Medical Examination and Poor Relief in Early Modern Germany

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Summary. This article investigates the role of the medical examination in municipal poor relief programmes between 1570 and 1620. Documents from the city of Nördlingen, a community of approximately 10,000 people in 1600, suggest that municipal facilities addressed a range of serious illnesses for a wide spectrum of the population. Practitioners were influenced by their Galenic medical milieu but ultimately focused on a range of practical resource questions rather than the diagnosis of an individual’s disease.

Keywords: physicians; medicine; poor relief; diagnosis; Nördlingen

In an article on the medical examination in Western medicine, Roy Porter observed that ‘it is revealing of both the preferences and prejudices of historians and the random survival of evidence, that we know so little about the conduct of routine consultations between practitioners and patients in earlier centuries’.1 While research in this area has increased—largely thanks to Porter’s own valuable contributions—for the early modern period the records of medical examinations, and of practice more generally, have not always received the same attention as the theoretical constructs devised for practitioners.

Where accounts of disease are concerned, the sixteenth century was an era of great intellectual vitality, as the development of Galenic theory approached its zenith among university professors and erudite court and city physicians. As Nancy Siraisi and Ian Maclean have shown, the relationship of sign, cause and disease was elaborated in various ways as theorists engaged and criticised Galenic methods and each other.2 Leading theorists such as Jean Fernel and Girolamo Cardano further distinguished symptoms (symptomata), which were outward manifestations or consequences of diseases, and signs (signa), the indications of disease that a physician interpreted for diagnosis, prognosis and treatment. Even in vernacular accounts such as the Mirror of Medicine (Spiegel der Artzney), published in 1534 by the Colmar physician Lorenz Fries, authors

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1Porter in Bynum and Porter (eds) 1993, p. 179. 2Siraisi in Kessler and Maclean (eds) 2002; Maclean 2002, pp. 261–6.
highlighted the doctor’s discernment of signs and his interpretive skill in fashioning a unique diagnosis. In the genre of medical observationes that burgeoned later in the century, authors such as Felix Platter and Pieter van Foreest applied Galenic semeiology to observations drawn from decades of municipal practice.

As these physicians well understood, much of what their elite patients (and readers) paid for was a learned conversation, an account that placed suffering in a meaningful framework and inspired confidence in eventual recovery. However, the extent to which practitioners deployed refined diagnostic strategies in more modest contexts remains an open, largely unresearched question. In addition to their service for an elite clientele, physicians such as Platter and van Foreest worked alongside barber-surgeons and sometimes midwives as linchpins in civic poor relief and health care schemes. Among their most important tasks was the examination of individuals for the evidence of disease, either to identify dangerous contagions or to verify that a person would benefit from public assistance. The medical attestation, already a component of Italian health schemes for some time, assumed greater significance as government officials investigated a person’s physical and legal status for poor relief and other purposes. Hospitals, municipal alms offices and other agencies required preliminary examinations for a variety of purposes as their medical and custodial responsibilities expanded. A prime example of this is the response to the malady known most often in the German lands as ‘the French disease’ (Franzosenkrankheit) or the ‘evil pox’ (böse Blättern). In the decades following its eruption across western Europe in the late 1490s, nearly two dozen cities sponsored a ‘pox house’ (Blätterhaus), which often evolved from makeshift arrangements to become a healing facility that was more or less permanent. In larger cities, such as Nuremberg and Augsburg, thousands of people submitted to examinations in order to qualify for treatment.

From the mid-sixteenth century onwards, such encounters with city officials were among the most frequent means by which non-elites received the attention of a trained practitioner. Despite their significance, these examinations are not easy to investigate, largely because the relevant city records such as account books or censuses concentrate on expenses and other quantitative information, while individual experiences are recorded only in infrequent episodes or sequences of events. This is the case in Margaret Pelling’s study of the remarkable ‘Census of the Poor’ that was conducted in the English town of Norwich in 1570. Pelling’s research highlights the role of lazar-houses on the outskirts of town as sites of residential care in the later sixteenth century. She also suggests that roughly 9 per cent of the adult population was sick or somehow disabled when the survey was conducted. From a thorough analysis of disparate archival documents in Ulm and Überlingen, Anne-marie Kinzelbach has compiled a roster of the illnesses that were mentioned most frequently by medical practitioners and laypeople between 1500 and 1660. However, the available documentation only permits a schematic overview of how the sick were

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3 Fries 1534, Hiii recto; Stein 2006, pp. 627–9.
4 Pomata in Pomata and Siraisi (eds) 2005; Midelfort 1999, pp. 168–81.
5 Kitzinger in Johanek (ed.) 2000. These institutions are most often discussed in the context of poor relief reform: Jütte 1984; Grell in Grell and Cunningham (eds) 1997; Safley in Safley (ed.) 2003.
6 Cipolla 1976, pp. 24–32; Groebner 2004, pp. 127, 145–7.
7 Jütte in Finzsch and Jütte (eds) 1996; Stein 2003.
8 Pelling 1985.
examined and treated in various hospitals and isolation facilities. In other studies, descriptions of illnesses survive in supplications from the sick, often drafted with the help of a notary, rather than in the assessments of the practitioners themselves. While these requests can indeed yield valuable information, they rely on expressions that reveal more about the applicants’ needs and status, and their perception of what help they might obtain, than their actual physical conditions. Other forms of accounting, such as the barber-surgeon Beleidbücher analysed in Cologne by Robert Jütte, primarily concern occupational injuries among a segment of the population.

In view of these challenges, the fortunate survival of archival material in the city of Nördlingen, a community with roughly 10,000 inhabitants at the turn of the seventeenth century, offers an exceptional opportunity to investigate the encounters that linked early modern patients, practitioners and health care facilities. Beginning around 1530, physicians and barber-surgeons employed by the city drafted medical examinations that referred petitioners for treatment, often in one of several city facilities. The extant documents—which include over 1,500 reports of examinations conducted between 1570 and 1620—are an exceptionally complete portrait of procedures that were widespread in the Holy Roman Empire, the Swiss cantons and urban settings elsewhere in Europe. They suggest that the provisions for medical poor relief in Nördlingen and other cities were substantial, and that municipal facilities addressed a range of serious illnesses for a wide spectrum of the population. The reports also suggest that the practitioners, although they were deeply influenced by their Galenic medical milieu, ultimately focused on a range of practical resource questions rather than the diagnosis of an individual’s disease.

Examining the Sick Poor

Nördlingen functioned as a regional distribution centre for the larger metropolises of Nürnberg, Ulm and Augsburg, and it had long hosted one of south Germany’s largest annual fairs. The city participated in the wave of reform in the 1520s and it consolidated municipal charities, including medical care for the poor, within an Alms Office. Although Nördlingen adopted the Lutheran confession and dismantled its cloisters, the city refrained from overt conflict with the pro-Catholic policies of Emperor Charles V. After 1550, Nördlingen shared the declining fortunes of larger trading centres as inflationary pressures and growing populations strained municipal resources. Similar to Augsburg, Ulm and Regensburg, Nördlingen was home to a large underclass of textile workers, especially weavers of woollens.

The city’s resources for its less advantaged residents, like those in other imperial cities, formed a patchwork of institutions and services that had evolved over several centuries.

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9Kinzelbach 1995, pp. 319–90, Table A 6.
10Stein 2003, pp. 172–202.
11Jütte 1991, especially p. 240.
12Particularly in southern Germany, Protestant and Catholic cities organised their services in a similar fashion. See the brief overview in Friess in Safley (ed.) 2003.
13All archival citations are from the Stadtarchiv Nördlingen (hereafter StANö). The examination reports are preserved in a holding entitled ‘Unfortunates’ (Verunglueckte Personen): R39 F2, folders 12–37. Hereafter individual documents in R39 F2 will be cited by their folder number and date.
14Friedrichs 1979.
15The moderate reform movement in Nördlingen is discussed in Rublack 1982.
16This pattern of poverty among cloth workers is described in Clasen 1983.
17Frickinger 1918–19, pp. 64–73, 83–6.
Care for the sick poor was concentrated in two locations. The Hospital of the Holy Ghost provided both short-term care for convalescents and a residence for the aged and infirm. Another set of buildings took shape around a natural spring southeast of the city walls, which enjoyed a reputation for healing properties and attracted visitors in the spring for an annual May bath. Beginning in the later fourteenth century, the city isolated suspected lepers at this location. By the later sixteenth century, the complex had grown to include several distinct facilities that were overseen by two barber-surgeons. One building contained a bath and a facility referred to as either the ‘pox house’ (Blätterhaus) or the ‘wood house’ (Holtzhaus), where patients underwent a cure for a period of weeks. The designation ‘wood house’ referred to potions and baths that were prepared from the bark of the guaiac tree, which were popular treatments for the ‘French pox’ and a range of other afflictions.18 An adjoining building (Siechenhaus) provided isolation for other infirm people with severe infections or who required sustained attention. They received treatment with salves and bandages and sometimes lodged in a chamber referred to as the ‘upper room’ (obere Stube). The barber-surgeon appointed to this latter facility also treated individuals in the hospital and city orphanage.

Several times a month, a barber-surgeon examined the sick poor to determine what treatment was possible and what facility might be most suitable.19 While the documents shed relatively little light on the origins of the system in the first half of the century, beginning in 1570 dozens of dated reports survive for most years until 1600. The reports document the observations of medical practitioners and hence are only indirect sources of information about the examinees’ perceptions and experiences. Nevertheless, there is an abundance of detailed information, recorded under stable conditions for a single office, and the collection is all the more remarkable because the documents focus upon the examinations and the conclusions drawn from them.

The period between January 1590 and December 1602 provides a representative sample comprising 405 examinations of roughly 320 different individuals. In 140 cases, the reports noted the status or occupation of the examinees. Ninety-nine of these individuals, or roughly 70 per cent, belonged to the families of tradespeople from the less prestigious guilds, and well over half of this group were weavers or other clothworkers. Day-labourers, carpenters and domestic servants also presented themselves for assistance. Among these poorer residents of Nördlingen, a wide spectrum of the populace sought care, although women were more likely to be examined than men. Two hundred and thirty-eight of the reports, or roughly 60 per cent, described examinations of women, of whom 30 (7.4 per cent) were identified as widows. Additionally, 42 people, just over 10 per cent, were designated as 60 years or older or simply ‘in old age’, and at least another 34 individuals (roughly 8 per cent) were children, including several wards of the city orphanage. The practitioners considered age an important consideration as they recommended treatments and they often warned against aggressive purges for the elderly or very young.20

In most cases, a mayor referred individuals to the practitioners for examination. As illustrated by Figure 1, the number of examinations in each month fluctuated over the course of the year. In general, the practitioners conducted examinations with greater frequency

18Arrizabalaga et al. 1997, pp. 100–2.
19StANö R39 F2, Verunglueckte Personen, nos 12–37.
20For example, no. 28, 15 March 1593; no. 29, 27 January 1594.
in winter and early spring than in other seasons. In March, the number of examinations began tapering to a low in September and October before rising again in November. The one exception to the general pattern was a large number of examinations conducted in the month of April, substantially more than any other month. The reason for this large number of referrals was that practitioners provided for an annual May bath at a spring outside the city. In the reports submitted each April between 1590 and 1602, the examiners recommended bathing as a treatment 36 times. This was just over half the total number of April examinations in the period, and several times the frequency that the practitioners recommended bathing during any other month. Thus, inclement weather and the resources sponsored by the city apparently influenced the individuals who came forward for examination and the recommendations they received.

In a few cases, the practitioners drafted reports that were intended to confirm that an individual was healthy, for example so that a city employee could discharge his duties or that a person could safely lodge alongside others in the hospital.\(^{21}\) The vast majority of examinations, however, describe disfiguring or painful skin conditions, internal illnesses, diminished function of limbs, or other conditions that required assistance. Very few of these health problems resulted directly from accidents or violence, although some people suffered from wounds that had not healed after a previous event.\(^ {22}\) During the actual examinations, the practitioners generally concentrated upon visual inspection and palpitation of swollen or disfigured areas. Individuals might be asked to remove their shirts and bare their legs but their blood or other excretions were not examined in detail. The practitioners drafted their reports (Schauzetzel) shortly after the examinations and submitted their findings to the city council, to serve in most cases as instructions for the patient’s future care.

The examination of Apell Lencken, which the surgeon Hans Hörtzog performed on 28 April 1590, provides a useful example of the format of the reports and the range of issues that the practitioners considered. In his note to the city council, Hörtzog wrote the following:

Honorable, prudent, worthy, wise, benevolent lords: by order of the lord mayor I have examined Jochem Lenck’s housewife Apell. She informs me that she has

\(^{21}\)For example, no. 26, 13 March 1590; no. 28, 30 January 1592; no. 30, 28 August 1599. Two examiners also conducted an autopsy, no. 28, 31 March 1592.

\(^{22}\)For example, no. 30, 16 March 1597.
severe pain in her leg but I cannot see anything concerning that. However, she is a bit scabious on her body; therefore the honourable council might allow her into the infirm house to bathe, according to what the honourable council will determine. 28 August 1590. Hans Hörtzog, city doctor etc. 23

At the start of each report the examiners addressed the city council and identified the city officer who had requested the examination. The practitioner then stated that he had examined or inspected (besichtigt) the individuals in question, who were identified with their own name or, in the case of many married women, by their husband’s name. In many instances, practitioners noted that they had ‘observed all the circumstances of the illness’, thereby indicating their legal accountability with terms reminiscent of the imperial penal code then in force. 24 The main contents of the examinations varied considerably according to the conditions that were discussed, but the reports almost invariably included signs discerned by sight or touch, such as skin disfigurements, swellings, fevers and coughs.

While the practitioners routinely referred to the examinees’ complaints, which were most often ‘headache’ (Kopfschmerz) or ‘pain’ (Wehetumb, Schmerz), such information was clearly not deemed obligatory. In most cases, the practitioners also refrained from identifying the causes of distress or factors that contributed to a particular illness. Instead, they proceeded from observations to recommend one of several therapies, which presumably were adapted to individual circumstances at a later point. The practitioners sometimes cited an examinee’s age or general health as grounds for optimism or, in the case of poor health or infirmity, as a reason to avoid more aggressive treatments. 25 In closing, they referred the matter to the discretion of the city council and provided a date and signature.

The basic structure of the reports remained stable over time but the dynamics of the procedure shifted during the 1590s when individual surgeons were replaced by examiners working in pairs. In the spring of 1591, a physician named Hieronymus Reusner expressed concern that barber-surgeons—in particular an examiner named Hans Hörtzog—were admitting and releasing individuals from city facilities without sufficient cause. 26 Apparently on Reusner’s suggestion, the city council instructed that a physician attend the examinations, and from May 1591 onwards two or more practitioners usually submitted a joint report. The document might be written either by the surgeon or the physician and in significant respects, the content of the reports remained largely the same. The types of individuals who were examined and the suggested treatments remained approximately stable, and the later reports were no more likely to include discussions of cause or prognosis than the earlier ones. To judge from the surviving records, however, the number of examinations dropped immediately in the spring of 1591 and remained at a lower level thereafter (Figure 2). In the years 1586 to 1591, the average number of examinations

23 No. 26, 28 August 1590: ‘Ernuest Fýrsÿchtig Ersam weis gunstig Heren. Aus I befelch des Heren burger maisters Hab Ich Jochem I Lencken Haus fraw Apell besÿchtigett so zaigtt sy I mir Ann sy Hab grossen schmertzten Jm schenckell I Jch kan Aber nichts daran sehen Aber sy ist Ain I wenig kretzig Am leib[,] der wegen sy ain erber rathh I im siech Haus mag baden lassen doch was Aines IErbern raths
glegen Haitt wirtt sein[,] datum den 128 Augustus 90 IHanns Hörtzog statt IArtzatt &c’

24 Cf. Article 149 of the ‘Carolina’ Penal Code, reprinted in Frankfurt (1565), 44 verso. The language of the code is discussed in Witenberg 2000, pp. 717–19.

25 No. 28, 15 August 1593.

26 STANo R39 F1 no. 14, Sammelakte, 5 March 1591.
each year was just under 81. From 1592 to 1596, the average declined to 29 and it remained at that level or lower throughout the 1620s. It remains unclear how the city limited the number of examinations—or, possibly, the number of individuals seeking assistance—but the net effect was clearly an overall reduction in the programme, rather than a narrowing of its focus to a particular group.

Alongside the decrease in the number of examinations, other discernible shifts in the composition of the reports may indicate how the presence of physicians, or the dynamic of working in pairs, influenced the examination procedures. In the 1570s and 1580s, the examining surgeons occasionally noted information from an examinee’s experience prior to the examination, such as an extended illness, efforts to treat their conditions, or an earlier sojourn in a city facility. The examiners’ practices varied substantially in this regard; one surgeon named Thomas Greiffenstain included such comments frequently, while Hans Hörztog rarely did so. However, beginning in the summer of 1591, the reports referred to the examinees’ earlier experiences with increasing regularity, and by the summer of 1594 a substantial majority of the reports included such information. By the end of the decade, most examinations probably included a short interview, which may have been conducted by the physician alongside the physical examination by the barber-surgeon.

From the mid-1590s onwards, many reports also indicate that the practitioners had consulted previous examinations as they charted a patient’s progress and an overall approach to treatment. These records also allowed them to assess the opinions of another examiner or to evaluate the care that had been provided. In a case from January 1600, Reusner and a surgeon named Veit Gentzler criticised the care of a wool weaver’s daughter who had been released from the Siechenhaus three weeks previously after extended treatment for boils. Her one remaining abscess was treatable but Gentzler and Reusner claimed she would not recover fully unless the bandaging was done with greater precision. The reports of previous encounters could also provide a useful tool for dealing with examinees whose actions were hostile or suspicious. In July 1594, a resident of the hospital named Hans Mencker vigorously insisted to Reusner and Greiffenstain that he be admitted to the wood cure. They refused on the grounds that such a treatment was unsuitable during the heat of the summer months. In August, Mencker

27No. 31, 8 January 1600.
renewed his request and accused the practitioners of denying him treatment, whereupon they commented that ‘the previous report indicates that he is not yet to be recommended for it [the treatment]’. In November 1594, the practitioners identified a woman who had separately approached four surgeons and physicians for assistance with her face and neck, claiming that the city council had authorised her for a sweat bath treatment. To forestall further confusion, they resubmitted her examination report with a caution about her suspicious behaviour.

### Maladies and Treatments

To judge from the extant documents, as a rule the city examiners did not investigate suspected cases of plague or pestilential fever. Otherwise, they encountered a wide range of complaints and signs of disease. While the reports do not concentrate upon the causes of disease, their contents indicate the influence of prevailing Galenic understandings of humoral flows within the body. For example, the examiners attributed swollen extremities or fistulas to an excessive ‘cold flow’ (kalter Fluss), that had not been released through a body’s normal purging processes such as sweating, bowel movements or, for women, menstruation. Likewise, coughing or shortness of breath was associated with the accumulation of putrefactive matter in the lungs or with drinking excessive amounts of cold water. The examiners also believed that diminished liver function contributed to various disorders—a reflection of the Galenic view that the liver manufactured blood—and they frequently noted ‘jaundice’ (Gelbsucht) as a condition that accompanied disturbances in the lungs or stomach.

These broad principles influenced the overall approach to the examinations, but the practitioners did not assign the diseases they discerned to fixed nosological categories. Instead they applied a flexible repertoire of descriptive terms to individual cases. For example, ‘dropsy’ referred to an accumulation of moist, unhealthy matter in various parts of the body. However, the term could also be used more equivocally to describe an ‘onset of dropsy’ (Anfang der Wassersucht) or to describe the qualities of another disorder, such as a ‘dropsical swelling’ (wassersuchtige Geschwulst). The same variability characterised references to pulmonary conditions, which they described as ‘bad lungs and liver’ (bese Lunge vnd Leber), as ‘a half consumption’ (ein halbe Schwindsucht) or as ‘a true consumption’ (ein rechtt Schwindsucht). The examiners also used the latter term to describe a person’s overall condition, as in the case of a bricklayer’s daughter who was described both as ‘consumptive’ (lung-unnd schwindsichtig) and suffering from ‘black jaundice’ (die schwartze Geelsucht). Broadly speaking, these descriptions correspond to the roster of terms recorded by Kinzelbach in the records of Ulm and Überlingen. The examiners’ use of vocabulary to refer interchangeably to diseases, symptoms or qualities parallels the ‘semantic network’ that Michael Stolberg has

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28 ‘nach andeüttung dess vorigen schwatztels noch nicht darzu zu radten’. No. 29, 13 August 1594.
29 No. 29, 20 November 1594.
30 No. 14, 15 August 1572.
31 No. 29, 18 January 1595; no. 30, 26 March 1599.
32 For example, no. 28, 19 April 1593; no. 30, 2 August 1598.
33 No. 29, 14 October 1594; no. 29, 13 January 1594; no. 27, 18 August 1591.
34 No. 29, 14 October 1594; no. 30, 19 June 1597; no. 29, 13 June 1594.
35 No. 31, 15 February 1600.
36 Kinzelbach 1995, Table A 6.
identified in descriptions of illness composed by upper-class patients in the seventeenth and eighteenth centuries.\textsuperscript{37} Using terms that many laypeople could recognise, Nördlingen’s practitioners aimed to describe particular circumstances precisely rather than to identify common patterns among several individuals.

The examiners’ observations influenced their deliberation of the more pressing issues: what treatment was necessary and whether or not an individual should enter a city facility. For some cases, particularly when death was at hand, the practitioners recommended no treatment at all. However, as illustrated by Figure 3, the vast majority of recommendations fell into one of several categories.

Amid the range of conditions they encountered, the practitioners focused most frequently on the health problems caused by poverty and indigence. They recognised that hunger was among the worst enemies of health and that an impoverished patient was less likely to benefit from prescribed treatments. This was certainly one reason that rest and improved nourishment (\textit{gebürliche Unterhaltung}), often during a short stay in the hospital, were recommended more than any other measures. In March 1571, Hans Hörtzog examined three orphan children, and noted of the eldest that ‘there is nothing on him but skin and bones’, while the youngest, about four years old, had suppurating dark sores on his legs.\textsuperscript{38} All that was needed was the proper food and rest, Hörtzog believed, but he doubted the boys would receive it. As the work of Thomas Safley has shown, such conditions were not unexpected for orphans at the time, especially during periods of dearth such as the early 1570s.\textsuperscript{39} But even intact families within the trades could have similar difficulties. On 29 April 1600, Reusner and the surgeon Veit Gentzler examined a carpenter’s wife who had suffered from shortness of breath, swollen legs and a ‘cold flow’. The pair noted that a purge and proper food were urgently required, or the woman ran the risk of developing dropsy (\textit{Wassersucht}). She was admitted into the hospital for five weeks, which apparently led to some improvement prior to her release. However, Reusner and Gentzler examined her again on 26 August and noted that,
while she was capable of improvement, she required another stay in the hospital to increase her strength.40

In addition to conditions related to subsistence, the examiners also attended to irregularities on the skin and often considered them a reflection of internal maladies. While their concern reflects the primacy of visual inspection in the examination itself, it also illustrates the widespread impact of the French pox and related illnesses. Pelling has accurately noted that while plague was the most lethal disease in the late sixteenth and early seventeenth centuries, the French pox demanded more consistent attention.41 Individuals with rashes (Raude) or a scabious appearance (kretzig, ausgefallen) were usually instructed to visit the May bath or to undergo a more regular bathing regimen. When these measures were unsuccessful, the practitioners occasionally recommended a visit to the nearby Wembding bath, which was deemed to have therapeutic qualities that excelled the bath outside Nördlingen’s wall. Individuals with open sores were sent to the wood house, where they received a ‘cure’ involving either preparations from guaiac or, less frequently, application of a mercury salve. The surviving documents do not record exits from the treatment. Stein’s study of similar facilities in Augsburg suggests that the duration could vary from several weeks to several months.42

While the ‘wood cure’ was not reserved solely for those deemed to suffer from the French pox, this disease aroused particular concern and, at times, a sharper focus upon diagnostic signs. In the 1570s and afterwards, anxieties about the pox merged with older fears concerning various forms of leprosy. Physicians sometimes noted the difficulty in telling the diseases apart, or claimed that a person was afflicted by a mixture of the two.43 Hence, in May 1593, Hieronymus Reusner and Thomas Greiffenstain described Thomas Schelhamer’s wife as an individual ‘who has been for a long time afflicted with a French mange that inclines to leprosy’.44 Understandably, given the social and economic consequences, practitioners tended to characterise ‘leprous’ illnesses on a spectrum with other disfiguring disorders, leaving open the possibility of recovery as long as possible. They also avoided treatments, such as warm baths, that might contribute to heating or ‘burning’ of the blood, which could encourage leprosy to emerge from another condition.45

The well-documented example of Madelena Fischer, who was first examined by Hans Hörtzog in December 1581, illustrates the practitioner’s reluctance to diagnose leprosy unequivocally. Initially, Hörtzog noted that Madelena’s body was dangerously unclean and displayed ‘several signs of a leprosy’ (ettliche Zaichen einer Maltzeÿ). However, in view of her relative youth—Madelena was approximately 22 years old at the time—Hörtzog suggested that treatment was possible.46 Over the next ten years, Madelena attempted a wood cure at least three times. When she was examined in March 1591 by the physician Gutbert Varius and the surgeon Stefan Schwan, they characterised her

40No. 31, 29 April 1600.
41Pelling 1985, p. 130.
42Stein 2003, pp. 237–8.
43In one examination, a physician named Hermann Siderens characterised a girl’s disease as ‘a mixture of the French disease and leprosy’ (mixtu ex morbo gallico et lepra). No. 13, 12 January 1571. Kinzelbach 1995, pp. 362–3, notes a similar tendency.
44‘welche mit einer frantzosischen Rauden, so auff die aussatz neiget seit lange her beladen gewesen’. No. 28, 14 August 1593.
45No. 17, 7 October 1577; no. 18, 7 February 1578.
46No. 19, 6 December 1581.
as ‘still afflicted with severe scabies on her entire body’ and recommended purges, blood-letting and a therapeutic bath. But these measures also led to no significant improvement, and in May 1592 Schwan and Hieronymus Reusner finally determined that Madelena was ‘afflicted with leprosy’ (mit dem Aussatz beladen) and recommended that she be separated from healthy people. Some examiners might have been willing to assign a conclusive diagnosis earlier than others, but Madelena’s case illustrates the prevailing approach. The Nördlingen practitioners postponed a definitive verdict until a patient’s lack of response to numerous treatments corroborated visual signs that often appeared years earlier.

Alongside diseases that manifested on the body’s surface, the practitioners considered internal disturbances signalled by coughing, shortness of breath, fever or digestive discomfort. Routinely, they observed disorders concentrated in the lungs (Schwindsucht, Lungensiech), for which they recommended a combination of purges, food and rest. Many of these cases were severe and the examinees indicated that their condition had worsened over months or even years. In November 1597, Simon Kratzer complained of shortness of breath and declining strength that had lasted for around nine months. Reusner and Gentzler commented that he ‘resembled a consumptive person’ (einer lungenkranken Person gleich ist) and recommended a mild purge and a series of drinks alongside food and rest. In some instances, practitioners observed that the illness had progressed past the point where intervention could help. Concerning Adam Brunner, a cloth worker whom he examined in June 1596, Reusner commented that ‘salty sharp flows’ (gesaltzene scharffe Flüsse) had damaged his organs over the last year and a half. The only effective human aid was food and nourishment to ease Brunner’s few remaining days.

Such severe afflictions did not comprise the majority of cases, but the practitioners examined a substantial number of individuals with apparently chronic conditions. In roughly 10 per cent of the reports between 1590 and 1602, practitioners discussed the progress of a person they had assessed previously, and many other reports summarised courses of treatment that had already lasted months or even years. For example, the linen weaver Martin Herpffer was examined four times between April 1592 and July 1593 to treat swellings and rashes attributed to the French pox. Although he received two courses of the ‘wood cure’, followed by a ‘smear cure’, his condition did not improve and it was recommended that he lodge in the Siechenhaus until further treatments could be considered. Probably the most persistent examinee of all was Apollonia Zillerin, who repeatedly sought help for sores on her legs through the 1580s. By November 1591 she had been approved for 15 different treatments, and the examiners Reusner and Schwan argued that no lasting cure was possible. Although she was permitted to visit the city bath several more times, the following November the practitioners recommended that she receive no further assistance.

47 ‘am gantzen leib mit einer bosser scabie noch behafft’. No. 27, 25 March 1591.
48 No. 28, 19 May 1592.
49 No. 30, 9 November 1597.
50 No. 29, 28 June 1596.
51 No. 28, 11 April 1592; no. 28, 2 September 1592; no. 28, 22 May 1593; no. 28, 22 July 1593.
52 No. 27, 30 November 1591; no. 28, 12 November 1592.
Conclusion

Historians of medicine and poor relief have long identified the pox houses founded in the early sixteenth century as early attempts to provide short-term care for curable ailments. Research in Germany has often focused upon larger communities such as Augsburg, Strasbourg and Ulm, but the Nördlingen evidence suggests that more modest-sized communities also combined residential facilities and non-resident care to treat a wide range of illnesses. Where medical poor relief was concerned, the second half of the sixteenth century was not a period of inertia and decline, as Christoph Sachße and Florian Tennstedt suggested for poor relief schemes in general. Many cities developed new programmes for the sick poor although, as the case of Nördlingen suggests, improvements in oversight were deemed necessary to keep the expenditures and scope of the initiatives in check. Elsewhere in Europe and Britain, the Norwich poor relief office researched by Margaret Pelling and the houses for incurabili in Rome described by John Henderson both pursued objectives similar to those of the Nördlingen Alms Office. Timothy McHugh has recently pointed out that the Paris Hôtel Dieu created its first official post for a physician in 1568, and Timothy Fehler has drawn attention to the inclusion of medical poor relief in Emden’s reforms after 1557.

As research in this area progresses, several further conclusions from the Nördlingen documents may have comparative value. Some studies of sixteenth- and seventeenth-century Germany and England have suggested that the majority of individuals who received care from surgeons and physicians were men. The Nördlingen documents indicate that German cities, as Pelling found for Norwich, may have redressed the imbalance in the ‘medical marketplace’ by allowing women access to inexpensive or free care. Women accounted for nearly two-thirds of the examinations conducted by the Nördlingen practitioners. Apart from this significant disparity, it is clear that both male and female individuals sought help throughout their lives in proportions that represented a broad spectrum of the population. As practitioners examined the most feeble individuals, they occasionally weighed the costs of treatment against the likelihood of recovery. However, the fact that appreciable numbers of children and very elderly people were recommended for treatment suggests that the provision of care was not linked directly to one’s ability to work or the prospect of a return to fully able-bodied status.

The Nördlingen documents also suggest general patterns in the frequency of examinations and types of care that were recommended. For the majority of examinees, the need for care was transient and the practitioners often attributed their difficulties to a lack of adequate nourishment. The practitioners recognised that privation posed a challenge to Nördlingen’s poor, and the ‘treatment’ that they most often prescribed was food and rest, in many cases at the city hospital. Several other forms of assistance, including the annual May bath, bloodletting and the pox house ‘cure’, rounded out the principal measures that the practitioners recommended singly or in combination. While the

53Sudhoff 1933; Jütte in Finzsch and Jütte (eds) 1996.
54Sachße and Tennstedt (eds) 1998, p. 34.
55For Catholic Überlingen, see Friess in Safley (ed.) 2003, p. 81; for bi-confessional Augsburg, see Hammond in Gilomen et al. (eds) 2002.
56Pelling 1985; Arrizabalaga et al. 1997, pp. 171–233. Henderson has also drawn renewed attention to the achievements of Florentine hospitals; see Henderson 2006.
57McHugh 2006, pp. 213–14; Fehler 1999, pp. 194–5.
58Kinzelbach 1995, p. 277, especially note 44.
majority of individuals consulted a practitioner only once, roughly 10 per cent of the examinees accounted for about one quarter of the encounters. Within this group, a small number of chronically infirm individuals relied heavily upon municipal support, returning several times or more over a period of years. For a few individuals who were examined repeatedly, such as Appolonia Zillerin, the practitioners eventually recommended palliative measures or no further help at all. Before reaching this point, however, they attempted a series of measures escalating from milder baths and salves to stronger purges and, in some cases, an expensive trip outside the city environs to the Wembding bath. While there was room for discretion in the execution of each treatment, in most examinations the practitioners usually chose from a list of standard options that the city was in a position to provide.

This last point also informs our view of the relationship between the practitioners’ objectives during an examination, the means for therapy at their disposal, and their status as city employees. In their examinations for the Alms Office, the Nördlingen practitioners were not primarily concerned with ‘diagnosis’, if by this term we mean attempts to define a condition by the presenting signs, identify its causes and locate it within a spectrum of known disorders. Such analyses were certainly possible, at least for some of the Nördlingen practitioners. For example, Hieronymus Reusner wrote Latin case histories and recipes for therapies that were eventually published in Augsburg in 1668, decades after his death. But examinations for the city required something else: as a practical matter the main goal of most examinations was not to define a disease but, rather, to suggest a course of action. The practitioners’ recommendations were shaped by civic events, such as Nördlingen’s annual May bath, or environmental conditions that influenced subsistence. When an individual’s symptoms posed problems of interpretation, the overriding questions were usually ‘where does this person belong?’ or ‘how can this person be treated?’, rather than ‘what disease does this person have?’

The limited evidence available elsewhere suggests that other city governments also used medical examinations in a heuristic fashion to determine how to assist a sufferer and protect the public without unfairly burdening an institution. This meant that some individuals were accepted to municipal ‘pox houses’ because of their disfiguring symptoms rather than a conclusive diagnosis. An official in Strasbourg acknowledged this when he described residents of the Blätterhaus in 1545: ‘...although a few do not have the pox, they do have foul, stinking, open sores, rashes and blemishes, each of them repulsive’. Conversely, administrators also attempted to protect their facilities from unnecessary or inappropriate responsibilities, particularly incurable cases. Hence, in 1602, the Alms Lords in Augsburg instructed the medical staff of the Alms House to exercise diligence in their examinations ‘...so that, because of an inaccurate report, the house will not be contaminated by someone who slips in with a congenital disease or other condition that cannot be healed at that location’. While many medical

59Welser 1668. 60...ob schon etlich nit blottern haben, haben sie doch wieste stinkende offen schäden, ruden, flechten, jederman abschüblich’. Quoted in Winckelmann 1971, vol. ii, p. 80. 61...damit auf ungleichen bericht niemandt so mit ainicher Erbsucht, oder anndern Krankheiten, so der orten nit curiert werden können, behaft, dasselbst eingeschlaicht unnd das Hauß verunrainiget werden mochte’. Quoted in Hammond in Gilomen et al. (eds) 2002, p. 71, note 28.
practitioners were versed in Galenic medical theory, a refined analytical system that enabled delicate nuance, in their reports they were expected to focus attention on the most appropriate use of resources for the facilities they managed and their municipal employer.

Matters were slightly different, however, when practitioners investigated maladies that appeared related to the ‘French pox’ or various species of leprosy. Many communities sponsored both a pox house, founded in the first half of the sixteenth century, and one or more leprosaria of earlier vintage. Treatment for the pox demanded a substantial municipal investment, while a diagnosis of leprosy brought the prospect of isolation and damaging social consequences for an individual’s immediate circle. Despite the different consequences these diseases carried for the afflicted, many observers deemed their symptoms (and sometimes their causes) to be quite similar, at times barely distinguishable. The reluctance of city officials to justify dramatic measures, and the desire of facility administrators to avoid expensive commitments, helps to explain the interest in the signa of leprosy that Luke Demaitre has identified in late sixteenth-century treatises.62 In Nördlingen, as the cases of Schelhamer and Fischer illustrate, the practitioners viewed these maladies along a spectrum of bodily contamination. They attempted a variety of treatments on patients whose cases were deemed equivocal or had not progressed to an incurable state. However, their willingness to explore a range of therapies was also tempered by a reluctance to waste resources upon individuals with hopeless conditions or who might petition for help elsewhere.63 In Nördlingen and elsewhere, the crux of many vigorous debates concerning bodily signs was the problem of which facility would accept responsibility for vulnerable members of a community.

Many poor individuals in early modern Germany received the attention of a trained practitioner but the initial terms of engagement were usually not those of a diagnostic encounter. When practitioners examined the urban poor, in a milieu that demanded actionable results and presented a choice among several distinct treatment options, they usually set aside the refinements of Galenic semeiology that increasingly took centre-stage in learned collections of case histories. There was more than one way ‘to think like a doctor’ in the later sixteenth century.64

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62Demaitre 2007, pp. 26–7.
63This is the broader context of the disputes over bodily signs that are discussed in Stein 2003, especially pp. 644–7.
64Maclean 2002, pp. 341–2.
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