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# Medicine and Religion at the Early Modern Deathbed: How Can We Reframe the Narrative?

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## Abstract

Since the 1960s, at a time when medicine was transforming Western conceptions of, and approaches to, the end of life, historians, historians of medicine, and specialists of religious studies have delved into death from a historical perspective. In the wake of *historiens de la mentalité* like Philippe Ariès and Michel Vovelle, studies commonly emphasise the limited autonomy of medicine vis-à-vis religion in conceptualising death and care for the dying. Only in the late eighteenth century, with Enlightenment culture and the secularization of society, were physicians supposedly encouraged to adopt a more active stance on the end of life. The aim of this paper is to survey recent scholarship that revisits the interaction of medicine and religion at the deathbed. In doing so, it presents an alternative to the rather dichotomous interpretation of the rise of medicine going hand in hand with the downfall of religion. It points to problems and sources that might be reconsidered in order to gain a more nuanced understanding of the interaction and reciprocal developments of medicine and religion in early modern Europe.

## Keywords

early modern medicine – death and dying – incurability – Reformation – Catholic Reformation – terminal care – medical resuscitation – medical ethics

In 1571, Antonio Secco, a reputed practitioner and a member of the College of physicians in Venice, was denounced to the State Inquisitors for allegedly letting one of his patients die without the administration of the sacraments. As Alessandra Celati has demonstrated, Secco's was one of several proceedings regarding the end of life filed by the Venetian Inquisition.[1] Since the Middle Ages – more precisely, since the Fourth Lateran Council of 1215 – sick Christians were obligated to take confession before embarking on medical treatment.[2] Three centuries later, the Counter-Reformation Church was determined to enforce this obligation. A bull on the duties of medical practitioners, *Super gregem dominicum,* was issued by Pope Pius V in 1566. It forbade physicians from treating, after three visits, anyone who had not taken confession, under threat of being excommunicated, stripped of their doctorate, and fined. Moreover, because the confession of sins was one of the Roman institutions contested by the Reformation, failure to comply entailed the risk of being investigated on a suspicion of heresy.

In Venice, as early as 1558, the patriarch demanded that physicians should not offer treatment to unrepentant patients. In the years following *Super gregem*, local inquisitors filed accusations against medical practitioners and repeatedly exhorted the College of physicians to enforce the law. Significantly, however, just like that of Secco, most of the proceedings languished in the archives. From time to time, the College reminded all practitioners of their duties through circular letters and public meetings, but never took action against any of them.

Judicial records like the Venetian proceedings *contra medicos* encapsulate different aspects of the early modern history of medicine and religion at the deathbed. On the one hand, they indicate that the Counter-Reformation Catholic Church bended the balance of power, at least in Italy, re-enforcing rules of conduct that implied the subordination of medicine to religion. On the other hand, however, they point to discrepancies between norms and practices. Practitioners developed different strategies to cope with the moral and

1 Alessandra Celati, "Contra medicos: Physicians Facing the Inquisition in Sixteenth-Century Venice," In *Medicine and the Inquisition in the Early Modern World*, ed. Maria Pia Donato (Leiden, 2019), 72–91. On unorthodox medical practitioners, see Richard Palmer, "Physicians and the Inquisition in Sixteenth-Century Venice: The Case of Girolamo Donzellini," in *Medicine and the Reformation*, ed. Ole Peter Grell and Andrew Cunningham (London, 1993), 118–133. Translations are mine unless stated otherwise.

2 On the consolidation of the Christian death rituals, see Frederick S. Paxton, *Christianizing Death: The Creation of a Ritual Process in Early Medieval Europe* (Ithaca, NY–London, 1990); Paul Binski, *Medieval Death: Ritual and Representation* (London, 1996); Cécile Treffort, *L'Église carolingienne et la mort: christianisme, rites funéraires et pratiques commemoratives* (Lyon, 1996).

professional dilemmas involved in the Christianization of death, in a complex interplay of accommodation and collaboration.

Death, religion, and the doctors in early modern Europe are the subject of this paper. It is surely not an original topic, and yet it has its rightful place within the major theme *Faith, Medicine and Religion*, which the European Association for the History of Medicine and Health chose for its meeting in 2021. Although death, as is well known, had long been at the forefront of disciplines such as ethnology, religious studies and the history of the Church – not to mention archaeology – it became a fully-fledged critical object in and of itself only in the late 1960s. At that time, social sciences and humanities turned towards the investigation of the subject, prompted by new patterns of dying, corpse management and burial, and by momentous breakthroughs in medicine and surgery. These breakthroughs were of course the spectacular improvement of cardiopulmonary resuscitation and organ transplant, as well as the concomitant changes to the definition of death from a cardiac to a brain criterion as proposed by the Harvard Medical School ad hoc committee. The increasing hospitalisation of dying, the rise of the hospice movement for the terminally ill, and the creation of palliative care units all played an important role in what many contemporaries perceived, and – in a somewhat contradictory way – analysed, as a radical, irreversible and meaningless medicalization of death. To borrow Ivan Illich's famous polemical definition, the process could be described as an expropriation of death.[3]

Among historians, the most influential was Philippe Ariès, who outlined a millennial history of the desacralization of death in his *Western Attitudes toward Death: from the Middle Ages to the Present* (1974) and in *L'Homme devant la mort* (1977). Although his methods and assumptions were rapidly called into question, by virtue of the sheer ambition of his chronology, Ariès set the stage for three generations of scholars.[4] Over the years, an incredibly vast body of scholarship has delved into historical demography and paleopathology, learned and popular conceptions of death, *ars moriendi* literature and visual culture, mourning and burial practices, funerary art and architecture, beliefs on the afterlife and the dead.

3 Ivan Illich, *Medical Nemesis: The Expropriation of Health* (London, 1975). From a large body of scholarship, see Margaret Lock, *Twice Dead: Organ Transplants and the Reinvention of Death* (Berkeley, CA, 2002); Milton Lewis, *Medicine and the Care of Dying: A Modern History* (Oxford, 2007); Gary Belkin, *Death before Dying: History, Medicine, and Brain Death* (Oxford, 2014).

4 It should be noted, however, that *histoire de la mentalité* is an etiquette for different methodological approaches to the history of death. Michel Vovelle, *La mort et l'Occident de 1300 à nos jours* (Paris, 1983) was likewise influential in shaping 1980s and 1990s historiography, especially in Italy and Spain.

At the same time, historians of medicine also engaged with death. They concentrated on the ancient roots of medico-legal and ethical problems like the obligation to prolong life.[5] Such a perspective was attuned to the mindset of medical professionals, to whom the history of medicine was generally taught by scholars who were themselves trained in medicine or in Classics (often in both).[6] Still today, much literature on such topics is addressed to medical students and professionals, particularly in the USA, where health services are still organised and distributed largely on a confessional basis. As many excellent papers in the 2021 EAHMH conference highlighted, issues like the definition of death and terminal care still pose dramatically concrete questions to practitioners, administrators, ministers and, of course, the sick persons, their families, and those to whom they have yielded powers to make decisions on their behalf.

In recent years, valuable studies on death and medicine in historical perspective saw the light, including the excellent *History of Palliative Care* by Michael Stolberg, which has the merit of moving beyond texts to scrutinize practices in the early modern and modern periods.[7] Yet, while in the past decades scholars have crafted new visions of how medicine and religion interacted, putting belief, hope and devotion centre stage in the history of medicine and health, when it comes to death, the master narrative still more or less posits a quasi-linear evolution from a sacred and community-centred culture of death to an individualistic medicine-centred one. The process of *désenchantement* and incipient medicalization are deemed to have taken place in the late eighteenth century, when Enlightenment culture and the secularisation of society had transformative effects on collective attitudes towards illness, death, and the afterlife.

5 For example, Erwin W. Ackerknecht, "Death in the History of Medicine," *Bulletin of the History of Medicine*, 42 (1969), 19–23; Richard V. Lee, "Cardiopulmonary Resuscitation in the Eighteenth Century: A Historical Perspective on Present Practice," *Journal of the History of Medicine and Allied Sciences*, 27 (1972), 418–433; Darrel W. Amundsen, "The Physician's Obligation to Prolong Life: A Medical Duty without Classical Roots," *Hastings Center Report*, 8 (1978), 4, 23–30; Bruce W. Fye, "Active Euthanasia: A Historical Survey," *Bulletin of the History of Medicine,* 52 (1978), 492–502; Paul Carrick, *Medical Ethics in Antiquity: Philosophical Perspectives on Abortion and Euthanasia* (Dordrecht, 1985).

6 On the history of the discipline, see the Frank Huisman and John Harley Warner, eds., *Locating Medical History: The Stories and Their Meanings* (Baltimore, MD–London, 1997).

7 Michael Stolberg, *Die Geschichte der Palliativmedizin: medizinische Sterbebegleitung von 1500 bis heute* (Frankfurt, 2011; English translation: Cham, 2017). See further, Anne Carol, *Les médecins et la mort: XIXe–XXe siècles* (Paris, 2004); Giorgio Cosmacini and Georges Vigarello, eds., *Il medico di fronte alla morte* (*secoli XVI-XXI*) (Turin, 2008), and especially Karen Nolte, *Todkrank. Sterbebegleitung im 19. Jahrhundert. Medizin, Krankenpflege und Religion* (Göttingen, 2016). For an introduction to medical ethics in history, see Klaus Bergdolt, *Das Gewissen der Medizin: Ärztliche Moral von der Antike bis heute* (Munich, 2004).

Although indisputably correct, in what follows, I will tentatively argue that this narrative is too broad to open new research directions on early modern medicine and its interplay with religion. I suggest that a finer chronology and geography is needed in order to move beyond a rather dichotomous interpretation of the rise of 'modern' medicine going hand in hand with the downfall of 'traditional' religious beliefs. I will briefly touch upon some of the intertwined questions which could be re-examined in the light of recent critical trends on medicine and religion, to yield more nuanced appraisals of their encounter at the deathbed, particularly in early modern Catholic Europe. I will draw attention to sources that might help us to move away from a story that is still too focused on their opposition, and that can perhaps expand our understanding of their reciprocal development, both intellectual and social.

## 1 Conflict at the Deathbed?

*Tres medici, duo athei* was the medieval dictum, and indeed mistrust and suspicion were a widespread attitude among clerics vis-à-vis doctors in early modern Europe.

Let us begin with the Catholic obligation to call the priest for confession. Unsurprisingly, the clergy were unyielding on this point, especially in the increasingly popular *ars moriendi* literature for the laity. Physicians must obey Church decrees unconditionally, warned the Dominican friar Bartolomeo D'Angelo, whose *Ricordo di ben morire* was published shortly after Pius V's *Super gregem* and went through more than 20 editions.[8] Three decades later, Omobono de Bonis of the Clerics Regulars of Somasca (one of the new Catholic congregations devoted to the spiritual and material care of the poor) wrote that doctors would commit a mortal sin if they neglected to call the sick to contrition or failed to warn them of the risk of an impending death.[9] Canonists agreed, although some conceded that it was enough to warn their families of the dangers involved.

But did physicians comply? Things were, of course, more nuanced. Medical deontology was not unanimous. To be sure, some authors took on the task of teasing out the medical implications of ecclesiastical injunctions. In a treatise on the "Christian and perfect method of healing," Giovan Battista Codronchi

8 Bartolomeo D'Angelo, *Ricordo del ben morire dove s'insegna a ben vivere e ben morire* (Venice, 1576).

9 Omobono De Bonis, *Arte teorica e pratica per aiutare nello spirito gl'infermi divisa in cinque parti* (Bologna, 1616).

from Imola in Central Italy argued that there were no excuses whatsoever for physicians not to immediately require their patients to call upon a priest.[10] Scipione Mercurio, a Roman practitioner who eventually took holy orders, wrote that doctors must admonish sick persons to take confession at the very start of their treatment for two reasons: first, they should do so in obedience of the Church; secondly, they should seek to convince patients from the outset that calling upon a priest had no bearing, one way or the other, on their prognosis. Should they refuse, the "good God-fearing Christian doctor" must not waste his time and leave.[11] According to Juan Alonso de Fontecha, professor at Alcalà de Henares, talking the sick into taking confession, especially those seriously ill, was one of the first things to do upon entering their house. Confession soothed the soul, and hence also the body, but doctors must, in any case, stop treating patients who refused confession for the simple reason that the Church forbade the provision of treatment to the unrepentant.[12]

Others were a little less forthright, saying that physicians should only prompt patients and their families to send for the confessor. Paolo Zacchia, Protomedicus of the Papal States and a most influential author in early forensic medicine, appealed to the practitioner's discretion: physicians must persuade patients to receive the sacraments, but could not ultimately abandon them.[13] In the frontier territories of the Catholic Flanders, Michael Boudewijns leaned towards a similarly charitable opinion.[14] Like their medieval predecessors, anyway, most authors found some kind of excuse not to disclose poor prognoses too early. It was generally only in these situations that the priest was called, despite the Church's best efforts to routinize confession and Communion.[15]

Reading this literature through the sole lens of a clash between medicine and religion, and positing a pervasive inquisitorial control over medical practice, can be as misleading as it is tempting. Obviously, when writing about death and the sacraments, there was a gulf between the goals of practitioners and ecclesiastics (who, after all, looked upon medics as lay persons like any

10 Giovan Battista Codronchi, *De christiana ac tuta medendi ratione* (Ferrara, 1591), 57–59.

11 Scipione Mercurio, *Degli errori popolari d'Italia* (Venice, 1603), 139–141.

12 Juan Alonso y de Los Ruyzes de Fontecha, *Medicorum incipientium medicina, seu medicinæ christianæ speculum* (Madrid, 1598). On the incorporation of confession into late-medieval regimen, see Naama Cohen-Hanegbi, *Caring for the Living Soul: Emotions, Medicine and Penance in the Late Medieval Mediterranean* (Leiden, 2017).

13 Paolo Zacchia, *Quaestiones medico-legales*, 5th edition (Avignon, 1661), 403.

14 Michael Boudewijns, *Ventilabrum medico-theologicum, quo omnes casus cum medicos tum aegros aliosque concernentes eventilantur* (Antwerp, 1666), 241.

15 Michael R. McVaugh, "Bedside Manners in the Middle Ages," *Bulletin of the History of Medicine*, 71 (1997), 201–223; Danielle Jacquart, "Le difficile pronostic de mort (XIVe–XVe siècles)," *Médiévales*, 46 (2004), 11–22.

others). Nonetheless, we should not forget that physicians addressed these issues tangentially, as part of a wider redefinition of the ideals of the good practitioner, and in the broader context of the reinforcement of the corporate organisation of medical education and practice, the expansion of the health market, and the increasing rigidity of social hierarchies. Treatises on medical deontology, particularly in the sixteenth century, concentrated on questions like remuneration, demeanour, manual *vs.* liberal activities and, above all, the superiority of physicians over surgeons, over apothecaries and over irregular healers (especially women). Most tracts were in fact commentaries on deontological texts from Antiquity such as *Decorum* and the *Law*, and tackled the dual necessity of legitimising the professional pyramid upon ancient authorities and, only secondarily, adapting them to ecclesiastical injunctions. When, later in the seventeenth century, both the confessionalization and medicalization of society appeared to be more firmly established, a casuistic approach prevailed that somewhat paradoxically pushed the Ancients into the background while allowing more room for addressing religious issues and introducing further nuances.

Alessandro Pastore has documented how, in their statutes, professional colleges in Northern Italy progressively included norms relating to religious conformity and the sacraments, while at the same time those colleges increasingly excluded practitioners of lower descent and undignified demeanour. In several cities, medical colleges functioned simultaneously as guarantors of religious conformity and defenders of their (more or less orthodox) affiliates; likewise, prominent physicians acted as proponents of stricter professional regulations while criticizing the Church.[16] Early modern confessional statecraft did not merely imply control, it also established favourable conditions in the marketplace and the social order at large. Compliance with the law, both civil and canon, was at once instrument and proof of the superiority claimed by university-trained physicians. Trials like those in Venice offer evidence of the mutual entrenchment of medicine and religion, rather than of a forcibly established subordination. After all, the College of physicians, as mentioned, did defend their independence and they refused to sanction individual practitioners.

16 Alessandro Pastore, *Le regole dei corpi. Medicina e disciplina nell'Italia moderna* (Bologna, 2006), 125–155. On Cremona, see Federico Chabod, *Lo Stato e la vita religiosa a Milano nell'epoca di Carlo* V (Turin, 1971), 357–360, 449–450. On Modena, though emphasising the role of the Inquisition, see Domizia Weber, *Sanare e maleficiare. Guaritrici, streghe e medicina a Modena nel XVI secolo* (Rome, 2011), 34–44.

In light of these caveats, can historians gain any new insights on what happened in practice? Admittedly, we must still fall back upon reading texts along and against the grain.

Arguably, the strength of the clerical insistence on the obligation to send for the confessor hints at some leniency on the part of the physicians, and especially on the part of the families (who, incidentally, feared that clergymen could extort last-minute donations from the moribund).[17] Priests incessantly complained about the reluctance of doctors and, even more so, of the patients' families to call the confessor until it was too late. As the Jesuit Emerio de Bonis wrote to his superiors in 1567, the result was that "a large part of the infirm do not take confession until they are unable to speak, because physicians do not want to tell them anything in order not to scare them, and even less so do families [...] until they have lost their mind [...] and threaten to send away the physician who wants to fulfil his duty."[18]

In the Kingdom of Naples alone, Michele Miele listed a dozen late sixteenth-century diocesan and provincial synods that sought to strengthen *Super gregem dominicum*.[19] At the end of the seventeenth century, when a movement of neo-Tridentine reformism gained impetus, Pope Innocent XI called upon bishops to exercise greater vigilance, and ordered the bull to be reprinted every year and all parish priests to enforce it. Over time, moreover, the Catholic Church refined its pastoral strategy, putting greater pressure on the clergy. In his influential moral theology handbook first published in 1755, the future saint Alfonso de' Liguori spelled out six questions that confessors must ask physicians, the most important of which was, of course, asked to determine whether or not they had prompted their patients to call the confessor in due time.[20] Civil authorities played their part in reinforcing canon laws. In France, royal *ordonnances* on the matter were issued in 1707 and 1712. As late as 1779, the governor of Outer Austria issued a similar edict, as did the Emperor of Austria himself in 1812. Incidentally, it should be noted that, particularly in the Habsburg lands, such a policy went hand in hand with efforts to curb the role of religious orders, especially mendicants, and with the idea

17 Mercurio, *Errori*, 196–197.

18 I quote from Giovanni Romeo, *Ricerche su confessione dei peccati e inquisizione nell'Italia del Cinquecento* (Naples, 1997), 109–110.

19 Michele Miele, "Confessione, confessori e penitenti nei sinodi di area napoletana nella seconda metà del Cinquecento," in *Ricerche sulla confessione dei peccati a Napoli tra '500 e '600*, ed. Boris Ulianic (Naples, 1997), 15–64. Notably, in Rome the three-visit rule was enforced as early as 1543.

20 Alfonso de' Liguori, *Istruzione e pratica pei confessori*, I quote from the Venice, 1761 edition, vol. 3, 116–117.

of implementing state control over the population through both ecclesiastical and medical police. Against such a backdrop, a famous text like Johann Peter Frank's *System einer vollständigen medizinische Polizey* and its criticism of extra-zealous clergymen will appear to be an intrusion by the medical profession into the Church's jurisdiction as much as part of the reform of baroque piety and clerical education that were quintessentially part of Josephinism and Catholic enlightenment.[21]

In 1976, the Jesuit historian Giacomo Martina wrote an article on medicine, religion and politics in Pisa in the mid-nineteenth century. Although focusing on a later period than this paper, his article raised some interesting points. He described the local bishop asking parish priests whether physicians complied with their canonical duty. Their assessments varied: 49 priests answered positively, 19 in the negative, and 37 gave equivocal answers. Still, none of the reports mentioned practitioners giving up on recalcitrant patients. Interestingly, some priests highlighted the fact that doctors' behaviour was seemingly influenced by the social status of patients. "Physicians are very diligent, especially with those of lesser condition," reported the provost of Barga in 1863, while the rector of S. Paolo a Ripa d'Arno wrote that "it would seem that physicians obey Pius V's bull. For sure, if the sick are poor, we [priests] are usually called to administer them the sacraments in due time, but if the sick are rich or noble, we are usually called in a hurry, when they are already unconscious and unresponsive."[22] Based on clerical complaints, however biased, I suspect that their early modern predecessors did the same. As Alfonso de' Liguori lamented, many sick ones, "especially if they are of some standing," put things in order "when they are nearly cadavers already, so that they can only hardly speak, sense hardly anything and hardly conceive the state of their conscience and the sorrow for their sins." He was neither the first nor the only one to make complaints along these lines.[23]

To date, diocesan archives have been relatively neglected by historians of early modern medicine. For the purpose of studying Church control over medical practice, they might shed light on moments of tension and changing priorities. It is not a coincidence, I think, that in 1682, at the very moment when Innocent XI called for greater vigilance, the rigorist bishop of Brugnato in the

21 First published in Mannheim 1779–1788, I use the Italian translation Milan, 1808, vol. IX, 215–302. For an overview, see Caren Möller, *Medizinalpolizei: Die Theorie des staatlichen Gesundheitswesens im 18. und 19 Jahrhundert* (Frankfurt am Main 2005).

22 Giacomo Martina, "Rilievi circa l'osservanza della Bolla di Pio V sui medici nella diocesi di Pisa intorno alla metà dell'Ottocento," *Gregorianum*, 57 (1976), 351–364.

23 Liguori, *Istruzione*.

Republic of Genoa investigated Marco Bernabò, a physician who purportedly refused to swear allegiance to Pius V's bull.[24] But rather than focusing on the conflict between doctors and priests, diocesan and other ecclesiastical records such as bishops' visitations *ad limina* could be used to probe into the attitudes of lay people towards doctors and priests, and what they expected from both. Ecclesiastical records can also be used to disclose how medicine and religion combined in underpinning social order through differentiated ways of managing death.

Furthermore, innumerable medical manuscripts still await in-depth consideration, particularly lecture transcripts and students' notebooks, which, by contrast with printed books, were only rarely subject to external scrutiny, although any form of teaching was, of course, liable to elicit complaints. Did physicians and surgeons teach small circles of apprentices anything different in their lessons than in printed texts? So far, in fact, I have only come across exhortations to take care of the spiritual welfare of patients. In his early eighteenth-century lessons on surgical cases, the Roman surgeon Domenico Cecchini, for example, was clear on this point while discussing wounds to the lungs: first, administer the salvation of the soul, and then, if time allows, try to secure that of the body.[25]

## 2 Sites of Negotiation

This order of priorities prompts another question as to whether the calling of the priest meant that the doctor would quit the patient's bedside, or be expected to stay?

Of course, the overwhelming majority of men and women in the past died without any medical care. If they were attended by a doctor, the doctor usually withdrew at the final moment, out of dignity and humility (and, more prosaically, to attend to other patients). The duty of physicians to assist their patients until the very end was nevertheless commonly acknowledged in early modern deontology. The love of Jesus should inspire Christian healers in comforting the sick in any circumstance. As Leonardo Botallo, surgeon to Catherine de Medici queen of France, put it, charity and kindness are excellent medicines in their own right.[26] Two centuries later, the English physician Thomas Percival

24 Marco Cavarzere, *La giustizia del vescovo. I tribunali ecclesiastici della Liguria orientale, secc. XVI-XVIII* (Pisa, 2021), 239.

25 MS Rome, Biblioteca Medica Statale, *Archn,* fol. 402.

26 Leonardo Botallo, *Commentarioli duo, alter de medici, alter de aegroti munere* (Lyon, 1565), 46–47.

and the Anglican minister Thomas Gisborne asserted the duty of doctors to attend patients until the very end, for "the presence of physicians will compose the mind, and alleviate the sorrows of friends and relations"; moreover, he could, and should, open his heart to patients "who have fallen into vice and scepticism", persuading them into recognising the mercy of God "during the pangs of racking pain" and reminding them how "to die with hope, with gratitude, and with exultation".[27]

Still, the terminally ill posed grave professional dilemmas for their doctors. Needless to say, an expectant attitude characterised Western medicine in general. In the 'Hippocratic triangle' – the sick person, the disease, and the doctor – medicine was conceived as support for the sick in their fight against illness. Hence, medicine must imitate the healing powers of Nature with a full awareness of its own limitations. Death was the obvious limit of medicine's scope. Numerous writings made reference to more cynical considerations. Not only was agony unpleasant to witness, it could harm one's reputation if too many patients died in one's care.[28] As a matter of fact, both refusing serious cases and treating them could prove professionally dangerous, and practitioners must therefore walk a fine line and contend with contradictory expectations.

In order to move a step away from the cliché of the conflict at the deathbed, however, a spectrum of sources could be re-evaluated. In his classic study of Lutheran *Leichenpredigten*, Werner Kümmel noted that positive remarks associated with medicine were frequent and theologically-based insofar as a patient's accepting of treatment implied not being in a state of sin (which is also true for Catholics). Moreover, it was not uncommon for sermons to praise the spiritual comfort given by physicians until the very end.[29] Of course, sermons are normative texts, and yet they disclose that the reality of the deathbed experiences did not measure up to the ideal deathbed scene – seriality enables historians to see these deviations. They also offer glimpses of a more animated

27 Thomas Percival, *Medical Ethics; or a Code of Institutes and Precepts, Adapted to the Professional Interests of Physicians and Surgeons* (Manchester, 1803), 39; Thomas Gisborne, *An Enquiry into the Duties of Men in the Higher and Middle Classes of Society* (London, 1794), 403–406, on which see Roy Porter, "Thomas Gisborne: Physicians, Christians and Gentlemen," in *Doctors and Ethics: The Earlier Historical Setting of Professional Ethics*, ed. Andrew Wear, Johanna Geyer-Kordesch and Roger French (Amsterdam–Atlanta, GA, 1993), 252–273.

28 See, e.g., Roderigo de Castro, *Medicus-politicus: sive de officiis medico-politicis tractatus* (Hamburg, 1662), 104-105,132-138, 175–180, 204–205.

29 Werner F. Kümmel, "Der sanfte und selige Tod. Verklärung und Wirklichkeit des Sterbens im Spiegel lutherischer Leichenpredigten des 16. bis 18. Jahrhunderts," in *Leichenpredigten als Quelle historischer Wissenschaften*, ed. Rudolf Lenz, vol. 3 (Cologne, 1984), 199–226.

reality at the deathbed, and the fact that these were normative, not descriptive, texts makes them no less significant.

Keeping multiple layers of mediation in mind, Catholic funerary sermons could be systematically re-examined too, as well as visual depictions of the scene of death.[30] Likewise, libraries and archives are full of reports, penned by physicians and surgeons, of the "last illness and death" of distinguished persons. Admittedly, in Catholic Europe these reports generally concern only high-rank ecclesiastics, aristocrats and, of course, popes and royals, so it is no surprise that their agony was attended by medical staff (see Figure 1).[31] Still,


FIGURE 1 *King Henry II of France on his deathbed, with members of the royal family and the royal household in attendance*. Woodcut. Courtesy of the Wellcome Collection.

30 On the layers of mediation, see Ludmilla Jordanova, "Medicine and the Senses: Towards Integrative Practice," *European Journal for the History of Medicine and Health*, 78 (2021), 155–180.

31 It should be noted, however, that popular depictions of grave illness and agony in *ex voto* murals and tablets do also sometimes represent the physician and the priest side by side at the sufferer's bed. On this, see, e.g., Antonio Ermanno Giardino, *Per grazia ricevuta: le tavolette dipinte ex voto per la Madonna dell'Arco: il Cinquecento* (Naples, 1983), 195–196; for later examples, see *Trecentosettantasette ex voto dipinti. Basilica del SS. Crocifisso Como* (Lecco, 2002), 293–294; Giancarlo Cerasoli, *Storie dipinte di grazie* ricevute (Bologna, 2020), 78, 134.

idealized and prescriptive as they are, do they not hint at the compatibility between doctors and the spiritual experience of death? (see Figure 2).

Canonization processes would certainly prove fruitful in reassessing this point too, and useful more generally in investigating medicine and religion at the deathbed. We need scarcely draw attention to the richness of miracles narratives. To medievalists and early modernists, these narratives have disclosed the agency of common men and women with regard to sickness and health, and provided information about everyday medical practice,[32] while


FIGURE 2 *The deathbed of Pope Pius VI.* Engraving by A. Campanella after J. Beys, 1802. Courtesy of the Wellcome Collection. The kneeling man on the right probably represents Dr Duchadoz, who is reported in Pietro Baldassari, *Relazione delle avversità e patimenti del glorioso Papa Pio VI*, vol. 4 (Modena, 1843), to have held the dying pope's hand until he expired (here replaced by a priest).

32 In a vast literature, see David Gentilcore, *Healers and Healing in Early Modern Italy* (Manchester, 1998); Sofia Boesch Gajano and Marilena Modica, eds., *Miracoli: dai segni alla storia* (Rome, 1999); Albrecht Burkardt, *Les clients des saints: maladie et quête du miracle à travers les procès de canonisation de la première moitié du XVIIe siècle en France* (Rome, 2004).

historians of religion have analysed the place of pain in the making of sainthood, especially for female saints (a place that became even bigger in modern Catholicism).[33] Excellent studies have documented how the role of physicians grew along with the reform and centralisation of canonisation procedures.[34] As the Roman Church strove to reassert the cult of saints, the ways of understanding miracles underwent a process of medicalization, and medical experts acquired a more important function in every step of the tortuous way towards sainthood.[35] Scholars, however, have not systematically used canonisation processes to track the presence of medics at the deathbed, nor ideas and practices related to death and dying, and how medical and lay cultures intertwined in this regard.

Three post-Reformation saints, who embody different versions of modern sainthood – the pedagogue, the missionary, and the Church reformer – can serve as cases in point. All three were members of new orders: the Piarists (founded 1602), the Capuchins (founded 1532 and at the forefront of the Christianisation of death) and the Clerics Regulars Theatines (founded 1524). A literal reading of testimonies and medical statements, as well as of the holy men's "lives and miracles" offer glimpses on how death was experienced by medical practitioners, clergymen and laypersons, and how they interacted.

José de Calasanz was an Aragonese theologian who moved to Rome where he served as parish priest and founded the Congregation of the Poor of the Mother of God of the Pious Schools for the education of deprived children. The *Vita* published by Urbano Tosetti for José's canonisation is a typical modern

33 Sarah F. Matthews Grieco, "Modelli di santità femminile nell'Italia del Rinascimento e della Controriforma," in *Donne e fede*, ed. Lucetta Scaraffia and Gabriella Zarri (Bari, 1994), 320–322. Examples famously include the prominent female mystics and stigmatics, Teresa of Avila and Maria Maddalena de' Pazzi. See also Anne J. Schutte, *Aspiring Saints: Pretense of Holiness, Inquisition, and Gender in the Republic of Venice, 1618–1750* (Baltimore, MD, 2001); Tine Van Osselaer, Andrea Graus, Leonardo Rossi, Kristof Smeyers, *The Devotion and Promotion of Stigmatics in Europe, c. 1800–1950* (Leiden, 2020).

34 Gabriella Zarri, ed., *Finzione e santità tra medioevo ed età moderna* (Turin, 1991); Josef Ziegler, "Practitioners and Saints: Medical Men in Canonisation Processes in the Thirteenth to Fifteenth Centuries," *Social History of Medicine*, 12 (1999), 191–225; Fernando Vidal, "Miracles, Science, and Testimony in Post-Tridentine Saint-Making," *Science in Context*, 20 (2007), 481–508; Jacalyn Duffin, *Medical Miracles: Doctors, Saints, and Healing in the Modern World* (New York, 2009).

35 This progressively included the post-mortem examination of the prospective saint's corpse; see Bradford A. Bouley, *Pious Post-mortems: Anatomy, Sanctity, and the Catholic Church in Early Modern Europe* (Philadelphia, PA, 2017). For two early Roman cases, Elisa Andretta, "Anatomie du Vénérable dans la Rome de la Contre-réforme. Les autopsies d'Ignace de Loyola et de Philippe Neri," in *Conflicting Duties: Science, Medicine and Religion in Rome, 1550–1750*, ed. Maria Pia Donato and Jill Kraye (London–Turin, 2009), 275–300.

hagiographic text, touching upon all the aspects that were canonically considered for sanctity.[36] Unsurprisingly for a religious leader in a highly medicalized city like Rome and for a congregation that, by the mid-eighteenth century, had turned to the education of the urban middle classes, physicians are ubiquitous. Tosetti expatiates at great length over the last illness and exemplary death of José. He gives details on every single visit by the treating physicians, their fees, the "even horrendous" cures they prescribe (including the exact spot of venesection), their prognoses, which José endures patiently yet knows to be wrong by virtue of his God-given *prescientia*.[37] Doctors are said to attend the holy man until very late at night, leaving him to return first thing in the morning; at dawn, however, Calasanz passes away among his brethren, without the attendance of physicians but not before taking the medicine they had prescribed.[38] Moreover, several of Calasanz's miracles feature medical practitioners comforting fatally ill persons and calling the priest in for the last sacraments.

Less medicalized is the world depicted in the biographies and canonisation proceedings of Joseph from Leonessa, a capuchin who first travelled to Constantinople to comfort and free Christians enslaved by the Turks, and then to the mountainous region of Abruzzi. Nonetheless, physicians and surgeons alike play a crucial role. Like Calasanz, Joseph is portrayed as a reluctant yet obedient patient: although he stubbornly refuses to take too costly drugs, he stoically endures the "martyrdom" of surgery on a "monstrous" testicular cancer, which is "diagnosed by physicians to be incurable, but not to be left without treatment, in order to keep the godly man in this world as long as possible".[39] He is assisted in his final illness by the friars of his convent and a devoted physician, in whose presence he gives a "very thorough confession" and receives

36 Urbano Tosetti, *Compendio storico della vita di S. Giuseppe Calasanzio della Madre di Dio fondatore delle scuole pie* (Rome, 1767). On the death motif in earlier hagiography, see Michel Lauwers, "La mort et le corps dans les Vitae du haut Moyen Âge," *Le Moyen Age*, 94 (1988), 21–50; Jacques Dalarun, "La mort des saints fondateurs: De Martin à François," in *Les fonctions des saints dans le monde occidental* (*IIIe-XIIIe siècle*), introd. Jean-Yves Tilliette (Rome, 1991), 193–215, Dieter von der Nahmer, *Der Heilige und sein Tod: Sterben im Mittelalter* (Darmstadt, 2013).

37 On the compliance with medical prescriptions and the cardinal virtue of patience, see Carlos M. N. Eire, *From Madrid to Purgatory*: *The Art and Craft of Dying in Sixteenth-Century Spain* (Cambridge, 1995); Silvia De Renzi, "Tales from Cardinals' Deathbeds: Medical Hierarchy, Courtly Etiquette and Authority in the Counter Reformation," in *Être médecin à la cour* (*Italie, France, Espagne, XIIIe-XVIIIe siècle*), ed. Elisa Andretta and Marilyn Nicoud (Florence, 2013), 235–258; Georges Minois, *Le prêtre et le médecin: Des saints guérisseurs à la bioéthique* (Paris, 2015), 183–187.

38 Tosetti, *Vita*, 210–214.

39 Angelo M. De Rossi, *Vita del ven. Servo di Dio p. Giuseppe da Leonessa* (Genoa, 1695), 206.

the viaticum, and with whom he prays for the last time before his demise. The miracle narratives then introduce the whole range of physicians' and surgeons' attitudes towards incurable and terminal patients: there are those who leave, those who give up treatment but offer spiritual advice, those who despair but keep visiting their moribund patients …[40] On one occasion, a boy with what should have been a fatal wound to his throat, is saved by Joseph's relics in the presence of a capuchin friar and a physician, who has just declared that the boy's life could not be saved and yet remains in the house.[41]

Last but not least, Andrea Avellino was a Cleric Regular Theatine, mostly active in Naples, a reformer imposing Tridentine discipline upon a riotous clergy. In 1608 he was struck by apoplexy while officiating the Holy Mass and died immediately afterwards (see Figure 3). Evidence in support of his


FIGURE 3 *Saint Andrew Avellino*. Engraving by Savorelli (ca. 1700). Courtesy of the Wellcome Collection.

40 *Sacra rituum congregatione … Spoletana beatificationis, & canonizationis ven. servi Dei fr. Josephi a Leonissa sacerdotis ordinis s. Francisci capuccinorum* (Rome, 1693), 190, 215 and passim.

41 Giuseppe M. da Terni, *Ristretto della vita di San Giuseppe da Leonessa* (Rome, 1746), 81.

beatification and canonisation include several miracles related to resuscitation and resurrection, all recounted with a profusion of medical terms and featuring physicians at all stages of the process. There is, for instance, a man who loses "all senses, motion and any apparent sign of life in a moment, such that if he were not dead already, he was deemed soon to be dead", on whom physicians try everything "their art allowed them to make him return to his senses in any possible way, but all to no avail", but who is eventually saved by the Blessed Avellino's hair.[42] When a baby boy is "attacked by many ailments at the same time, with an apoplectic accident", his mother first tries to resuscitate him herself "peering to see whether he exhaled any breath, but in vain; she shook and shook him again, believing that he may be won over by lethargy, but without any result"; after a doctor certifies the infant's death, the father makes preparations for burial, but at Andrew's tomb, "the child already stiff and cold, and dead for many hours, immediately recovered life, began to yawn, stretching out his little hands and body, and looking for the nurse to have the breast, as if he were just awakened from sleep and not raised from the dead."[43] In another miracle, a young boy fallen off a cliff is examined by a physician: after "duly pondering the lack of pulse", the practitioner concludes "from the extinguished heat and the privation of senses, and from that large compression in the forehead and dislocation of the vertebrae of the neck, that he could not naturally live", and therefore "deemed […] he was dead, and said he could but urge [the mother] to go and bury him"; by virtue of her devotion to Andrew, however, the mother witnesses her child come back to life with rosy cheeks, as if he had just woken from sleep.[44]

Clearly, hagiographic sources are normative texts, which primarily reveal how dying was framed into a religiously acceptable idealisation. Both the sceptical and the pious physician taking part in the death scenes are functional in asserting and extolling divine intervention. Still, literal reading unveils shared expectations and factual elements nested within the main narrative, and point at the medicalization of death going hand in hand with its Christianisation.

True, most of the tropes that I have highlighted date back from the Middle Ages – the crying mother, the stupefied father, the description of the lifeless little bodies, the signs of recovery…[45] As Leigh Ann Craig has argued for Medieval

42 Giovan Battista Bagatta, *Vita dell'ammirabile servo di Dio B. Andrea Avellino dell'ordine de Cherici Regolari* (Naples, 1696), 244.

43 Ibid., 262–263.

44 Ibid., 306–307.

45 Didier Lett, *L'enfant des miracles: Enfance et société au Moyen Âge* (*XIIe-XIIIe s.*) (Paris, 1997); Ronald C. Finucane, *The Rescue of the Innocents: Endangered Children in Medieval Miracles* (Basingstoke, 1997).

England, resurrection miracles needed to provide theologically and medically audible statements, and descriptions were therefore couched in the terminology of learned medicine, even if physicians did not take part in any stage of the process.[46] This is precisely the difference, however: physicians and surgeons progressively populated miracle narratives and canonisation processes and, more importantly for the scope of this article, the scene of death, up to a point that by the early eighteenth century their absence had begun to be pinpointed as suspect.

As a matter of fact, the lapse of time usually separating beatification and canonisation enables us to appreciate how death, and more specifically the medicalization of death, acquired a more prominent place over time, and how medical theory evolved and was put to work in vetting the natural and the supernatural. In the documents on the death of Andrea Avellino, for instance, whereas the earlier biographies show physicians remaining in the background, the later texts show them standing by the holy man's deathbed. And whereas his first biographer characterised agony as the apparition of "a tempting spirit […] in the form of an ugly man", later texts concentrate on his physical pain, the "frightening blackness" and "horribly inflating visage […] frantic gaze, and increasing breathlessness in his chest".[47]

As for his miracles, when at the end of the seventeenth century theologians and medical experts examined the new prodigies credited to Avellino, and particularly the healing of a boy crushed in an accident and left for dead, the key arguments against were that no medic had declared him dead, and no attempts at resuscitation had been made – to the great disparagement of the solicitor who pointed at the fact that canon law did not formally require it. The boy's recovery was eventually recognised to be miraculous, though not a proper resurrection.[48]

Changing definitions of life and death can similarly be charted. The two roman physicians acting as medical experts in Avellino's 1695 canonization relied heavily on circulatory physiology in debating whether any *reviviscentia* from apparent death was medically possible. Two decades later, in the process for the beatification of Pierre Fourier, a canon regular from Lorraine and

46 Leigh Ann Craig, "Describing Death and Resurrection: Medicine and the Humors in Two Late Medieval Miracles," in *The Sacred and the Secular in Medieval Medicine*, ed. Barbara Bowers and Linda Migl Keyser (London, 2016), 103–115.

47 Respectively: Giovan Battista Castaldo, *Vita del padre don Andrea Avellino* (Naples, 1613), 168, and Bagatta, *Vita*, 109–111.

48 *Sac. Ritum Congregatione… Canonizationis B. Andreae Avellini…positio super dubio an et de quibus miraculis constet* (Rome, 1695); medical expert reports by Bartolomeo Santinelli and Paolo Manfredi have their own pagination.

the founder of a female congregation dedicated to the care of poor children, the wondrous resuscitation of two boys crushed by a cart were examined by the papal physician Giovanni M. Lancisi and his former student Francesco Soldati, and both argued their case according to the mechanical conception of life and death put forward by Lancisi himself in his 1707 treatise *De subitaneis mortibus*.[49]

In other words, I suggest that saint-making was a site where different cultures of death – ecclesiastical and medical, learned and popular – were negotiated. As Tiago Pieres Marques has noted, the intersections of medicine and religion need to be studied

> from the perspective of the ways in which the dynamic relationship between scientific and religious epistemologies interfere with the actual experiences […]. Medical knowledge was interwoven with religious experience which, in turn, actualized or helped displace certain scientific themes. […] Some Catholic milieus adapted well to the rationalist requirements of modernity by […] constructing hybrid epistemologies.[50]

The same thing can be argued for the early modern period, and for death as much as illness. Sanctity and the miraculous are the loci where the negotiation took place and medical and religious epistemologies interacted with each other, and with personal experience.

## 3 Incurable Disease and Terminal Care: Defining and Accepting the Inevitable

The torments of medicine, especially in those situations where the cure could be regarded as worse than the disease, introduce a further question related to the pursuit of cures for the incurable and the fatally ill.

Just like they are today, incurable diseases and terminal illness were very different things in past medical culture. Since Antiquity, defining and accepting

49 Both statements in *Sac. Ritum Congregatione…beatificationis et canonizationis ….Petri Forerij Canonicorum Regularium Ordinis S. Augustini …position super dubio* (Rome, 1717), separate pagination.

50 Tiago Pieres Marques, "Experiencing Religion and Medicine: Marian Apparitions and Victim Souls in Portugal, 1910–1950," in *Signs or Symptoms? Exceptional Corporeal Phenomena in Religion and Medicine in the 19th and 20th Centuries*, ed. Tine Van Osselaer, Henk de Smaele and Kaat Wils (Leuven, 2017), 141–162, at 142.

incurability had a philosophical, medical and practical stake.[51] Obviously, these drives remained powerful in the early modern age, while religion added an extra layer of motivation: Christians must accept the divine will and trust in the afterlife. Hence, the Hippocratic no-harm principle implied a refusal of violent treatment, futile care and experimental therapies, even in hopeless cases. Authors agreed over these points across confessional divides. All deontological texts scorned those practitioners who prescribed costly and useless drugs and shared profits with the – invariably depicted as greedy – apothecaries.

Of course, the clergy preached the advantages of the medicine of the soul over that of the body. Inducing acceptance of sickness and death was the priest's task according to no less than the official *Rituale romanun* of 1614, although the refusal of medical care was seen as wrong, and was even sinful according to many canonists.[52] Interestingly, clerics drew profusely upon medicine to argue the cause of faith; and the circulation of medical knowledge among the clergy should be investigated in greater depth for a fuller understanding of this. Clinically realistic descriptions were not uncommon in *ars moriendi* literature. "The feet get cold […] the teeth almost black, the nose sharp, the eyes are blind and moist, the forehead becomes hard […] the ears livid and deaf, the tongue big, rough and black, the chest swells and the throat tightens, and one loses consciousness", wrote the Carmelite Jaime Montanes in 1588, in an obvious description of the *facies hippocratica*.[53] The Jesuit theologian and polemist Juan Baptista Poza devoted an entire chapter of his *Practica de ayudar a bien morir* to the physiology of death.[54]

In actuality, hopelessness did imply giving up all treatment. No disease is ever so desperate that a physician cannot act upon it, stated Boudewijns, a Catholic, in 1665.[55] Friedrich Hoffmann, a Lutheran, summarized the consensual opinion in his *Medicus politicus*: physicians have not the power to heal everything, and yet they "must not despair nor desist from treatment,

51 Renate Wittern, *Grenzen der Helkunst: eine historische Betrachtung* (Stuttgart, 1982); Heinrich von Staden, "Incurability and Hopelessness: The 'Hippocratic corpus'," in *La maladie et les malades dans la Collection hippocratique: actes du VIe Colloque international Hippocratique*, ed. Paul Potter, Gilles Maloney and Jacques Desautels (Québec, 1990), 75–112.

52 Tommaso Azzio, *Tractatus novus legalis de infirmitate, eiusque priuilegijs, et effectibus* (Venice, 1603), 92–93.

53 Jaime Montanes, *Espejo de bien vivir y para ayudar a bien morir* (Cagliari, 1588). See Anne Milhou-Roudie, "Un transito espantoso: la peur de l'agonie dans les preparations à la mort et sermons espagnols du XVIe et XVIIe siècles," in *La peur de la mort en Espagne au Siècle d'Or: littérature et iconographie*, ed. Augustin Redondo (Paris, 1993), 9–16.

54 Juan Baptista Poza, *Practica de ayudar a bien morir, para que qualquiera que supiere leer pueda ayuda, y consolar à los enfermos* (Madrid, 1619).

55 Boudewijns, *Ventilabrum,* 180.

nevertheless always act cautiously and heed the counsel of other colleagues".[56] What we would call palliative care was in fact considered a legitimate pursuit. Stolberg has provided an excellent overview of such cures, as do histories of cancer.[57] Historians also tend to agree that the market for health services expanded through the early modern age. Through probate accounts, Ian Mortimer estimated the extent of the purchase of medical and nursing services in the English county of Kent and concluded that serious illness involved the increased attendance of practitioners at the bedside.[58]

New research on childhood confirms such an interpretation. Classic *histoire des mentalités* posited that the loss of infants and children was accepted as an inevitable fact in pre-modern societies. Historians of childhood, of religion and, more recently, of emotions have disputed such a view and revisited the emotional response to the illnesses and death of a child.[59] Historians of medicine moved along the same line. Hannah Newton has documented the extent to which parents struggled to be reconciled to the prospect of their offspring's demise.[60] Although Newton does not uphold the idea of an increasing medicalization, she shows that parents embarked upon cumbersome, expensive and strenuous efforts until the very end, as does Claudia Pancino in her recent book.[61] To borrow Didier Lett's conclusion, godly resignation was little more than a clerical desideratum.[62]

What is certain is that the late seventeenth and eighteenth centuries saw a surge in writings dedicated to medical notions of a good or bad death, *signa mortifera* and care for the dying.[63] Because many of those who authored

56 Friedrich Hoffmann, *Medicus politicus sive regulæ prudentiæ secundum quas medicus juvenis studia sua et vitæ rationem dirigere debet* (Leiden, 1738), 181–184.

57 Stolberg, *Die Geschichte,* 28–56; Daniel de Moulin, *A Short History of Breast Cancer* (Boston, MA–The Hague, 1983); Marjo Kaartinen, *Breast Cancer in the Eighteenth Century* (London, 2013).

58 Ian Mortimer, *The Dying and the Doctors: The Medical Revolution in Seventeenth-Century England* (Woodbridge, 2009), 82.

59 For a critical reassessment, see Katie Barclay, Kimberley Reynolds, Clara Rawnsley, eds., *Death, Emotion and Childhood in Premodern Europe* (Basingstoke, 2016).

60 Hannah Newton, *The Sick Child in Early Modern England 1580–1720* (Oxford, 2012).

61 Claudia Pancino, *La natura dei bambini: Cura del corpo, malattie e medicina della prima infanzia fra Cinquecento e Settecento* (Bologna, 2015).

62 Lett, *L'enfant*, 197. On the *sanctuaires à répit* for stillborn babies, see Jacques Gélis, *Les enfants des limbes: mort-nés et parents dans l'Europe chrétienne* (Paris, 2006).

63 See, e.g., two thesis that seem to complement each other, both focusing on the death prognosis: one by Zacharias Philippus Schulz, *Dissertatio ...de euthanasia medica* (Halle, 1735), and the other by Carolus Christianus Hennig, *Dissertatio ... de dysthanasia medica* (Halle, 1735). For a bibliographical overview, see Wilhelm Gottfried Ploucquet, *Initia Bibliothecae Medico-Practicae et Chirurgicae*, vol. 5 (Tubingen, 1795), 676–697.

medical texts on the end of life were Lutherans and had the University of Halle as their epicentre, it could be tempting to suggest that Pietism contributed to this shift, through its peculiar emphasis on sickness as spiritual rebirth and its introspective culture of exemplary death.[64] I am not sure that this argument is conclusive, however. True, Catholic physicians, especially in the Italian and Iberian peninsulas, refrained from the discussion of topics that might catch the eye of censors – they often circulated new and potentially controversial ideas through the academic genre of compendia. But if we keep sight of the fact that much of the medical literature on dying was in fact constituted by doctoral theses, then the spectacular rise of universities in the German territories and the newly founded University of Halle's ambition to take their lead might, in and of themselves, explain such developments.

Still, I think that religion did play a role. Histories of medicine and religion tend to assume a degree of equitable access to the ministers of both, but this was certainly not true for Renaissance Europe. But, as I have indicated, it was less untrue a century later. By the late seventeenth century, an impetus for reform grew in Catholic and Protestant Europe alike. It is not by chance that the late seventeenth century witnessed a revival of *artes moriendi* and ecclesiastic regulation. Likewise, the provision of medical services seems to have increased, especially if one looks beyond traditionally medicalized areas like Italy. In short, although we lack a cross-thematic overview, I would say that a larger medicalization and a deeper confessionalization combined in making death a more prominent theme.

These late-seventeenth- and eighteenth-century medical texts, in any case, are ambivalent. On the one hand, they advocated the physicians' duty and prerogative to continue treatment until the very end. On the other, the cures they recommended amounted to little more than minimal nursing, like hydrating the moribund drop-by-drop, instead of administering painful remedies like scarification and revulsive medicines or forcing food on them, which was after all consistent with what their predecessors recommended when they rebuked costly and unnecessary cures. There was one notable difference, however: violent and sudden death *vs.* natural death was a distinction that had been thoroughly debated in medieval medicine and was now revived to tackle new ethical and practical challenges.[65] While preaching an expectant and

64 Ulriche Gleixner, *Pietismus und Bürgertum. Eine historische Anthropologie der Frömmigkeit. Württemberg 17.–19. Jahrhundert* (Göttingen, 2005), 195–208; Jürgen Helm, *Krankheit, Bekehrung und Reform. Medizin und Krankenfürsorge im Halleschen Pietismus* (Tübingen, 2006).

65 Karine van't Land, "Long Life, Natural Death: The Learned Ideal of Dying in Late Medieval Commentaries on Avicenna's Canon," *Early Science and Medicine*, 19 (2014), 558–583.

restrained therapeutic strategy in treating the terminally ill – without trying to subvert the natural, God-given length of life – these texts also posited a more active strategy in trying to avert unexpected death, be it from apoplexy, drowning, or strangulation. Georg Christoph Detharding's oft-cited dissertation *De mortis cura* is a perfect example.[66] On the distinction between natural and violent death, Detharding drew at once the obligation not to intrude on the natural extinction of life in cases of the former, and the obligation to attempt resuscitation in cases of the latter. Of course, only God can call the dead back to life, but there are nonetheless circumstances in which dying or apparent dead persons can be revived by prompt intervention: no death, however swift, occurs in a single instant, leaving physicians and surgeons an opportunity to act – which was precisely what Lancisi argued some years earlier in his *De Subitaneis Mortibus*, comparing physicians to semi-divine figures.[67]

As a matter of fact, sudden death emerged as a fully-fledged object of study both in Catholic and Protestant contexts in the late seventeenth century. Apoplexy, a classic 'disease of the head,' attracted new attention, and such interest is clearly connected to contemporary research on the anatomy of the brain and the physiology of the nerves, and more generally to a post-Cartesian understanding of sensation and movement. Yet, in many texts, the emphasis now fell on medical intervention, and the insistence on the supposedly greater frequency of apoplexies is also revealing of a new sense of urgency.[68] Of course, the argument that sudden death could be sometimes avoided was not totally new, and a panoply of remedies were recommended since Antiquity. But physicians and surgeons now begun to move beyond a millennium-long expectant attitude in the face of sudden death, which was considered an ugly, spiritually dangerous way of passing.

Indeed, the influence of religion on medicine was crucial in reframing the medical approach to sudden death and resuscitation. Classic histories of the Western attitudes towards death attributed the emergence of modern medical interventionism to the Enlightenment lust for life.[69] In fact, it can be

66 Published as a doctoral thesis in Rostock, 1723.

67 Lancisi, *De subitaneis mortibus*, 37.

68 Johann Jakob Wepfer, *Observationes anatomicae, ex cadaveribus eorum, quos sustulit apoplexia* (Schaffhausen, 1658); François Bayle, *Tractatus de apoplexia* (The Hague, 1678); William Cole, *A Physico-medical Essay, Concerning the Late Frequency of Apoplexies* (Oxford, 1699).

69 John McManners, *Death and the Enlightenment: Changing Attitudes to Death Among Christians and Unbelievers in Eighteenth-Century France* (Oxford, 1981); Claudio Milanesi, *Morte apparente e morte intermedia: medicina e mentalità nel dibattito sull'incertezza dei segni della morte (1740–1789)* (Rome, 1989); Maurice Goulon et al., *La réanimation: naissance et développement d'un concept* (Paris, 2004).

back-dated by a century, and connected to religion, or more precisely, to parallel mutual developments in medicine and religion.

The new medical stance, which I posited some years ago, was in fact linked to the rise of moral Rigorism.[70] More specifically for Catholic theology, the renewal of Augustinianism entailed a reassessment on the subject of contrition, arousing fears that salvation could not be gained unless one had received valid sacraments, thus rekindling the dread of an unexpected and unprepared death.[71]

One book in particular that I have already quoted, marked a turning point: Lancisi's *De subitaneis mortibus*. Systematizing three decades of mechanical pathology and debates on the physiology of death, Lancisi argued that sudden death ensues from a blockage in the circulation of the three main life-supporting systems – respiration, blood circulation, and the circulation of nervous fluid – corresponding to the traditional notions of suffocation, syncope, and apoplexy. These circulatory systems must come to a complete and irreversible stop, and before this happens, it is sometimes possible to remove the obstruction and restore circulation, thus avoiding death.

*De Subitaneis mortibus* is a milestone in the understanding of death as a process, and in encouraging a more active stance in relation to the dying patient. For both, the religious backdrop is crucial. For a Roman Catholic physician like Lancisi, prevention through a finer understanding of the mechanisms of death is the ultimate goal of medicine, while resuscitation is at one and the same time a medical and a religious issue: doctors must try to resuscitate the dying, not least to give them time to repent for the sake of their souls. Others followed this line of reasoning, making a clinical stance on sudden death – and the religious implications thereof – a central concern.[72] Recently, Anton Serdeczny has claimed that the origins of resuscitation medicine are to be found in

70 Maria Pia Donato, *Sudden Death: Medicine and Religion in Eighteenth-Century Rome* (Farnham, 2014).

71 Jean Delumeau, *L'aveu et le pardon: les difficultés de la confession, XIIIe–XVIIIe siècle* (Paris, 1992), 128–135. For similarities with England, see Ralph Houlbrooke, *Death, Religion, and the Family in England, 1480–1750* (Oxford, 1998), 211–213.

72 See, e.g., Domenico Mistichelli, *Trattato dell'apoplessia* (Rome, 1709); Pierre Dionis, *Dissertation sur la mort subite et sur la catalepsie* (Paris, 1710); Jacques Geoffron, *Traité de l'apoplexie* (Dijon, 1716). Among early eighteenth-century texts by Protestant authors, Georg Heinrich Kornmann, *Disputatio inauguralis medica de morte subita praecavenda* (Halle, 1707); John Catherwood, *A New Method of Curing the Apoplexy* (London, 1715); Benjamin Grosvenor, *Observations on Sudden Death, Occasioned by the Late Frequent Instances of it, Both in City and Country* (London, 1720); and Johan Sigismundus Möller, *Dissertatio … in qua mortis subitaneae non vulgaris causas et remedia* (Wittenberg, 1723).

Calvinist Switzerland in the 1730s.[73] I would insist here on my interpretation that resuscitation medicine emerged earlier, but the point is that closer scrutiny of theological debates can afford us a finer understanding of early modern medical approaches to death in their non-linear evolution.

## 4 The Door from Which Life Escapes

The last question that I would like to briefly address is that of active euthanasia – a most forbidding field for early modernists.

In an inspiring article of 1969, René Graziani unearthed a sixteenth-century description of the means used by laypersons to end the agony of the dying. More recently, Stolberg brilliantly re-interpreted practices that were long mistaken for expressions of devotion – like laying the moribund on bare ground – but which could in fact have been carried out as acts of "murderous mercy", especially among the lower classes.[74]

Generally speaking and unsurprisingly, medical practitioners worked under the strictest obligation not to do anything *mortem vel retardantibus, vel acceleranti*bus. Shortening life through medicines or surgery in an attempt to alleviate pain, even terrible pains, amounted to killing, warned Boudewijns, and drugs like hemlock and opium, wrote Ernest Struve, "open the door from which life escapes".[75] Since Antiquity, the redoubtable properties of opium were understood and commented upon. On occasions, medical ethics also touched upon the uses of narcotics. Botallo, for instance, argued that abortifacient drugs and opium should be given if absolutely necessary; Codronchi cautioned that prescribing sedatives to healthy people was wrongful, and criminal if instrumental to suicide.[76]

In the seventeenth century, numerous writings dealt expressly with opium. As Johannes Hartmann, famous chemist, physician and professor at Marburg, put it, critics of opium were less numerous by the day.[77] The growing global commerce of drugs, the diffusion of chemical medicine and, more generally, the rise of all things related to *practica* fuelled such an interest. As Roy and

73 Anton Serdeczny, *Du tabac pour le mort: Une histoire de la réanimation* (Ceyzérieu, 2018).

74 René Graziani, "Non-utopian Euthanasia: An Italian Report, c. 1554," *Renaissance Quarterly*, 22 (1969), 329–333; Michael Stolberg, "Active Euthanasia in Pre-Modern Society, 1500–1800: Learned Debates and Popular Practices," *Social History of Medicine*, 20 (2007), 205–221.

75 Boudewijns, *Ventilabrum,* 219; Ernst Gotthold Struve, *Dissertatione solenni mortis theoriam medicam …*, (Halle, 1702), 37–40.

76 Botallo, *Commentarioli*, 49–52; Codronchi, *De Christiana*, 75.

77 Johann Hartmann, *Tractatus de opio* (Wittenberg, 1635), 133.

Dorothy Porter noted years ago, by the late eighteenth century the medical prescription of opium had become commonplace among the British elites, as Great Britain became the undisputed leader in its trade.[78]

And with wider consumption, there came errors. Matias Garcia, professor at Valencia, imputed abuses to inexperienced colleagues (whence the urge to instruct them by means of learned treatises), as well as to incompetent apothecaries and to the sick themselves, who "devour opiate medicines prescribed by their doctor and exchange life for death".[79] Even proponents of the generous use of opium cautioned against "accidents" and against considering opium the ultimate panacea. It is not really possible to glean information on the intentional use of opium with the purpose of shortening agony, but advice against prescribing it to the very elderly, the terminally ill, or to persons suffering from critical conditions like apoplexy could point to the fact that it was used in this way. In such cases, opium was "the viaticum to eternal life", wrote Georg Wolfgang Wedel, reprimanding "a certain practitioner" who facilitated the passing of those who were in agony and acutely fearful of death.[80]

Some authors addressed the issue more explicitly. Hartmann posited that opium should not be withheld from the incurably ill who demanded it.[81] Angelo Sala, a Paracelsian practitioner from Vicenza who converted to Calvinism and was the author of a successful booklet *Opiologia,* listed 23 types of extreme pain, from dysentery to menstruation, from calculi to infected wounds, for which *laudanum opiatum* offered the best remedy, both curative and palliative, "when any person is tormented with any malady whatsoever, and having tried all ordinary remedies than can be de devised to take away the cause, […] remains in continual torments, dolor, vexation and watching". Sala's rationale was medical: pain and sleeplessness exhaust the sufferer's radical moisture and hinder his or her recovery. His ultimate argument, however, was religious: laudanum gives "comfort and ease", so that dying patients "have in farre better sense recommended themselves unto God, given order concerning

78 Dorothy Porter and Roy Porter, *Patient's Progress: Doctors and Doctoring in Eighteenth-Century England* (Cambridge, 1998); Virginia Berridge and Griffith Edwards, *Opium and the People: Opiate Use in Nineteenth-Century England* (New York, 1981).

79 Matias Garcia, *Disputationes medicinae selectae, in duas partes distributae; quarum prima quinque complectitur disputationes, nempe 1. De venenis, 2. De antidotis, 3. De opio …* (Lyon, 1677), 136.

80 Georg Wolfgang Wedel, *Opiologia ad mentem Academiae naturae curiosorum* (Jena, 1674), 143–144.

81 Hartmann, *Tractatus,* 147; Michael Aloysius Sinapius, *Tractatus de remedio doloris, sive materia anodynorum, nec non opii causa criminali in foro medico* (Amsterdam, 1699), 104–108.

their worldly estate, and yielded their spirit into the hands of their Maker with quietnesse, greater comfort and edification of all them that were present about them"; therefore, "no reason, particular opinion, nor argument" should prevent physicians to use it in the final hour.[82]

Again, it could be tempting to posit a difference between Catholics and Protestants on this point. Dying with a clear mind was essential in the Christian ideal of a good death across confessional divides. In predestination theology, however, a good death was regarded more as an edifying experience for the community since it could not be understood as the last battle to endure in the hope of gaining salvation. One might deduce from texts like Sala's that allowing a peaceful passing was a greater asset in the eyes of practitioners of Reformed denominations, but in fact, strong opinions against what we would call terminal sedation were voiced among Lutherans as well as Anglicans: pain must be alleviated, but never at the risk of shortening life.[83] As for Catholics, theologians were unanimous in wishing the moribund to be alert when they took their last confession and extreme unction. A few rigorist theologians taught that only real contrition made the confession valid, hence a clear mind was indispensable; but in fact the edifice of Roman Catholicism rested on the intrinsic value of sacraments. Hence, while deploring the administration of last rites to agonizing semi-unconscious persons – those "nearly cadavers" scorned by Alfonso de' Liguori – priests would not withhold them. To date, we lack sufficient empirical research to conclude that narcotics were less socially accepted in Catholic than in Reformed Europe, for any reasons other than their higher cost.[84] I tend to agree with Jason Szabo, when he posits with regard to France that there was not a peculiar Catholic palliative culture, although it is true that, as Anne Carol argued, Catholic and free-thinking physicians diverged vis-à-vis resuscitation in the late nineteenth and early twentieth centuries.[85]

82 I quote from the English translation by Thomas Bretnor, *Opiologia. Or, a Treatise concerning the Nature, Properties, True Preparation and Safe Use and Administration of Opium* (London, 1618), 63–66.

83 For example, Dethering, *De mortis,* 87; Gisborne, *Enquiry*, 403. On the spiritual significance of pain, Percival, *Medical Ethics*, 197–199.

84 In fact, projects for the production of opium that could short-circuit overseas trade multiplied; see, e.g., for Italy, *L'oppio nostrale suoi effetti e virtù* (Naples, 1788); *Proposizione sulla necessità d'introdurre in Toscana la coltivazione dei papaveri in grande per estrarne l'oppio* (Florence, 1807); Francesco Ambrosi, *Memoria sulla coltivazione dei papaveri e sulla memoria di cavarne l'oppio* (Naples, 1817).

85 Jason Szabo, *Incurable and Intolerable: Chronic Disease and Slow Death in Nineteenth-century France* (New Brunswick, NJ, 2009), 139–142, 156–58; Carol, *Les médecins*; Stolberg, *History of*

Could case records shed new light on the actual use of narcotics and help refine such a broad-stroke picture? Could recipes books and apothecaries' bills give evidence of medical and lay consumption beyond the reticence of medical textbooks? Possibly, but I suspect we would find very indirect evidence.

Still, omission and self-censorship are historical problems per se, which, I suggest, deserve new consideration. How did physicians emotionally and philosophically confront death, the dying other, the corpse? In some ways, I think that the history of medicine is still tainted by a binary understanding of faith, dating back to the nineteenth century, when the nascent discipline unintentionally appropriated the clerical stance. But why do we so often tacitly imply that physicians only paid lip service when they wrote about religion? Why do we still so often assume that there were only two sorts of practitioners, the pious and the atheists, whereas the real question for historians should be how each of them coped with their multiple identities?

To this aim, we could use some fresh research, starting from a second look at meditations and *artes moriendi* written by physicians, like Girolamo Cardano's *Dialogue on Death*, or *Athanatophilia* by Fabio Glissenti, or Daniel Sennert's *De bene vivendi beateque moriendi*.[86] Glissenti, for example, was a reputed practitioner and man of letters in Venice and his *Athanatophilia* is a bulky dialogue – interspersed with allegoric novellas – on the acceptance of death; as Cynthia Klestinec has recently argued, this book was an integral part of Counter-Reformation culture but nonetheless crafted a notion of the good death in which the physician was centre stage.[87] In the same vein, although historians have investigated how students learned detachment,[88] I think there

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*Palliative Medicine*, 101–103 notes that in the early twentieth century medical professionals became more wary of the addictive properties of painkillers and more cautious in prescribing them.

86 Girolamo Cardano, *Somniorum synesorium omnis generis insomnia explicantes, libri 4…quibus accedunt…Dialogus de morte* (Basel, 1585); Fabio Glissenti, *Discorsi morali contra il dispiacer del morire, detto Athanatophilia* (Venice, 1598); Daniel Sennert, *Christliche Gedancken wie man Wol Leben und Selig Sterben soll* (Wittenberg, 1636), translated into Latin (Wittenberg, 1637, 1650) and English (London, 1694, 1704).

87 Cynthia Klestinic, "Fabio Glissenti and the Art of Dying Well in Early Modern Venice," unpublished paper given at the AAHMH 2021 conference. See further George W. McClure, "The 'Artes' and the 'Ars moriendi' in late Renaissance Venice: The Professions in Fabio Glissenti's 'Discorsi morali contra il dispiacer del morire, detto Athanatophilia' (1596)," *Renaissance Quarterly*, 51 (1998), 92–127. Glissenti was fined for not complying with the censors' corrections of his book: Luca Piantoni, "Morte a Venezia. L'«Athanatophilia» di Fabio Glissenti, 1596," in *Visibile teologia. Il libro sacro figurato in Italia tra Cinque e Seicento*, ed Elisabetta Selmi, Erminia Ardissino (Rome, 2012), 221–250.

88 See, e.g., Howard S. Becker et al., *Boys in White: Student Culture in Medical School* (Chicago, IL, 1961); Lynda Payne, *With Words and Knives: Learning Medical Dispassion in Early Modern*

is still much to learn on the question of how doctors and surgeons experienced and prepared for death.

## 5 Concluding Remarks

Historians live in the present; this is the truism on which our profession is built. Today, as in the past, we face cultural and ethical challenges related to death, some of which are brought about by the very achievements of medicine and technology. Controversy over the end of life is sparked by tragic cases again and again – cases like those of Terri Schiavo, Eluana Englaro, Pier Giorgio Welby, Jahi McMath, Vincent Lambert, Alta Fixsler, DJ Fabo. Euthanasia was decriminalised in the Netherlands in 2001 (and later extended to minors), in Belgium in 2002, in Luxembourg in 2009, in Germany in 2020, and just weeks ago, in January 2022, in Austria. Some months ago, Spain also adopted new legislation on life-ending assistance, whereas a similar law was rejected by Portugal's Supreme Court. In a recent poll in the UK, two thirds of the interviewees declared themselves in favour of more liberal regulations, and for the first time the British Medical Association adopted a neutral position on assisted dying. As I write, the Italian Parliament is working on a law on medically assisted euthanasia, in response to rulings by the Constitutional Court and a pending referendum. Notably, the large measure of discretion left to medical professionals over patients' advance decisions in extant laws is fiercely contested in Italy and in France, although religious sensibilities and organised Catholic activism are very different in the two countries. At the same time, proposals circulate in the USA to allow faith and philosophical beliefs to be accounted for in the legal definition of death.[89] In fact, the authority of both doctors and clerics is disputed in post-modern societies in an unstable configuration of arguments.

Meanwhile, the COVID-19 pandemic has dramatically torn the veil from some of the incongruities that exist between secular representations of death – or rather, its concealment – and the rude realities of medicine at the deathbed. Triage of patients for intensive care, for example, was propelled into the

*England* (Aldershot, 2007); John Harley Warner and James M. Edmonson, *Dissection: Photographs of a Rite of Passage in American Medicine: 1880–1930* (New York, 2009); Cynthia Klestinec, *Theaters of Anatomy: Students, Teachers, and Traditions of Dissection in Renaissance Venice* (Baltimore, MD, 2011).

89 Robert M. Veatch and Lainie F. Ross, *The Case for Choice* (Washington, D.C., 2016). The State of New Jersey already allows such a choice, as does Japan; see Alireza Bagheri, "Individual Choice in the Definition of Death," *Journal of Medical Ethics,* 33 (2007), 146–149.

media sphere, generating huge misunderstandings, especially in those countries like Italy and France, where the guidelines for critical care were the well-guarded preserve of medical professionals. The isolation of those dying from COVID reminded us that the ideals of good death and bereavement are still profoundly embedded in religious cultures. Somehow incongruously, though, society now demands that medics play different roles at the deathbed and meet conflicting expectations. Moreover, the pandemic has shone a light on the (too easily overlooked) fact that Europeans do not share the same attitudes vis-à-vis religion or medical expertise, not least because some areas are more, and differently, multicultural and multi-confessional than others.

Hence, it is not surprising that historians wish to confront the theme and engage in the public arena. It would be preposterous to claim that they can bring meaning to those who suffer, fear and doubt. But I believe they can produce new scholarship without indulging in simplistic visions of an idealised past, a risk that is paradoxically greater now that the media turn to such issues and solicit historical insights. I agree with Allan Kellehear and Julie-Marie Strange that, rather than pitching medicine against religion, it is more helpful to view both as non-static paradigms with which the dying and bereaved can engage in diverse ways and in different contexts.[90] Yet the question remains: how?

Part of the answer, I think, comes from the history of medical practice, which cultural historians have often overlooked, and which historians of medicine should carefully consider in order to distance themselves from an ethno-historical approach to death, and to medicine and religion in general. Closer scrutiny of the norms, practices, intellectual traditions and writing genres helps us to disentangle what seems to depend on some *Zeitgeist* or *mentalité* but what did in fact depend on institutions and professional expectations and codes. Someone like Botallo, for instance, could be taken for a lukewarm Catholic, and maybe he was, but we should definitely not forget that his book was, first and foremost, a comment on Hippocratic texts aiming to extol the dignity of surgery.

Secondly, I would say that, although in the last decades there has been a tremendous amount of excellent scholarship reframing histories of medicine and religion, we still need a greater degree of theological specification, within a common Christian culture, especially for periods of rapid change like that which occurred in early modern Europe. Sometimes historians of medicine could use a finely grained knowledge of religious controversies, just as

90 Allan Kellehear, *A Social History of Dying* (Cambridge, 2007); Julie-Marie Strange, "Death," in *The Oxford Handbook of the History of Medicine*, ed. Mark Jackson (Oxford, 2011), 355–372.

historians could use a finely grained knowledge of medical theory and practice. In other words, complicating the history of medicine and religion at the deathbed, not least with the aim of making it significant in questioning the present, implies the seemingly contradictory choices of probing into the religious and theological roots of medical ideas and practices, while abstaining from attributing to religion what did in fact depend on intellectual and institutional circumstances specific to medicine.

In any case, there is no better place to promote the conversation among scholars of different background and fields of expertise as can be found in the European Association for the History of Medicine and Health and in this journal.

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