
**200** Ibid., pp. V–VII.
**201** Ibid., p. 5 f.

ed to barbers and midwives, or other practitioners who lacked even minimal formal training.[202]

The treatise itself follows a schematic and logical approach: topics are identified and introduced in relatively autonomous chapters, each constituting a separate discussion. In total, the work comprises seventeen chapters, addressing a wide array of topics such as disease simulation, general methodology of expertise, traumatology, toxicology, and advice on how to treat certain illnesses.[203] Rather than delving into a detailed analysis of each chapter, this discussion will focus on Chapter III, which outlines the general methodology for composing medical reports in court. Here, the caution required when delivering a prognosis before a judge is directly compared to the care a conscientious doctor must take during a bedside examination.

Beyond methodological prudence, Codronchi emphasizes the moral profile of the ideal medical expert. The expert must express his opinion with scrupulous care, without being overwhelmed by his passions. He is to tell the judge the truth—nothing more and nothing less. He must avoid both arrogance and ignorance, always bearing in mind that medicine is a conjectural art, and, as such, should express his opinions with the utmost caution. Above all, Codronchi insists that loyalty to the public good should always take precedence over any potential gain, including bribes or favors promised by the accused.[204]

In Palermo in 1602, Fortunato Fedeli (1551–1630) published *De relationibus medicorum.* Apparently unaware of Codronchi's work, which had been published just five years earlier, Fedeli believed himself to be the first to address the subject.[205] This treatise is divided into four books, each addressing a distinct set of medico-legal concerns: the sanitary conditions of various locations—an essential concept in humoral theory; congenital and acquired functional limitations with sections on disease simulation and the considerations to be made before subjecting a witness to torture; sexual and obstetric problems; and finally, injuries and violent deaths. A chapter on the attributes a doctor should display in court is also included, appearing in the eighth section of Book II titled *De erroribus eorum qui Medicinam faciunt* [On the Errors Committed by Those practicing Medicine]. Once again, contemporary physicians were denounced for their over-reliance on book learning, which—lacking practical application—inevitably led

**202** Ibid.
**203** Ibid., pp. 89–91.
**204** Ibid., pp. 11–13.
**205** Ibid., p. 88.

to ignorance and recklessness, resulting in rushed and often erroneous conclusions.[206]

The uniformity of the subjects covered "for the first time" by the three authors suggests that these were the key issues on which doctors were frequently called upon to provide evidence in court. This is why I have chosen not to dwell on the content of the various chapters. While none of the authors appears to have been aware of each other's work—or at least claimed not to—their occasional references to one another indicate a shared effort to systemize and codify traditional practices and knowledge. It is also plausible to hypothesize that their common regional backgrounds—Palermo in the Spanish Empire and Imola in the Papal States, both familiar with the inquisitorial system—help explain the early development of such reflections on the subject, in contrast to other parts of the Italian peninsula, which would have to wait for Zacchia's work in the first half of the 17th century.[207] In any case, rather than focusing on the content of the treatises, it is the very existence of the treatises that merits attention, as they signal the emergence of a new and more mature medical self-awareness.

The work of the Portuguese physician Rodrigo de Castro represents an ideal convergence between the literary tradition focused on the characteristics of the *optimus medicus* and the *methodus testificandi.* The need to offer contemporary physicians an ideal model of conduct to which they could aspire is grounded in the belief that medicine—as the title of de Castro's work clearly indicates—serves a political function, and, as such, must contribute optimally to the public good. The civic role is predicated on the assumption that medicine, in de Castro's words, is "an art based on reason and experience to obtain and preserve health" with deeply ancient origins, taking the form of a gift from God to mankind.[208] The passage the Lusitanian doctor referred to is taken from the Old Testament, specifically from *Ecclesiasticus* (38:1–15): "Give doctors the honor they deserve, for the Lord gave them their work to do. Their skill came from the Most High, and kings reward them for it. Their knowledge gives them a position of importance, and powerful people hold them in high regard. The Lord created medicines from the Earth."[209] Written around 180 BC, *Ecclesiasticus* is one of the Bible's Wisdom books. Clearly influenced by Greek philosophy, it was frequently cited in Christian medical circles to justify medical practice. However, as the text emphasizes, a doctor was simply God's instrument: it is God who creates the medicines

**206** Fidelis, *De Relationibus Medicorum*, pp. 311–336.

**207** De Renzi, Witnesses of the Body; Pastore, *Il medico in tribunale.*

**208** De Castro, *Medicus* Politicus, p. 4 cited in Arrizabalaga, Medical Ideals, p. 116: "ars cum ratione, et experientia faciendae conservandaeque sanitatis."

**209** De Castro, *Medicus Politicus*, pp. 29–34.

and performs the cures, albeit through the doctor's hands.[210] De Castro invoked this biblical passage to support his thesis on the elevated status of medicine. In particular, he links the medical profession to tasks associated with governing a State, asserting medicine's centrality as an instrument of governance and discipline at the service of the political authorities. Viewed from this perspective, the figure of the court physician becomes pivotal.

Book IV addresses illegal practices—such as magic spells and love potions—but, more importantly, centers on medico-legal expertise. Chapters IX to XI are particularly relevant to the present study, with Chapter XII focusing on diagnosing a woman's virginity and a man's putative sterility. Chapter IX is devoted to the simulation of diseases [*Qua ratione morbum simulantes deprehendi queant*]. This chapter's content is particularly original, as de Castro introduces personal experience, presenting concrete cases in which he exposes deception, such as the case of a prostitute who faked an abortion, or Portuguese sailors who feigned illness to avoid fighting against the English navy.[211] Chapter X deals with the methods for identifying poisoning [*Testificandi methodus circa eos, quibus venenum fuit exhibitum*], while Chapter XI offers guidance on how to judge the severity of injuries and deaths by drowning [*Testificandi ratione in vulneribus capitis: & in iis qui aqua fuerunt suffocati*].[212] Although de Castro was largely reiterating the teachings of his colleagues, the very fact that topics of a forensic nature found their way into a treatise whose ultimate aim was to assert medicine's predominant political function in pre-modern European society is significant.

It is also worth noting that in de Castro's work, the defense of the public utility of learned medicine—and of its practitioners—assumes an even greater significance. Born in Lisbon to a family of Jewish converts, de Castro moved to Hamburg in the late 1580s due to the growing pressure of the Portuguese Inquisition against Jews and Christian converts. His name appears in the city's list of Jews, even though he had his children baptized.[213] His work, therefore, not only vindicates the political role of medicine, but also the political function and utility of doctors of Jewish origin in an increasingly anti-Semitic context, such as that of 1614 Hamburg.[214]

Although he would later go on to publish more extensively, Paolo Zacchia (1584–1659) is still regarded as the father of modern forensic medicine.[215] Author

**210** Minois, *Il prete e il medico*, p. 22.
**211** De Castro, *Medicus Politicus*, p. 251.
**212** Ibid., pp. 254–259.
**213** Arrizabalaga, Medical Ideals, pp. 111–114.
**214** Ibid., p. 122.
**215** De Renzi, Paolo Zacchia, pp. 53–56.

of numerous medical treatises, he is best known for his *Quaestiones medico-legales*, published in nine volumes between 1621 and 1635, and reprinted in several editions by Italian and European printers until the late 18th century.[216] Presented as a veritable summary of contemporary medical and legal knowledge, this work specifically targeted an audience of physicians and jurists, seeking to assert the legitimacy of the physician's presence in the legal world as an expert worthy of the highest consideration. Zacchia's methodology for the medical *peritiae* is fundamentally based on treating individual *quaestiones*—addressing the content of the individual cases in their own right by choosing the specific concepts and methods necessary for solving the concrete cases at hand. More significant than the content of the individual *quaestiones*—which largely reiterate what had been asserted by the previously mentioned authors, all of whom Zacchia cites—with the exception of Ingrassia's unpublished work—is the revolutionary tenor of the treatise, given the boldness and the outright radicality of the positions expressed therein.

Zacchia's *Quaestiones medico-legales* was intended to position the medical practitioner in court—not merely as a simple expert to be occasionally consulted on matters of criminal justice, but as a meticulous professional figure who assumed, in his words, "the prerogative of prescribing if, how, and when any act must be performed in order to be valid in its legal consequences."[217] Far from being an art [*ars medica*] subservient to jurisprudence, forensic medicine asserted its full legitimacy by establishing itself as a distinct science, employing interdisciplinary methods. It was Zacchia who formulated the earliest definition of what would later come to be known as forensic medicine: the examination of medical issues through the lens of the law [*rebus medicis sub specie iuris*].[218]This was not merely a matter of providing clinical opinions on legal questions outside the bounds of medicine, but rather a specialized field in which medical and legal knowledge were required to interact and collaborate. Superseding the works of his predecessors, Zacchia's *Quaestiones medico-legales* was to become the European benchmark for medico-legal practice until the 19th century.

**216** di Renzo Villata, Paolo Zacchia, p. 12 f.
**217** Zacchia, *Quaestiones*, p. 342.
**218** Pastore, *Il medico in tribunale*, p. 8.

## 7 A question of loyalty: the physician's dilemma

Among the multiple topics addressed in the various *Methodus Testificandi*, one in particular held a dominant ethical and deontological significance: the problem of the *secretus* [secrecy or privacy]. This issue is central to any further analysis of the ambivalent nature of the doctor-patient relationship. As previously noted, in theory, both doctors and patients were regarded as having a moral obligation to always tell the truth, especially to ensure the patient's good recovery. Consequently, the patient was never permitted to lie, while the doctor was only exempt from this obligation in a limited number of circumstances, such as when a patient's condition was so severe that informing them of their imminent death would likely hasten their demise.

Furthermore, the Hippocratic Oath required physicians to remain silent about what they had discovered during medical examinations, in accordance with what might be termed professional secrecy.[219] The Oath states: "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about."[220] Yet this principle lost much of its force whenever physicians acted in an institutional capacity, such as when called as a court-appointed medical expert [*peritus*] to provide opinions in judicial proceedings, or when examining patients under suspicion.

The importance of professional secrecy is underscored by the fact that Zacchia concerns himself with the topic on three occasions, in Books II, III, and V.[221] As noted earlier, the professional secrecy to which a doctor was compelled to adhere was first theorized in the Hippocratic Oath. Western Christianity adopted the Hippocratic Oath from its pagan origins, and, inspired by Christian mores, the vow to confidentiality assumed an ever deeper meaning during early modern times. The physician's practice, concerned with the care of the body, had frequently been compared to that of a priest, who cares for souls. While these two spheres should not be conflated, it is worth noting that before delivering a prognosis of death, a doctor was obliged to consult a priest to ensure that the patient had confessed and received Extreme Unction. The two roles were clearly complementary. The diagnostic examination thus took the form of confession, with the patient revealing intimate details to the doctor, who—like the priest—was not supposed to disclose what he had learned to any third party.

**219** Nutton, Medicine in Greek World, p. 29.
**220** MacKinney, Medical Ethics, p. 31.
**221** Laugier, *Paul Zacchias*, p. 21.

Although numerous authors equated the violation of medical secrecy with a mortal sin, Zacchia openly argued that there were certain situations in which this rule could not—and indeed should not—be upheld. For him, the true mortal sin for a doctor was to give false testimony about a patient's or a defendant's symptoms when acting as an expert or a witness in court.[222]

This ambivalence inherent in the doctor-patient relationship is most clearly reflected in the duty to report, to which medical personnel were subject in the early modern period. If the medical examination revealed signs of involvement in activities considered illegal or immoral—often two sides of the same coin—the physician was legally obliged to breach professional secrecy and notify the political authorities. While this obligation was externally imposed, it only became truly effective when doctors themselves recognized its significance for maintaining order and social stability. Undoubtedly, the threat of physical or financial punishment for failure to comply with the obligation served as an incentive for doctors to cooperate with the authorities. Yet coercion alone was not enough to achieve total obedience; a degree of personal assent was also required.

Thus, while the primary goal of medical practice has always been to ensure the patient's good health, a physician's loyalty often aligned more closely with those exercising political power than with the patient—especially when that patient was deemed "suspect" due to their actions, morals, or religion.

In this regard, the galleys offer a particularly revealing context for examining the complex nature of medical vigilance and, by extension, the doctor-patient relationship. Physicians assigned for rowers were responsible not only for maintaining their health—vital to the vessel's operations—but also for supervising men who were often slaves or convicts. This dual role blurred the boundaries between healing, discipline, and vigilance. These tensions between care and control lie at the heart of the complex medico-legal dynamics explored in the following chapter.

222 Ibid., p. 21f.