The Physician-Patient Relationship

Historical scholarship on the physician-patient relationship in the sixteenth and seventeenth centuries, has so far largely relied on normative, deontological texts, which outlined how physicians and patients should behave.\textsuperscript{164} Deontological works such as Gabriele Zerbi’s \textit{De cautelis medicorum},\textsuperscript{165} Leonardo Botalli’s \textit{De officio medici},\textsuperscript{166} as well as the literature on the \textit{medicus politicus}\textsuperscript{167} that blossomed after 1600 provide valuable insights into physicians’ self-understanding and into the way physicians wanted to be seen by others.\textsuperscript{168}

Whether such normative texts can be seen as a reflection of lived practice, however – of the interactions between physicians and patients that took place on a daily basis – is a different question. At times, the very recommendations for the “right” behavior already reveal certain tensions, for example when it is recommended to physician readers that they stay away from the terminally ill and not treat children, pregnant women or those with eye diseases because treating such cases was difficult and could lead to a tarnishing of one’s reputation.\textsuperscript{169}

If we want to arrive at a realistic picture of the physician-patient relationship we need to resort to sources that describe the actual interactions, as they took place on an everyday basis. Unfortunately, such sources are rare and the historical scholarship on this issue is so far very unsatisfactory for the Renaissance period.\textsuperscript{170} We have only fragmentary knowledge – even with respect to the educated upper classes – of how physicians and patients actually interacted and dealt with one another, what they said and did in everyday medical practice in the sixteenth century. We know very little, for example, about differences in the bedside manners of physicians when they were dealing with male as opposed to female patients.\textsuperscript{171} And the nature of the interactions between learned physicians

\textsuperscript{164} Historical overviews in Laín Entralgo, Relacion (1964); Elkeles, Arzt und Patient (1992); Sawyer, Friends or foes? (1995); Belmas/Nonnis Vigilante, Les relations (2013); Pancino, Doctor and patient (2015).
\textsuperscript{165} Zerbi (Opus perutile) ([after 1494]).
\textsuperscript{166} Botalli, Commentarioli duo (1565).
\textsuperscript{167} Castro, Medicus-politicus (1614); Hoffmann, Medicus politicus (1708); on the genre, in general, see Eckart, Anmerkungen (1992).
\textsuperscript{168} On ideas about the doctor-patient in medieval deontological writing (based, in particular, on the early manuscript tradition) see MacKinney, Medical ethics (1952).
\textsuperscript{169} Zerbi, Opus perutile ([after 1494]).
\textsuperscript{170} This includes recent surveys such as Pancino, Doctor and patient (2015).
\textsuperscript{171} Olivia Weisser has arrived at a similarly negative conclusion for seventeenth-century England (Weisser, Ill composed (2015), p. 18).
and patients from the lower classes – perhaps even with peasants or farmhands, or with simple tradespeople and journeymen – is almost entirely obscured.

Although Handsch’s notes are oriented on everyday practice and experience and are richly detailed in many respects, close descriptions of face-to-face encounters between learned physicians and patients are the exception; I will be presenting two detailed descriptions further along. However, in hundreds of entries he wrote down explanations and phrases that he could use in his dealings with patients and their relatives or that he or his colleagues had actually used in particular cases. With great care, Handsch furthermore noted down the mistakes that he himself or physicians in his professional environment had made when interacting with patients and their relatives. Repeatedly he even described the words and actions of patients and their relatives, their responses to physicians’ recommendations and actions, and the way in which they approached the physician. Although they are written from the perspective of a physician, and although the boundaries between his descriptions of lived reality and wholesale statements or even gross overgeneralizations are not always clear, his notes are of unique value to research on the physician-patient relationship in the sixteenth century. Supplemented by sources such as the above-mentioned practice journal of Hiob Finzel as well as pertinent references in ego-documents, Handsch’s notebooks shine welcome new light on essential aspects of this relationship.¹⁷²

Interactions

The modern reader of Handsch’s entries concerning bedside manner will immediately notice a distinct degree of reserve. One would search in vain for emotional statements let alone demonstrations of pity for suffering patients, as have been documented for some physicians of the eighteenth century with its “culture of sensibility”.¹⁷³ Rather, the patient emerges in large part as a foreign, stubborn, and sometimes downright hostile interlocutor who approaches the physician with skepticism, who often questions his advice or even flatly rejects it, who might cast him off in the end, and who fails to express the necessary gratitude. The physician, by contrast, seeks to be seen as a saviour or angel (Figs 13, 14) and turns to a variety of strategies to safeguard his authority and his economic interests vis-à-vis his patients and their relatives.

¹⁷² On what follows, see also Stolberg, Doctor-patient relationship (2021), which largely draws on the same sources.
Fig. 13 and 14: Egbert van Panderen (1581–1637?), The medical practitioner as Christ, angel, man and devil, Wellcome Collection, London.
Fig. 13 and 14 (continued)
A qualifying statement must be added right away: there were different groups of patients. On the one side of the spectrum, the distinctions between clientele and friends could be very blurred. Quite frequently patients who asked a learned physician for his medical advice were at the same time his friends, acquaintances, or relatives. “I was called because he was my friend” a young physician in Bologna reported; at the time he usually accompanied with his teacher Benedetto Vittore to see Vittore’s patients.174 When patients were also friends and close acquaintances, the physician-patient relationship was doubtlessly more personal and characterized by mutual trust. At the other end of the spectrum, there were the urban lower classes and the numerous country people who by all indications consulted a physician only rarely. Hiob Finzel’s practice journal as well as numerous entries in Handsch’s notebooks do show that even simple peasants sought the advice of a learned physician far more often than previously assumed by historians. However, the evidence provided by both physicians indicates that there was little room for establishing something like a personal relationship. The physician saw many of these patients only once. If the medicines he prescribed worked, there was no need to come back. And if it failed, it made sense, for patients with limited financial means that they try their luck with another healer or turned to home remedies. The sporadic nature and impersonal character of these encounters with patients from the country finds vivid expression in the way in which Finzel in particular made note of these people in his journal. They remain, as a rule, nameless. Usually he went no further than to note their places of residence, and sometimes not even that. Handsch, too, who otherwise so carefully noted down the name, rank, and sometimes family relations, made do with a simple “farmer” or “peasant” (“rusticus”) for dozens of rural patients, supplemented at best with a note about where or with whom he had seen the patient. Several of his entries even point to a serious dissociation from, and denigration of, country people on the part of the learned physician. The “peasant” (“rusticus”) was “like cattle”, he once noted; all that was missing were the horns. Further: peasants know how to shed tears, but not how to spread cheer. These sayings counted among many such adages and expressions Handsch collected and therefore may not necessarily have expressed his personal views.175 However, Handsch also wrote of his intention, to test the uncertain effects of opium on “some peasant”, thus indicating a striking distinction regarding the respect and consideration he owed to patients of different social classes.176

174 Biblioteca comunale Aurelio Saffi, Forlì, Fondo antico, Ms. 94, fol. 54r, 28 August 1540, “fui vocatus, quia erat meus amicus”. He treated patient’s fever himself, without Vittore’s support.
175 Cod. 9671, fol. 21r.
176 Cod. 11205, fol. 223r: “His ergo positis, omnino experiar in aliquo rustico”.

Interactions 451
What was crucial for a physician’s professional and economic success above all were patients from the middle and upper classes (Fig. 15). Handsch documented the interactions with them in greater detail in his notebooks. The conditions fores­tablishing a trusting and personal relationship were significantly better with these groups. With an average of only two or three consultations per day, there was ample time for extensive conversations, and the house calls that were typical for these classes strengthened the private, intimate character of the relationship. As a rule, the physician saw the patient in the hypocaustum, a room that could be heated, if necessary. Unlike Finzel, Handsch visited some patients every day over an extended period of time. Rich, noble patients even had physicians stay at their country estates for several days or even weeks. Multiple times, Handsch spent quite a few days with the Baroness of Hungerkasten when she was ill, for example. Most families from the upper nobility in Bohemia had such country estates.

It goes without saying that physicians had to do their best to maintain the trust and goodwill of patients and their relatives. They were well aware that, first of all, their demeanor was important. One of Handsch’s maxims was: “Do not make yourself unworthy. Retain your authority”. It was essential to maintain modesty, soberness, circumspection, and a pleasant human warmth, combined with prudence, steadfastness, truthfulness, and patience, and furthermore – and here Handsch repeatedly had to face reproach – one had to avoid drunkenness. Naturally, the physician was not to rush, thus showing that he took his patients seriously. “Nota bene”, Handsch wrote, “if a physician shows himself to be obliging, hardworking, and friendly, he will earn a name for himself and people will say that he has been reliable and diligent.” It was not enough to carefully inspect the urine. The physician also had to ask the patient many questions, and listen to what the patient had to say “patiently and attentively”

177 Cod. 11183, fol. 242v; in Roman times, the term “hypocaustum” referred to the heating of rooms from sources of heat in rooms underneath. Handsch and his contemporaries used “hypocaustum” as a general term for a warm, heatable room, however, as added adjectives such as “calidum” (”warm”) or references to an oven that could be lit in that room indicate. Jung­hans, Zeitpunkt (2017), pp. 29–31 has arrived at the same conclusion for Luther’s writing about “hypocaustum meum”.


179 Cod. 11240, fol. 2r.

180 Cod. 11205, fol. 560v: “Modestia morum, sobrietas, diligentia, blanda humanitas cum gravit­ate conjuncta, constantia et veritas, frugalitas. [...] Et in summa cave ebrietatem, ut etiam Hofrichterus, M. Ulricus et D. Gallus obiecit.”

181 Ibid., fol. 690v.
Fig. 15: Frans van Mieris, The doctor’s visit, 1667, Paul Getty Museum, Los Angeles.
To demonstrate his care ("ad ostendendam diligentiam"), he was to feel the pulse not only at one wrist but at both, which Handsch did. Handsch even considered small gestures worthy of note, for example that one shook the patient’s hand upon leaving. Ideally, dignified behavior that commanded respect and asserted authority was accompanied by a manner that was engaging and considerate. In Handsch’s words: “The physician is graced not only with experience, but also with humanity and affability” – he added the German word “Holdselickeit” (“sweetness”) – which “allows him to encourage and console a patient.”

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It appears that Handsch himself was not always adept at dealing with patients. He received serious criticism from his father, according to whom he was unfriendly to people, careless in his treatment, and did not bring the treatment to a conclusion, thus endangering his livelihood. Once a physician had gained the initial trust of a patient and his or her relatives, the conditions for a long-term relationship were essentially in place. Physicians benefitted from a conviction that was widespread among educated laypeople, namely the idea that if a physician was familiar with a person’s physical constitution and medical history, there was a better chance that his treatment would be successful. Finzel treated some patients over the course of many years, and there are records of close to 200 visits for certain families in his practice journal. Contemporary ego-documents by patients, for example

182 Cod. 11200, fol. 56v.
183 Cod. 11206, fol. 149v; cf. the chapter on pulse diagnosis.
184 Cod. 11205, fol. 513r.
185 Cod. 11206, fol. 178v: “Medicum non tantum decet experientia, sed humanitas & affabilitas.”
186 Cod. 11205, fol. 129v.
187 Cod. 11203, fol. 237r; Handsch only used the first name, Ludovicus, presumably referring to Ludovicus Tremenus. The wife of the semi-comatose ("lethargicus") Wilhelm called Ludovicus “an oxen” ("eyn Ochsen") (ibid., fol. 272r). Handsch thought that Ludovicus had acted with good intentions and wanted to stimulate the patient’s numbed senses in this way. It remains unclear, however, why he pressed the wrists so hard for this purpose that they looked bruised rather than pinching the skin, for example.
188 Cod. 11205, fol. 425v, “patris monitio”; Handsch had decided not to continue his treatment of a podagric woman as too laborious because the next pharmacy was four miles away.
the notes of the Cologne councilman Weinsberg, likewise indicate that families
tended to keep calling the same physicians when a family member was ill.\textsuperscript{189}

In many cases, however, the relationship between physicians and patients
outside the closer circle of friends and acquaintances had little in common with
our familiar image of the paternal family physician who cared for patients, even
whole families, from the cradle to the grave. This is shown by Handsch’s notes
and Finzel’s practice journal alike. Not only country people, but well-off crafts-
people, merchants, clergy, teachers, and other patients from the educated
middle classes in town sought the advice of the physician only sporadically
according to Finzel’s journal. They were content with one, two, or at most
three consultations, and it was the exception rather than the rule that they re-
turned to the physician when they fell ill again at some later point. In his note-
books, Handsch did record various cases where he or other physicians treated
patients over the course of days or weeks, attending them once or twice a day.
For more than twelve days, he treated an unmarried woman who was suffering
from daily febrile attacks.\textsuperscript{190} But in Handsch’s notes, too, it is striking how
only very few patients have entries dedicated to them that span longer periods
of time – and those who do tend to be from the nobility.

\textbf{Authority in Jeopardy}

Finzel and Handsch do not explain why the interactions between physicians
and patients were often limited to a short period of time or indeed to a single
visit. Of course, patients with acute diseases may quite simply have gotten better
and felt no need to come back. But patients often suffered from long-standing,
chronic diseases. When they did not get better with the medicines a physician
had prescribed many of them did not come back, it seems. Instead they sought
the help of another physician, a barber surgeon or some unlicensed medical prac-
titioners. “They hop from one to the other”, Handsch described this widespread
behavior.\textsuperscript{191}

There were good reasons for this. For many people, the trust the educated
classes invested in learned medicine as such went hand in hand with a good
dose of skepticism about the ability of the individual physician. Moreover, stan-
dardized treatment of different diseases according to the “rules of the art” existed

\textsuperscript{189} Jütte, Ärzte (1991).
\textsuperscript{190} Cod. 11207, fol. 209r.
\textsuperscript{191} Cod. 11205, fol. 290r.
to a very limited degree only. Experience taught that when consulted about the same case of illness, different physicians would frequently arrive at different diagnoses and treatment recommendations, and sometimes even express overt criticism of a colleague’s judgment. In the contemporary perspective, it therefore only made sense to try one’s luck with several different physicians provided that these physicians, on the whole, enjoyed a good reputation.

When patients did not recover or their condition even worsened – as often happened with more severe or prolonged illnesses – the cause for doubt and distrust was all the greater. Sick Malwitz, for example, told Handsch about being treated with guaiacum, first by Gallo, then by Mattioli. Although he did not have any noticeable skin changes, the physicians were convinced – probably due to his genital discharge – that he was suffering from the French disease. After the treatment, however, he was much worse: “I felt much healthier before than now that I have lain in the wood.” And he believed he knew the reason. The guaiacum, which had a heating and desiccating effect, was – as a court physician to the Duke of Cleve had told him – harmful in his case because his liver was already hot and dry.192

When it seemed that they were unable to cure the patient, physicians could urge patience. Handsch wrote down phrases to use on such occasions: one could not cut down a big tree in one stroke;193 it was a “dogged disease”;194 prolonged illnesses “like to take plenty of time”.195 They could also give an excuse, pointing to divine providence. Willenbroch, for instance, told the ill Blasius that he must bear the cross that God had laid upon him. God punished those He loved, he said.196 Without God’s blessing, the peasant, too, slaved away for nothing, Handsch explained to Count Sigismund von Berka.197 Another formulation he presumably noted down with a view to future use was: “I will do what is human and possible, and will ask for the help of God the Lord.”198 And further: “Health is not a rabbit I can pull out of a hat; I do as our art allows, but one has to grant the Lord his power.”199

192 Cod. 11207, fol. 222r.
193 Cod. 11206, fol. 179v, “nicht mit einem Streich abschlagen”.
194 Ibid., fol. 184r, “beharrliche Krankheit”.
195 Ibid., “ire bequeme Zeit haben”.
196 Ibid., fol. 180r.
197 Ibid., fol. 127r.
198 Ibid.: “Ich wil thun, was menschlich und möglich ist, und wil Gott den Herrn in Hülff nemen.”
199 Ibid., fol. 180v: “Ich kann die Gesundheit nicht aus dem Ermel schütteln, ich thue was unser Kunst vermag, aber man mus unserm Herrgott auch sein Gewalt lassen.”
But how were patients and their relatives to decide if ongoing ill health was
due to the nature of the disease, divine providence, or medical incompetence?
Sooner or later it only made sense from their point of view to try their luck with
a different physician or healer who was perhaps better equipped to identify the
true nature of the illness and to cure it. Without meaning to, learned physicians
encouraged this attitude. They tended to emphasize their ability to tailor their
treatment to the patient’s physical constitution and specific life circumstances.
Yet, these efforts necessarily heightened the differences between the recommen-
dations given by different physicians for the same medical case. Many physicians
furthermore boasted about the particular effects of their experimenta and secreta,
about the medicines and mixtures of drugs which in their own experience had
proven effective. If the promised effects of one physician’s medicine failed to ma-
terialize, patients could therefore always hope that perhaps another healer had a
more suitable and effective remedy in his arsenal.

Diagnostic and Prognostic Uncertainty

On the whole, physicians and patients alike believed that medicine had at its
disposal the necessary means to cure diseases. The key to a successful practice,
to attracting patients – especially those patients from wealthy and aristocratic
circles – in the circumstances that have been outlined was word of a physician’s
good results in treating illness. This is also shown by comments made by lay-
people in letters and other ego-documents when they sought to assess the qual-
ities of different physicians. From their perspective, being treated by a good,
experienced physician could make all the difference. When word got around
that a physician had cured numerous patients, even of severe diseases that had
perhaps been declared incurable by others, he could count on more patients
finding their way to him. Nothing was better able to bolster a physician’s reputa-
tion and authority in the eyes of future patients than stories of sick people he had
cured, ideally against all expectations. As a student, Handsch already noted that
his teacher Comes de Monte had been accorded “great glory and honor” for his
treatment of a woman with dropsy from obstructed menstruation.200

A physician could lose the trust of patients and their relatives as easily as
he had gained it, however. Making the initial diagnosis was already fraught with
challenges. Many patients and relatives expected an immediate, clear judgment,
well before it was actually possible for the physician to arrive at one in his own

200 Cod. 11238, fol. 71r.
estimation. As we have seen, many people even believed that a truly skillful physician was able to name the complaints in question simply by examining the urine. This could easily go awry. Handsch once diagnosed a girl suffering from febrile heat and vomiting with a *febris continua*, and wondered if she also had worms. Two days later, the girl developed the rash that was typical of measles, and Handsch was reproached by the father who told him that he should have known about the measles by looking at the girl’s urine.  

Physicians could resort to certain practical tricks to avoid potential humiliation following obvious misdiagnosis. Handsch entrusted his notebook with a number of these. If in doubt, the physician was well advised to diagnose widespread – and thus more probable – complaints and illnesses. With women, he could hardly err if he said to them, “It sometimes goes to your feet”. This was because with the widespread uterine complaints, but also with diseases of the liver and the spleen, the legs would typically swell. It was also a safe bet to say, “It sometimes goes up to your chest and you have difficulty breathing, especially when climbing stairs.” In the springtime, when prolonged fevers were common – this Handsch learned from Lehner – he could quite confidently conclude just by looking at the patient’s urine that there was a fever and say that it was a “hidden, inner, heating fever”, in case the patient had no corresponding symptoms. Older people often concocted their food insufficiently and had much liquid in their bodies and heads. With them, he could speak of a “weak, poorly digesting stomach” and fluxes, and “of a weak and liquid head” which carried the risk of a stroke or that fluid was dripping down into their legs, making them heavy.

In many cases, especially as the disease developed, one could avoid misjudgment that would later be patently obvious by diagnosing occult pathological processes within the body, for example an obstruction of the liver or spleen. Patients and their relatives were rarely able to judge such a diagnosis, but it was acceptable to them if it seemed sufficiently plausible and accorded with the changes the patient perceived. If a physician diagnosed a “hidden” fever, or “inner measles” in times when the measles were going around, he could hardly

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201 Cod. 11207, fol. 42r.
202 Cod. 11205, fol. 435v (“Es kompt euch bisweilenn ynn die Fuß”) and foll. 433v-434r.
203 Ibid., fol. 435v: “Es kompt euch auch bisweilen kegen der Brust, habt ein schweren Athem sonderlich wenn yr die Stigen auffsteiget.” Similarly ibid., fol. 534v.
204 Cod. 11206, fol. 25v, “heimlich, innerlich, hitzende Feber”.
205 Cod. 11205, fol. 542r, “schwachen, ubeldeuenden Magen”.
206 Ibid., fol. 433v: “Von eynem schwachen und flussigen Haeupt und ist zubesorgen, der Schlag wirt sich einmal ruren.”
go wrong. If the symptoms of a fever became manifest, or the rash typical of measles broke out, he had said the right thing ("bene dixisti"). And if not, he could not be blamed: the fever or measles had remained hidden inside the body.207

Another trick Handsch noted down was that the physician should, if possible, try to find out more about the illness and its potential causes before he even set foot in the sickroom. This, he added, would make it seem is if he already possessed a quasi-supernatural, divine knowledge about the person’s illness when he approached the patient, helping him to gain the patient’s trust.208

Treating a sick man by the name of Skala, Handsch experienced firsthand just how useful the information of third parties could be. Based on the complaints described by the patient, Handsch was about to speak of a liver obstruction or a constricted lung – both were diagnoses that were difficult to refute – in the hope that he might later hear something that would allow him to recognize the cause of the illness and to arrive at a “truer” (“verius”) judgment. But before he spoke to the patient, a maid happened to tell him something about the man’s stomach. Consequently, he explained to the patient that his stomach was not digesting food sufficiently and was also incompletely closed at the top, allowing many vapors to rise up from there when he was sleeping. Because these vapors could not exit through the thick roof of the skull, they condensed and became water and flowed down as catarrh into the lungs.209

Putting the physician’s authority and credibility most at risk was prognostic assessment. Many medical diagnoses were not verifiable for patients, and if a patient did not recover, there could be various reasons why; therefore, a misdiagnosis was not necessarily at the root of it. But whether or not a physician had correctly predicted the course of the disease was something that even uneducated laypeople could recognize, and the chances of disgracing oneself were accordingly high. It was ultimately difficult to determine with certainty how the disease would unfold on the basis of the current clinical picture, or even just to predict the effect of specific therapeutic measures accurately. Handsch learned from Musa Brasavola that Hippocrates had already alerted physicians to the uncertainty of prognosis. Even the best physicians had to experience with embarrassment ("cum pudore") how their predictions proved to be wrong. To remain on the safe side, then, it was best for the physician to dispense with making prognoses entirely. Handsch had heard that it was almost impossible to wrest a prediction

207 Ibid., fol. 213v.
208 Cod. 11200, fol. 56r.
209 Cod. 11205, foll. 274v-275r.
from some famous physicians, for example Leoniceno and Manardi in Ferrara. This was a privilege, however, that only great medical luminaries could afford, because the majority of patients and their relatives expected and demanded a clear prognosis from their physicians – if only because it helped them determine whether the medical treatment with its attendant costs and strains was worthwhile. It was difficult for the physician to turn down this request entirely.

The question of prognostic assessment had a preeminent position in Handsch’s rules for a successful practice, which he time and again drew attention to with an “ad cautelas” in the margin. By his own admission, Handsch had repeatedly made grave errors in this regard. The basic rule was easy to grasp: the physician was not to audaciously promise the success of his treatment and the recovery of the patient. If the patient were not cured – and here Handsch was cautioning himself – the physician would lose “esteem and faith.” Certainly, even from a strictly medical point of view, it was acceptable, indeed advisable, not to take away the patient’s last hope. After all, negative affects such as sorrow and anger were considered to have strong physical effects that could exacerbate the illness. In his conversations with relatives, however, the physician was well-advised not to shield them from the seriousness of the situation.

What was more: in his own interest, it was better for the physician to exaggerate the seriousness and make it seem as if the illness were difficult to cure. Handsch wrote that if the physician did this and the patient recovered, money and honor would be bestowed upon him. And if he died, there would be less criticism. This was Mattioli’s modus operandi. He “always portrays the illness to the sick and their relatives as greater than it is, because this, as he has said, is good for physicians.” Along these lines, another motto Handsch wrote down in Latin was: “Always make the illness great to those giving support (but to the sick [make it] small), because if he becomes healthy again, you will be accorded greater praise [and] if he dies, you will likely be excused because you had warned of the danger.” To those giving assistance to the patient, one could say such things as, “Truly, he is in a bad state of repair; a cause for concern; dangerous; he is hanging

210 Cod. 11183, fol. 332v, “quod nemo potuit ab eis extorquere prognosticum”; similarly Cod. 11205, fol. 494r.
211 Cod. 11205, fol. 410v, “aestimationem et fidem”.
212 Ibid., fol. 212r: “Simula difficilem esse morbum”.
213 Cod. 11206, fol. 128v: “D. Matthiolus apud astantes semper pluris facit morbum quam est, quia dicit bonum esse pro medicis.”
214 Cod. 11207, fol. 229r, “magnificias semper morbum apud astantes (apud aegrum vero parvi-facias), nam si sanatur maior laus tibi erit, si moritur excusatior eris quia monuisti de periculo.”
in the balance”. 215 But when it came to the patient, one was to “console him entirely, not make him frightened, not desert him.” 216 When a fourteen-year-old girl with a fever was increasingly deteriorating, he consequently gave the parents hope. Yet, he told their maid that the sick girl would die. When the girl indeed did succumb to her illness, the maid told the parents that Handsch had predicted the girl’s death and, as he noted explicitly, “they appreciated this.” 217

Even when he was convinced that a patient’s medical condition was irremediable, indeed terminal, the physician did well to refrain from clear, unambiguous statements. He could, after all, be mistaken and the illness could, against all expectations, take a favorable turn. Following Mattioli’s example, he could say in such cases, that the patient was “not without danger”. 218 In a different place, Handsch noted a further phrase he could use to get himself out of such corners: “Death is at the doorstep, but I don’t know whether or not he’ll come in.” 219 If a patient was seriously ill, it was furthermore advisable to send a boy ahead of oneself, so that when he made his call, the physician would not encounter a deceased patient, making it obvious to everyone that he had not expected the imminent death. Or he could first walk by the patient’s house and check if the windows were open. Opening windows was common practice when someone died. 220

In practice, however, Handsch found it difficult to comply with this rule. He suggested that he sometimes wanted to spare the patient the painful truth, and be pleasant to them instead (“gratia blandiendi”). But other times – here he was honest with himself – it was sheer vanity (“vanitas”) 221 when he believed that he could make a precise diagnosis by looking at the symptoms, or indeed that he could predict the time of death. With words like “be more careful in the future”, 222 he repeatedly and sometimes with capital letters brought himself back to his senses, admonished himself to practice reserve, and set the intention

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215 Cod. 11206, fol. 100v: “Es stehet warlich baufellig mit ym, sorglich, gefehrlich, auf der Wag.”
216 Ibid., “allwegen trösten, nicht feyge machen, yn nicht verlassen”.
217 Cod. 11183, fol. 140r.
218 Cod. 11207, fol. 217r.
219 Cod. 11205, fol. 212v: “Der Todt stehet vor der Thur, ich weis aber nicht, ob er hereyn wirt komen”.  
220 Cod. 11206, fol. 116v; on the practice in Innsbruck see Cod. 11183, fol. 410r. The custom of opening a window when someone is dying survived far into the twentieth century. Presumably, it served to facilitate the soul’s journey from the body to the heavens. For the same reason, tiles were lifted from the roof in some areas, when someone was dying; cf. Stolberg, Heilkunde (1986), pp. 282f.
221 Cod. 11183, fol. 331v.
222 Ibid., fol. 332r.
of no longer “making audacious promises and prognoses”. Yet, again and again, he made the same mistake of promising too much or omitting to communicate the seriousness of the situation, giving the patient hope – as was his duty – but then failing to at least tell the patient’s family the fatal prognosis.

He left a bad impression, for example, when he said of a seriously ill boy in Collinus’s private school that if he survived the night, he would live for a long time to come. For several days Handsch, knowing of the boy’s dire condition, had found out from a scout whether the boy was still alive before he made his visit, thus ensuring that it would not look as if he had not foreseen the boy’s death. This time he did not consult the scout. The boy survived the night, but when Handsch returned in the afternoon, he found him lying dead in his room.

Things also turned out badly for him in the case of a sick fishing warden named Hosska. He had to admit that he and his hapless methods had been anathematized because Hosska had died in his care. The patient he excused himself, had ingested none or only a little of Handsch’s medicines. Handsch’s mistake, indeed his failure or “offence” (“meum delictum”) had been to misjudge the seriousness of the situation despite the old man’s weakness and deathly pale face, and to have not warned the man’s wife about the looming death, not even when she made a point of asking if the disease was terminal, so that she could know if it made sense to continue giving him medicines. He had actually wanted to give the man antimony but did not get the chance because the man suffocated from his catarrhus just an hour after Handsch’s last visit. In the future, he decided once more, he wanted to tell bystanders that the patient’s life was in danger.

He also found himself repeatedly making the opposite mistake of giving an all too self-assured prognosis of imminent death. He marked the case of a fever patient named Kretzel with “error”, commenting, “I told him he would die”. The sick man lay in bed utterly weakened, delirious, with a brown-coated tongue and suffering from diarrhea – but he recovered.

When a peasant fell and seriously injured himself, he said to the man’s wife that he was “not going to beat about the bush, because you desire to hear the truth; so I will say that he will die”, whereupon the woman began to cry. A year later the man was still alive. Admonishing himself once more to practice reserve, Handsch wrote, “Therefore do not be too rash and daring when making your prognosis”. In this case at least, he

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223 Cod. 11205, fol. 276r.
224 Cod. 11183, fol. 50v.
225 Ibid., fol. 332v.
226 Cod. 11205, fol. 255v.
227 Ibid., foll. 127v-128r.
had added the consoling remark that he only judged by human reason. God was powerful. He was able to wake the dead, and to heal the sick all the more.228

Money

The question of remuneration posed great challenges for the physician-patient relationship and the physicians’ public self-fashioning. Expecting money and asking to be paid to treat patients tended to muddy the image they wanted to present to the public, and could potentially cause considerable conflict in their dealings with patients and their relatives. While physicians, like lawyers, were commonly alleged to be greedy, physicians did their fair share of complaining about the ungratefulness of patients. As Handsch hinted, some did not pay at all. “No recompense” he elaborated in one entry; there was “no gratitude”.229 In Finzel’s practice journal, we find a considerable number of entries in which he did not note down payment. Only some of them concerned patients whom he saw several times or indeed for an extended period and who would presumably not have paid for each consultation separately. As Finzel used the journal to calculate his annual income, we may assume that he documented all of his earnings. We thus must conclude that in fact hundreds of patients simply did not pay him or were offered pro bono treatment to begin with.230

It is important to keep in mind that those who acquired wealth at the expense of others were committing a far greater offence in sixteenth-century societies compared to today. This was true not only of money lending for interest. Recent work on the history of accounting has shown that merchants, even those doing business in prospering trading cities, believed that they had to justify themselves before God for the profits they made by reselling goods at a higher price than what they had paid. This was one of the reasons why contemporary manuals on how to keep account books recommended using religious elements such as an appeal to God on the first page and to include religious symbols such as the cross.231 Hiob Finzel followed these recommendations in his practice journals, putting small crosses along the upper edge of the page, appealing to God, and writing pious poems at the beginning or the end of each year.232

228 Ibid., foll. 420v-421r.
229 Cod. 11206, fol. 183r.
230 Ratschulbibliothek Zwickau, Ms QQQQ1, Ms QQQQ1a and Ms QQQQ1b.
232 A more detailed treatment of this issue can be found in Stolberg, Accounting (2020).
In some respects, the income a physician earned from treating the sick, was particularly offensive. After all, he profited from the suffering of his fellow human beings. And, even worse, he earned more if his treatment did not lead to a timely cure but dragged on – possibly due to his own errors. Today, the payment physicians receive is referred to in German as an “Honorar”, literally an honorarium, that is something conferred as an honor. Encapsulated in the term is the understanding that a physician’s help cannot be remunerated in the same way that other goods or services are. However, this term and the message it sends was not established in the sixteenth century. The common Latin expression used to describe a physician’s fee, which Handsch used as well, was, tellingly, “merces”, derived from “merx”, or merchandise, and closely related to “mercator”, the merchant.233

While Handsch’s notes do not include specific figures for the payments he or his colleagues received from patients, Finzel’s practice journal allows us to study the income of a common municipal physician in private practice quite closely. As mentioned above, what is immediately striking is the large number of patients who only paid him a very modest fee. A large majority gave him not more than two or at most three groschen for a consultation. One has to be careful with general statements, yet this seems to indicate that physicians – or at least town physicians like Finzel – made their services accessible to the populace at large and were willing to adapt to their patients’ financial circumstances. More affluent patients, by contrast, paid Finzel considerably more. One, two, or even five talers or gulden, the equivalent of about twenty to one hundred groschen were not uncommon, and some noble patients even paid considerably more.234

In one case, the treatment of even a simple servant warranted a gold coin, paid to Finzel by the man’s employer.235

We hardly know anything about the ways in which physicians “billed” their patients and about the extent to which patients knew how much they would have to pay. As we have seen, some towns set a – usually very modest – maximum fee which the municipal physician could demand from poor patients. Physicians who were not in the service of a town were, by all appearances, free

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233 The relevant section in Zerbi, Opus perutile ([after 1494]) was titled “De mercede medici accipienda”. Sometimes, Handsch also used the term “praemium” (Cod. 11205, fol. 312v and fol. 573v; Cod. 11206, fol. 183r).

234 Ratschulbibliothek Zwickau, Ms QQQQ1a, p. 299 and p. 310 and Ms QQQQ1b, p. 77 (on the wife of the Margrave of Brandenburg, who gave Finzel 20 gulden); four gulden was also the amount young Sebald Welser gave to the Nürnberg physician Melchior Ayrer for his repeated advice (Wolfangel, Ayrer (1957), p. 22).

235 Ratschulbibliothek Zwickau, MS QQQQ1a, p. 47.
to charge whatever they considered adequate and the only limit would have been, in the long run, that a physician who was known to charge exorbitant fees would no longer be consulted. In Münster, the town magistrate found, in fact, that some patients hesitated to consult a physician because they were uncertain about the cost. It decreed that physicians were, in principle, entitled to four batzen per visit or a taler per week but added the advice to ask the physician beforehand whether he would be content with this fee.236

More affluent patients seem to have considered it a matter of course, even a question of honor, to remunerate the physician according to their station and their financial abilities. This situation is confirmed by the fact that Finzel, in many cases, noted down payment in kind, for example with cheese, butter, fish, meat, or more rarely, beer and wine. One might think that payment in kind was widespread among common people, especially peasants, who practiced subsistence farming, but this would be mistaken, as Finzel’s journal tells us: almost exclusively it was the nobility and members of the upper classes who reciprocated in this way. While Finzel converted the value of the natural produce in groschen and gulden to calculate his annual income, his noble patients likely did not consider the produce they gave him payment at all, thinking of it instead as gifts which they graciously granted him and which also served to highlight their social status. When they sent Handsch a hare, a haunch of venison, different kinds of birds, or wild boar meat, they were expressing something about their privileged position. It was they who usually held the exclusive hunting rights, at least to bigger game. Even the cheese loaves, valued up to sixteen groschen, which Finzel received from them, presumably emphasized their rank insofar as they pointed to the command they held over subservient farmers.

In the course of a professionalization process that lasted hundreds of years, one of the decisive successes achieved by learned physicians was a detaching of the assessment of, and payment for, medical efforts from the success of the cure. Physicians practicing in the Renaissance were already working to establish this point of view among patients and their relatives. But recipients of medical care largely continued to regard them like other craftsmen who were paid for their goods or services. When a treatment did not bring the desired result, patients and their relatives held that the physician had not rendered the service they had expected, he therefore had forfeited his entitlement to a generous reward. According to Handsch’s account, some clients were not even willing to

236 Stadtarchiv Münster, A-RatsA_A II Nr. 20, minutes of the town magistrate, vol. 42 (1610), fol. 230v.
settle their debt with the apothecary when the medicines prescribed by the phy-
sician did not have the desired effect.\textsuperscript{237}

The physicians here were encountering a behavioral pattern that the sick
and their families also exhibited towards other medical practitioners. And con-
trary to the learned physicians, some barbers, barber-surgeons, and lay healers
were willing to make concessions. According to Handsch, some were prepared to
sign a \textit{pactum}, a healing contract, with their clients which made their payment
conditional, to a degree, on the success of their treatment. For example, one bar-
ber who was treating a patient for a painful abscess was to receive three talers in
total: one up front, one if the abscess got better, and another one if it healed
completely.\textsuperscript{238} Another agreement stipulated the payment of fifteen talers to a
barber for the three-week treatment of a young man suffering from the French
disease.\textsuperscript{239} This practice has been documented for other places as well, especially
in cases where healers took legal action against a patient or his or her heirs to
recover outstanding fees.\textsuperscript{240} A lay healer called Jakob Schäffer, a former cowherd
from the Stuttgart area, recounted in 1592 how he was called to a sick man with a
chronic abscess that other healers had attempted to cure in vain, and that he “of-
fered to try and help”, without, however, promising a sure “cure or healing”. He
sent to the apothecary for “several things” to give the sick man, asking that the
patient, for the time being, pay only for these medicines. Ultimately, he was un-
able to help the man who therefore did not have to pay him for his services.\textsuperscript{241}

One agreement, signed in 1528, stipulated that a Zurich surgeon was to receive
twenty gulden if he succeeded in making a sick woman healthy enough that she
could go to church again without pain or cane, otherwise he would get noth-
ing.\textsuperscript{242} And, as agreed upon in a \textit{pactum}, the Bamberg prince-bishop even paid
the sum of 175 gulden to an Englishman who cured a nun. She had been suffering
from a cancerous ulcer for three years, and the treatment took three months.\textsuperscript{243}
As late as the late seventeenth century, a draft tax bill on Württemberg barbers

\textsuperscript{237} Cod. 11205, fol. 676v.
\textsuperscript{238} Ibid., fol. 245v. See also ibid., fol. 267v, on the “pactum” between a Jewish healer and a
paralyzed nobleman; Handsch did not indicate the amount.
\textsuperscript{239} Cod. 11183, fol. 77v; the man had initially sought Handsch’s counsel.
\textsuperscript{240} Cf. Gianna Pomata’s detailed analysis of the relevant documents of the \textit{protomedicato} in
\textsuperscript{241} Hauptstaatsarchiv Stuttgart, A 209, Bü 725, letter of supplication from Schäffer; he ran an
extensive medical practice and had been accused of witchcraft.
\textsuperscript{242} Wehrli, Bader (1927), p. 68.
\textsuperscript{243} Letter from Sigismund Schnitzer to Andreas Libavius, Bamberg, 2 February 1603, printed
in Horst, Observationum (1628), pp. 463–465; Liphimeus, Warnung (1626) pp. 52–54, also men-
tioned this practice, here in connection with an itinerant theriac peddler who (allegedly)
stipulated that they would receive only half of the agreed-upon fee if they ampu-
tated legs or feet and the patient died.\textsuperscript{244}

In the absence of an explicit agreement, some clients still believed they
were entitled to withhold payment from a healer if they did not recover as prom-
ised or, worse yet, their condition deteriorated further under the treatment. In a
case documented for the year 1525 in Nuremberg, for example, a mother was
unwilling to pay the eight gulden charged by a surgeon for treating her little
daughter for an evil disease over the course of twenty-seven weeks. She com-
plained that he had crippled the child with his medicine, so it could not stand.\textsuperscript{245}
In Zurich, the case of a widower went on record who denied a physician payment
for treating his deceased wife, “because he killed his wife and now wants to
cheat him out of his chattels as well”.\textsuperscript{246}

Physicians, too, had to be prepared for the possibility that patients would
ask them to sign this kind of agreement. To do so went against their professional
self-image, however. From their point of view, these agreements were degrading,
demoting them to the level of an ordinary salesman or service provider. Handsch
wrote down what his reply might be “if they want to sign a contract”.\textsuperscript{247} He
would caution them not to bargain with the physician the way they would with a
mercenary or landsknecht;\textsuperscript{248} he was “no merchant” and did not desire to “sell
his art”.\textsuperscript{249} Considering that other healers accepted such requests, it remains
questionable whether his patients took these objections to heart. Nor might they
have been content with his assurances that “I will do what I can but I would not
promise you anything and I never have in all my life”.\textsuperscript{250} Georg Pictorius even
believed that the Hippocratic Oath prohibited such contracts. He claimed that it

\textsuperscript{244} Hauptstaatsarchiv Stuttgart, A 228, Bü 68.
\textsuperscript{245} Stadtarchiv Nürnberg, B 14 II, 20, fol. 100r; the municipal court sided with the surgeon
but reduced the amount the mother owed him from eight to six gulden.
\textsuperscript{246} Cit. in Wehrli, Bader (1927), p. 68, “derwyl er ime syn Husfrowen umbracht und welte ime
jetz ouch um sin Gutt bringen.”
\textsuperscript{247} Cod. 11205, fol. 215v: “Si volunt pactum facere”; ibid. fol. 291r, “si volunt facere pactum
ante curationem”.
\textsuperscript{248} Ibid., fol. 215v.
\textsuperscript{249} Cod. 11206, fol. 117v.
\textsuperscript{250} Ibid., fol. 127v: “Ich wil thuen was mir möglich ist, aber das ich euch solte was verspre-
chen, das habe ich mein Lebtag nicht gethan.”
said “that no one is to make a contract with a sick person for the sake of the mat-
ter, as someone who is sick would promise to give his fortune, and thus people
would be gravely overcharged.”251 And as late as 1636, Ludwig von Hörnigk in
his publication Politia medica cautioned the learned physician: “He must not ne-
gotiate or barter with the patient about the cure for an affliction or demand a spe-
cific fee before the cure is completed (in cases where this is possible).” Lawyers,
after all, were paid no matter how the legal proceedings ended.252 In Italy, Orazio
Augenio, too, stressed that a physician who was unable to heal a patient but
fought the disease with all available means was carrying out his task very well
indeed.253

Even in cases when there was no specific agreement, letters sent by patients
to physicians indicate that even upper-class patients believed that the “physi-
cian’s fee” should in part be decided on the basis of the success of his efforts. If
Thurneisser “helped” him, he would “reward him faithfully and well”, Valten
von Schaplo promised the Elector of Brandenburg’s court physician.254 Another
said that he would show “his full gratitude” if Thurneisser’s treatment, “with
divine grace” would help him.255 A third patient promised that “If God the Al-
mighty will bestow his grace and blessing, good fortune and salvation, and I
will recover,” Thurneisser’s efforts and labor would be amply remunerated.256
And there were still others who promised rich rewards if they “experience help
and recovery”.257 In its own way, the notion that more money was owed to the
physician when his treatment was successful is also reflected in Handsch’s ob-
servation that “many” patients who “recovered” pretended “to still be sick for
the purpose of giving nothing or giving less to the physician”.258

251 Pictorius, Von Zernichten Artzten (1557), fol. XVIv, “das keiner mit dem Krancken umb der
Ursach willen vorhien soll pacisieren, dieweil einer, so kranck, alles verhies zuo geben das
sein Vermögen were, unnd die Leut dardurch hart würden ubernommen.”
252 Hörnigk, Politia medica (1636), p. 7: “Doch soll er die Schwachheit zu Curiren nicht uber-
haupt mit dem Patienten dingen oder handlen, oder ein gewisen Lohn vor geendigter Cur
(wann die möglich ist) fordern.”
253 Augenio, Epistolarum (1602), fol. 88v.
254 Staatsbibliothek Berlin, Ms. germ. fol. 420a, fol. 163r, letter from Valten von Schaplo to
Leonhard Thurneisser, 1571.
255 Ibid., foll. 175r-176r, undated letter from Nicles von der Linde.
256 Ibid., fol. 216r, letter from Britt von Schlieben [?], 8 August 1571; he already sent 20 taler
with his letter, however.
257 Staatsbibliothek Berlin, Ms. germ, fol 420b, foll. 470r-471r, letter from Hans Kottwitz [?],
18 February [1575]; further examples ibid., fol. 245r-v.
258 Cod. 11205, fol. 676v.
Self-Confident Patients

The perception of physicians as “service providers” and the ever-present threat – which was often unspoken but could also be explicitly stated – of dispensing with the attending physician and seeking counsel from other healers if the diagnosis or the cure did not meet expectations also had a profound impact on the position of the patient in the physician-patient relationship. From the physicians’ perspective, the ideal patient “submitted”\textsuperscript{259} to their medical opinion and “obeyed”.\textsuperscript{260} When the Archduke declined to proceed with a suggested treatment, Mattioli held that, when it came to his health, the patient had to entrust himself to the physician as if he was the helmsman on a ship.\textsuperscript{261} But this was wishful thinking. In practice, Jakob Oetheus in Eichstätt found, many physicians complained “that most patients are quite unwilling to obey and to submit to the physician’s orders”, which was “not only harmful to the sick but also very much interferes with physicians’ decisions regarding treatment and its accomplishment”.\textsuperscript{262} Handsch noted down phrases that the physician could say to make a patient follow his instructions, including, “Your life is in your hands. If you follow [my instructions], you will get well, if not, you will be going on the scrap heap”\textsuperscript{263} or “If you don’t follow, you will be followed to the churchyard.”\textsuperscript{264} It seems doubtful, however, that he ever dared make such drastic statements to his patients. After all, as we see in Handsch’s notes all too clearly, everyday medical practice was marked by a precarious and complex balance of power. Patients and their relatives pinned their hopes on the physician but at the same time, they met him with great self-confidence. The physician for his part was always aware that he might be replaced by another healer and therefore had little choice: he had to do his best to meet the expectations and wishes of his clients and, if necessary, he had to compromise against his better judgment.

If a physician wanted to convince a patient of his diagnosis and the therapy he was recommending – and thereby indirectly convince him of his competence – he first of all had to describe the disease process clearly and provide good reasons for the way he intended to treat it. As becomes very clear from the physician’s notes as well as from epistolary consultations, many clients expected to hear these kinds of explanations, and they listened and paid attention

\textsuperscript{259} Cod. 11207, fol. 170v: “Submisit se patiens iudicio medico”.
\textsuperscript{260} Cod. 11205, fol. 691r.
\textsuperscript{261} Cod. 11206, fol. 133r.
\textsuperscript{262} Oetheus, Gründtlicher Bericht (1574), dedicatory epistle.
\textsuperscript{263} Cod. 11206, fol. 691r.
\textsuperscript{264} Cod. 11205, fol. 282v.
to them. The Latin jargon that might be used by physicians to underscore their erudition could not be palmed off on them. They mistrusted physicians whom they did not understand.\textsuperscript{265}

Handsch’s notebooks drive this point home very clearly. Handsch, who otherwise wrote almost exclusively in Latin, put down the exact wording of hundreds of phrases in German, which he and his colleagues had used to communicate medical conditions or that he considered useful at least for this purpose. The large number of these entries speaks for itself. They give expression to the conviction that an plausible and comprehensible explanation of the medical condition and rationale of the physician’s treatment was of utmost importance for winning the trust of the patients and their families. Sometimes, Handsch also wrote down how the patients responded to his explanations. When patients or their relatives returned to him, bringing the money for the medication he had recommended, this confirmed for him that he had found the right words.\textsuperscript{266} Here and there he even marked his entries on these vernacular explanations with a simple “placuit” or “non displi-cuit”: Handsch’s statements had been appreciated and he could hope that similar phrases would prove successful with other patients as well.\textsuperscript{267}

Frequently, the immediate, perceptible effect of the prescribed treatment helped the physician to establish the plausibility of his diagnosis and treatment plan in the mind of the patient and bystanders. For example, when a physician prescribed emetics or laxatives, the appearance and the smell of the matter that was brought up or passed with the stool illustrated vividly how highly impure, spoiled, harmful substances and possibly also worms had indeed accumulated in the stomach, in the lower abdomen, or in the body as a whole and had needed to be evacuated. Handsch recounted about the merchant Fabian that, after taking a purging agent several times, the sick man had personally lifted stringy mucus from his stool using a piece of brushwood “and he liked it”.\textsuperscript{268} When patients were bled, the physician could afterwards show them the bloodletting bowl and point out the phlegmy or blackish burnt nature of their blood as proof that it had been right, indeed even urgent, to prescribe bloodletting.

Handsch’s notes also show that the physician always had to be prepared to meet with objections. Some patients had their own ideas about their illness. For example, when Handsch located the cause of a female patient’s breathlessness

\textsuperscript{266} Cod. 11206, fol. 17r, fol. 35v and fol. 39v.  
\textsuperscript{267} E.g. Ibid., fol. 39v and fol. 40r; see also Stolberg, Kommunikative Praktiken (2015).  
\textsuperscript{268} Cod. 11183, fol. 180r.
in her head – according to current doctrine, catarrhs developed there, then emptied into the respiratory passages – she did not agree. She was convinced that the actual seat of the disease was in the lower regions of her body, which, incidentally, physicians, too, did commonly suspect was the true, ultimate origin of catarrhal matter. Some laypeople, as mentioned, also found it difficult to understand why a physician would prescribe a laxative for a patient who was already eating hardly anything and accordingly had little to excrete. Here, the physician could try to convince them that his remedies targeted the morbid matter specifically, helping to excrete it alone. When it came to “female troubles” (“Frauensachen”), the physician’s advice was sometimes at odds with what women knew about their own bodies. When, after she had been bled, Handsch advised the sick wife of a lapidary to interrupt breastfeeding for a couple of days and give her infant almond milk instead, she refused. She said this would make her breasts hurt from the incoming milk. She also refused when Handsch then suggested that she let off some of the milk and collect it in jars, and continued to breastfeed her child.

Some ideas had taken root so deeply in lay culture that physicians felt as if they were going up against a brick wall. For example, female patients very commonly and categorically objected to taking medication directly before or during menstruation and paused treatment that was already in progress. “Women will not accept medication during menstruation”, Handsch noted down when he was a young physician. This refusal, too, could be understood in the context of humoral pathology. Physicians themselves agreed, in principle, because many medicines had an expelling, purgative effect. Taking them during menstruation, women risked disturbing the natural, health-preserving downward flow of impure, corrupt matter into the uterus and then out of the body.

The prudent physician, as Handsch had to learn personally, also avoided giving certain diagnoses and using certain disease names. The mere mention of “acute fever” could set off warning bells for laypeople because it meant to them the possibility of pestilential fever. As we saw earlier, physicians furthermore had to be very careful when diagnosing the French disease as this almost inevitably led to the question of the route of infection, which we presume would

269 Cod. 11205, fol. 242v.
270 Ibid., fol. 287v.
271 Cod. 11206, fol. 180v.
272 Cod. 11183, fol. 46v.
273 Cod. 11207, fol. 221v.
274 Ibid., fol. 189v: “Fluentibus menstruis mulieres non accipiunt medicamenta.”
275 Cod. 11205, fol. 276r.
have been found morally reprehensible. This in turn might well have endangered the patient’s prospects for marriage.\(^{276}\)

Learned physicians faced particularly challenging difficulties with respect to the substantial trust laypeople placed in uroscopy. In the scholarly literature of the Middle Ages, the diagnosis of illness from an inspection of urine was still lauded as a major source of authority for physicians.\(^{277}\) As we have seen, however, doubts about this began to emerge in the medical literature. What was questioned first and foremost was the patients’ expectation that physicians should be able to identify diseases and pregnancies and even the patient’s age and sex from urine alone, without any additional patient information. Critics cautioned of the danger of an embarrassing false diagnosis or prognosis. It could so easily happen that a physician diagnosed a terminal illness and then, following treatment from a barber or blacksmith, the patient got better again and walked the earth for years to come! And how embarrassing it was when a physician identified and treated a case of obstructed menstruation and several months later the woman gave birth! Medical writers cautioned that people might even put their physician to the test, for example by giving him false information about the sex and age of the patient or by slipping him the urine of a cow, or indeed Malvasia wine.

The problem for the physicians was that other healers commonly diagnosed diseases and pregnancies simply from the urine people sent them, and patients were often satisfied with their judgment. Fruitlessly, learned physicians railed against the “piss prophets” or “urine prophets” who used all kinds of “fraudulent” tricks to arrive at their diagnoses, shrewdly questioning the messenger, for example, or listening from behind a curtain while their wives sounded out the messenger.\(^{278}\) In this situation it was inevitable that physicians, whether they wanted to or not, sometimes had to diagnose diseases from urine alone if they did not want to lose their patient’s trust. Handsch learned it the hard way. When a blade smith sent his urine and did not give Handsch anything else to go by, Handsch was unwilling to commit. He let the man know that, by itself, urine was deceptive – and that concluded their interaction. The blade smith looked for help elsewhere. Months later, he came back to Handsch, this time in person, consulting him about complaints in the stomach area. He praised an old woman (“vetula”) and her excellent uroscopic assessment of his previous condition. She had explained to him, “You drank too much, drank too often when you were not thirsty, and this extra drinking gave it to you”. She also told

\(^{276}\) Cf. the chapter on the French disease.

\(^{277}\) On the following see also my detailed analysis in Stolberg, Decline (2007) and Stolberg, Uroscopy (2015).

\(^{278}\) See e.g. Hornung, De uroscopia fraudulenta (1611); Hart, Arraignment (1623).
him that he was sad because his wife had died and that he sometimes had complaints of the loins. The man said that this was indeed the case when he was sitting down. Handsch had to acknowledge that the man liked ("placuit") the old uroscopist's assessment.\footnote{Cod. 11205, fol. 222r.}

In other cases, Handsch did not even try to convince the messenger, and with him the patient, that uroscopy by itself was unreliable. He gave in. In his notes, he frankly admits that he sometimes only pretended to be looking at the urine a messenger gave him.\footnote{Ibid., fol. 435r, "finxi me aspexisse".} Instead, he relied on plausible and most probable diagnoses. For example, if he learned from the messenger that the patient was a tailor, he could – likely considering the tailor's many hours of sitting – diagnose an obstruction of the spleen or liver. He added that one could generally use the term "obstruction" ("oppilatio") quite often.\footnote{Ibid., fol. 208.} If he was able to find out that the patient was older, he could be confident in stating that he had "fluxes in the head and that the fluxes fell down into the chest, stomach, loins, and limbs",\footnote{Ibid., fol. 424v; similarly but even more elaborately ibid., fol. 433r, on the urine of the old Jew Markus.} or that he had stomach complaints and produced a lot of sputum, especially in the morning.\footnote{Ibid., fol. 208.}

With women, determining a uterine complaint was a safe bet.\footnote{Ibid..} When urine was once taken to Handsch from four miles away, and he was only told that it came from a woman, he, according to his own notes, only pretended that he had inspected it and then, in his "usual way",\footnote{Ibid., fol. 435r, "dixi solito meo more".} announced a general diagnosis that would be useful to many female patients: the woman had phlegm in her uterus and therefore her menstruation was obstructed. She also sometimes had complaints in the area of the loins and in the legs and found breathing difficult. The person who delivered the urine confirmed everything and wanted to know whether the lungs or liver were affected. This was not surprising to Handsch, because after all, they – and here he was likely referring to the traditional uroscopists – were in the habit of saying that the lungs, the spleen, or the liver were rotting, were "obstructed, swollen, filled with mucus, ulcerous, withered, and shrunken".\footnote{Ibid., fol. 435r; "verstopfft, verschwollen, verschleimet, geschwurig, absemert, geschwindt"; "absemert" probably derived from the old German word "semmern" for "emaciate" and "geschwindt" clearly refers to the "schwinden" ("consumption") of the affected part.} Sometimes Handsch deliberately abstained from giving an obvious diagnosis, such as
mucus in the uterus, to avoid giving the impression that he always arrived at the same result ("ut variarem").

It was further possible to reduce the risk of giving an obvious misdiagnosis if one claimed that the complaints – supposedly identified from the urine – were either already present or would soon become manifest. One could also avoid saying, "The water further shows . . .", and instead ask: "Does she not sometimes complain about . . .?" or, "Has she never complained?"

In one entry Handsch even described a *Ceremonia pro simulanda diligentia*, a little diagnostic ritual designed to create the impression that he was working with great care, while in reality he was not basing his diagnosis on uroscopy at all. This was occasioned by a urine sample that was supposed to be that of a woman in a village who had not borne children for several years and was suffering from various ailments: ‘Hold the flask and inspect it carefully and say the following: ‘Her time is not arriving naturally the way it should be’. Hold one finger under the flask and look at your fingernail and say, ‘She has complaints in the area of the loins and sometimes it goes to the legs’. [. . .] Move the matula in a circular motion and say, ‘If the slime is stirred up, it rises as vapor to the stomach and the heart, which sometimes causes her complaints and she breathes with difficulty, especially when she goes up the stairs.’ Put your finger on the other side. ‘When the vapors from the slime in the mother rise up higher, they reach the head and make the brain sick.’’ And because he knew that the woman had not had a child in several years, he added, “With the slime, she cannot have children, because nothing can take hold in a place that is slimy and slippery; you cannot get wax to stick to a wet table.” He noted down that the separate steps of the *ceremonia* should be accompanied with utterances such as, “The water also shows . . .”

287 Ibid., fol. 436r.
288 Ibid., fol. 428v.
289 Ibid., fol. 429r.
290 Ibid., fol. 428r-v: “Halte das Harnglas und inspiziere es sorgfältig und äußere dich so: ‘Yre Zeit hat sie nicht natürlich wie es recht sein solte’. Tu einen Finger unter das Harnglas und schaue auf den Fingernagel und sage ‘Umb die Lennden ist yr schwer, und auch bisweilen kompt es yr ynn die Beyne’. [. . .] Bewege das Harnglas und lasse es kreisen und sage ‘Wenn sich der Schleym erreget, so dempfft er auff kegen dem Magen und Herz, das beschweret sie auch bisweilen und sonnderlich ist yr der Athem schwer, so sie eyn Stigen aufsteiget.’ Halte den Finger auf die gegenüberliegende Seite. ‘Auch so die Dempff aus der Mutter Schleym hocher auffsteigen, so kommen sie auch yns Haupt, und krencken das Gehirn’. [. . .] Si kan mit dem Schleym kein Kinder haben, denn wo es schleimig und schlipfrig ist, kann nichts hafften, Wachs kann man nicht ankleben an eynen nassen Tisch.”
291 Ibid., fol. 429r, “das Wasser zeigt auch an”.
Physicians often felt even more compelled to accommodate their patients’ expectations and wishes when it came to devising a therapy. First, there was the taste of medicines, a subject that was of major importance in everyday medical practice. In those days, it could not be taken for granted that patients would receive medication whose taste was more or less bearable and whose smell and consistency did not constitute an absolute affront to the senses. Standardized, packaged medicinal drugs hardly existed at the time. The pharmacists usually held a range of common medicinal mixtures in stock. Many medicines were prepared ad hoc, however, according to the physician’s instructions. As we learn from Handsch’s notes, physicians also quite frequently prescribed medicine such as herbal decoctions which could be prepared in the patient’s home, in the kitchen. Taste and consistency could therefore vary considerably, depending on the ingredients and the quantities prescribed by the physician, and depending on how they were prepared and administered. Composing suitable mixtures was far from banal, also because the ingredients in a mixture of drugs chosen for the individual patient did not always work well together. And some medicinal ingredients by themselves had a strong unpleasant taste that inevitably came through in a mixture.

Handsch dedicated many entries to the taste of different medicines, which underlines the importance of this aspect in everyday practice. One of his rules for a successful practice was that, if possible, a physician was to give gentle, reasonably palatable medicines so the patients would not refuse the treatment.292 “When medicines are mild and gentle, they praise the physician”, he noted.293 Sometimes Handsch tested medicines on himself by putting some in his mouth so he could judge the taste.294

Some patients found the widespread medical syrups cloying. This was the reason why one young patient refused a syrup Handsch had prescribed.295 An herbal decoction with syrup that Handsch recommended to a mason’s wife who suffered from gout had a “highly unpleasant” taste (“sapor ingratissimus”), as he found himself.296 Another female patient, to whom Handsch tried to give a herbal decoction that involved some very bitter plants, including chicory and

292 Cod. 11207, fol. 1r: “Sis studiosus in exhibendis suavibus medicamentis, scis enim quantum alienati sint patientes ob ingrata pharmaca.”
293 Cod. 11183, fol. 116v.
294 Cod. 11207, fol. 65r, fol. 95v and fol. 163v.
295 Cod. 11183, fol. 116v.
296 Cod. 11205, fol. 410v.
absinth, rejected the syrup in which it was administered as “very unpleasant”. Not only this, but a wretched foam had formed on the surface.  

Other remedies were very bitter. Again and again physicians had problems with cassia, a very commonly used, tried and tested laxative plant, and with the bitter *hiera picra*, which was produced from several different plants and was praised as an excellent medicine that cleansed and strengthened the stomach. One patient let him know that the prescribed cassia had tasted awful but had later warmed his stomach nicely. Handsch had the court apothecary Balthasar show him how to prepare cassia in such a way that it had a pleasant taste when taken by itself. But the apothecary cautioned him not to mix it with *hiera picra*: “It would be a pity to spoil such a lovely thing with hiera. I would rather eat pig dung than hiera; it is so repulsive”. Because he was to take *hiera*, the Archduke had once even sent for another physician instead, and, as Handsch added, the same had happened to Andrea Gallo, when he was treating a castellan. Handsch himself thought the remedy was “abhorrent” (“abominabile”) and was only willing to administer it with liquid, if he administered it at all. One of his own patients, he found, detested him for prescribing it. Gallo’s *mixtura cordialis* as well was “nauseating”, and some patients were reluctant to take it. 

Choosing a better way to administer the medicine could sometimes make the taste more bearable. When one of Gallo’s female patients refused to take *hiera picra* as a so-called *bolus* because of the bitter taste, he gave her the

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297 Cod. 11207, fol. 209v. 
298 Cod. 11205, fol. 147r. 
299 Cod. 11207, fol. 158r. 
300 Ibid., fol. 150v. 
301 Ibid.: “Es ist schade, das man solch liblich Ding mit Hiera verterben sol. Ich wolt lieber ein Seudrek essen, dann Hieram, es ist gar widerwertig.” 
302 Ibid. 
303 Ibid., fol. 55v. 
304 Ibid., fol. 150v. 
305 Cod. 11205, fol. 155r, “nauseabunda”. 
306 Ibid., fol. 94r-v.
medication in the form of a *pillula*, which still today refers to remedies that have a coating.\textsuperscript{307} Handsch wrote that when cassia was administered as a drink, it swelled up so much that one needed to drink it in large volumes, and that made patients “abhor this kind of drink”. He advised a patient to take cassia in solid form, because it was “sweet by itself”, and then drink some water of violet.\textsuperscript{308}

Physicians sometimes accommodated their patients in other matters of taste, too. For example, Handsch asked a sick man whether he preferred sour or sweet medication,\textsuperscript{309} and with other patients he left it up to them whether to take the remedy in solid or liquid form.\textsuperscript{310} He learned from another physician that the “matrons” preferred to take their purgatives if they were handed to them in spiced wine.\textsuperscript{311} Further, physicians advised their patients about what they could do to counteract the bad taste. According to Camenicenus, it helped to rinse the mouth with vinegar before and after taking medication.\textsuperscript{312} After taking a repulsive syrup – the sick Collinus, too, found it horrible – Mattioli recommended putting a few pomegranate kernels into the mouth, to swallow their juice and spit out the seeds.\textsuperscript{313}

Some patients found just the appearance of a medicine distasteful. The sheer sight of a cough remedy prescribed by Handsch not only made the sick man Knebel nauseous; Handsch had to admit that he was disgusted himself.\textsuperscript{314}

### Strong-Willed Patients

Patients and their relatives not only had a say in the taste of medicines, but quite often also played a very active part in deciding upon the treatment in general. Frequently they demanded certain therapeutic measures and rejected others. When one patient asked to be given something for her stomach – she was experiencing pain in her upper abdomen – in addition to remedies for her fever and cough, Gallo gave her an ointment that she could rub on the stomach area before

\textsuperscript{307} Cod. 11207, fol. 208v.
\textsuperscript{308} Ibid., fol. 168r, “grausen vor eynem solchen Tranck”.
\textsuperscript{309} Ibid., fol. 95v.
\textsuperscript{310} Ibid., fol. 51v.
\textsuperscript{311} Cod. 11205, fol. 222v.
\textsuperscript{312} Ibid.
\textsuperscript{313} Cod. 11183, fol. 204v.
\textsuperscript{314} Cod. 11205, fol. 107v.
eating. Handsch, too, yielded in cases like this. Adam Bohdanski, for example, complained of a cold stomach and asked why Handsch was not rubbing his stomach with something, whereupon Handsch seems to have personally (“unxi”) applied “stomach oils”. The matron Walpurgis, who had a fever and pain in her loins and then developed convulsive seizures, asked for bloodletting – and Willenbroch bled her, even though the illness, by Handsch’s judgment, was bilious and therefore would more likely respond to treatment with emetics or laxatives. It was no surprise then that the result she had hoped for did not materialize.

Some patients did not even readily allow the physician to make the decision about which vein was to be used for bloodletting. In the case of the sick wife of Heidenreich, for example, the physicians wanted to let blood from the vena saphena, first on one leg, then on the other. She however, wanted to be bled from the popliteal vein. In the case of a sick accountant, Handsch rejected the idea – because it was winter – of doing the bleeding from the vena mediana in the elbow, as the patient requested, preferring instead the much smaller vena salvatella at the back of the hand. A barber, however, explained that this was sometimes done even in the winter, and the patient got what he wanted in the end.

Sometimes other people’s negative experiences could make a patient dubious. The Countess of Thurn, for example, did not want to take a remedy to strengthen the teeth because it contained the bark of thus (frankincense tree). Her maid, she reported, had lost two teeth from it. Gallo was able to reassure her: the effect of the bark was different from that of the plant as such. But as Gallo told Handsch later, the plant itself did not cause teeth to fall out either.

Other patients were forceful in their demands for specific medicines. When the menstruation of Collinus’s sick wife did not arrive on the expected day, she urged Handsch to give her medication. As she refused liquid remedies on principle, and as Handsch had no solid, sweetened, and dried confectum at hand, he gave her a strong dose of antimony.

Another female patient wanted to get well again right away, and so he gave her an electuary to “dissolve” the morbid matter, without administering the preparatory remedies that were commonly given first to promote the concoction or “digestion” of the matter.

315 Cod. 11207, fol. 59v.
316 Cod. 11183, fol. 96v.
317 Ibid., fol. 466v.
318 Ibid., fol. 379v.
319 Cod. 11207, fol. 92r.
320 Ibid., fol. 160r.
321 Cod. 11205, fol. 251v.
322 Cod. 11207, fol. 152r.
“Do everything with a good conscience”, Handsch wrote, reminding himself to show some reserve with demanding patients. He wanted to respect the rules of the art (“canones curativos”) and not carry out treatments without using the necessary medicines simply to do the patient a favor (“in blandimentum aegrit”). Whenever decisive action was called for, he wanted to be brave, and when it was not, he wanted to say no: one should not allow patients to get their way just to be pleasant (“propter blanditias concedere”). In practice, however, he found it difficult at times to observe his own rules. He allowed one patient, for example, to drink cold water from a well, just because he wanted to please him, though he knew that this was not the right thing in this case. To be pleasant, he gave a scribe who was suffering from a fever and severe breathlessness less of the medicine than was necessary. When, contrary to Handsch’s prognosis, the illness ended in death, people rightly held him in contempt, he thought. He also admitted that, with some other patients, he prescribed medication or actively intervened in other ways only because he did not want to look bad. To avoid giving the impression that he was not doing anything (“ne nihil agere videar”), he gave something to the wife of Collinus that he happened to have with him: an essence of rhubarb. He even admitted to having treated a patient with severe stone complaints for eight days, more “for appearance’s sake than according to the rules”, using oil of chamomile and hiera picra. Against one of the fundamental rules of medical therapy, which said that very cold and very hot days were ill-suited for treatment – a rule Handsch’s teachers liked to stress – Handsch gave a medicine to the wife of Collinus when it was bitter cold. He wrote that he did this “for appearances” (“ad speciem aliquid agendum”) and without an assured method, “to be amenable” rather than out of conviction.

Patients frequently also had very clear ideas about what they did not want. Enemas, it seems, were especially unpopular. Handsch had heard that young women in the Netherlands had no reservations. They liked to be given enemas before they went dancing, “to be light”. And in Italy, the courtesans used the

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323 Cod. 11205, fol. 541r.
324 Cod. 11207, fol. 231v.
325 Ibid.
326 Cod. 11205, fol. 541r.
327 Ibid., fol. 250r.
328 Ibid., fol. 263r, “potius fuit ad videri quam ad regulam”.
329 Ibid., fol. 251r.
330 Ibid., fol. 268v, “laici illi, qui clysteres abominantur”.
331 Ibid., fol. 200v.
same remedy to be more “agile” (“agiliores”). The sick, however, were apparently often very reluctant. When Handsch wanted to give an enema to fourteen-year-old Friedrich von Kunritz, who had dysentery, the patient was adamant in his refusal (“obstinate recusavit”). With another sick boy, Handsch did not even try because he “might detest” it (“forsan abhorrebit”), even though an enema seemed indicated. He gave him a remedy that the boy could take orally as a first line of action, having decided that he would only take recourse to the enema if the medication did not yield good results. Gallo had a similar experience. Because a woman plagued by colics refused being administered medicines via an enema, he prescribed her pills instead. Mattioli, in particular, was nevertheless fond of prescribing them, but he could get away with it more easily because of his status.

It remains unclear why enemas apparently were often met with obstinate refusal. A young Englishman told Gallo of his worry that an enema might weaken him. But possibly some patients experienced the whole procedure as unpleasant or even embarrassing and humiliating. Jakob Fugger’s son was unwilling to accept even a suppository. Handsch’s notes further show us that enemas also came with certain risks if they were not administered by a capable hand. Stories about this may have circulated. The sick archivist Matthias experienced such massive and sustained bleeding following an enema that he, by his sister’s account, almost fainted and seemed close to dying. Mattioli, who had prescribed the enema, suspected an injury due to “bad use of the instrument”. A captain related that his grandfather had cried out in pain and died when he was given an enema.

Understandably, patients sometimes showed reluctance when it came to interventions that were necessarily painful. Even the pain of bloodletting – for which a blade was used to cut through the skin and the wall of the blood vessel – should not be underestimated. There were patients who were afraid of it. Handsch knew a man called Tuchel who said that, his feet trembled before he let blood.

332 Cod. 11206, fol. 118v.
333 Cod. 11183, fol. 105v.
334 Cod. 11207, fol. 195v.
335 Cod. 11238, fol. 63r.
336 Cod. 11183, fol. 135r.
337 Cod. 11238, fol. 128r, “dixit se debilitatum a clystere”.
338 Cod. 11207, fol. 25r.
339 Cod. 11183, fol. 118v; Handsch referred to the patient as a “chartarius”, a term used for archivists but also for people who sold paper. The patient had severe pain the upper abdominal region and died soon after.
340 Cod. 11205, fol. 150v, under the heading: “Mortuus ex clystere”.
341 Cod. 11183, fol. 88r.
was said about some patients that they experienced so much fear that the blood
did not flow when they were cut; physicians and laypeople alike assumed that fear
made the blood and the spirits withdraw to the heart. To counteract this effect, the
arm with the opened elbow vein was put in warm water.  

Not surprisingly, patients wanted to be all the more actively involved when
the promised effect of a treatment did not materialize or they experienced unde-
sirable effects. The wife of a lapidary removed poultice Handsch had prescribed
the very next morning because she thought that it drew too much fluid out.  
Another patient did not want to put up with the poultice he had been prescribed
because the stinging was too much to bear. Some patients put their physi-
cian’s patience to the test. After one or two applications, a sick young nobleman
was unwilling to tolerate further compresses for his belly. He claimed they were
not good for him: “My belly rumbled more and was hardened”. The sick young
man was then given hellebore as a syrup, but he was not content with that either.
After he took it, he complained, that he was dizzy, had no stool and was anxious.
A purging agent finally caused him to produce four to six stools per day. Now the
patient said he was getting weaker and the treatment was not helping much, “be-
cause my stomach is still gurgling and my head hurts with dizziness.”

From the physicians’ point of view, a patient’s “disobedience” not only jeopar-dized his or her health but also the physician’s standing and reputation.
Ultimately the physician would be held responsible when a patient did not get
better. In exceptional cases, Handsch gave up. He took his leave from the sick
Baron von Meseritz because “he did not want to obey”. Handsch likewise fi-
nally stopped going back to Spaner, who suffered from colics and epilepsy, be-
cause he “did not listen and made a mess of everything.”

At times physicians could profit from their patients’ lack of “obedience”. Handsch found out, for example, that one of his female patients drank Malva-
sia wine, which she had not told him. He did not believe that this was harm-
ful, but when in the following days she was faring very poorly, he pretended

342 Ibid., fol. 243v.
343 Ibid., fol. 47r.
344 Cod. 11207, fol. 221v.
345 Cod. 11183, fol. 434r; “denn es korret ym nach [sic!] ymmer ym Leibe, und das Heupt thet
wehe mit eynem Schwindel”; the term “korren” (also: “kerren”) usually referred to gurgling sounds
in the abdomen. The patient died three years later, from excessive drinking, Handsch believed.
346 Ibid., fol. 114r, “dum obedire noluit”.
347 Ibid., fol. 321v, “quia non obediebat et omnia confundebat.”
("praetexui") that this came from drinking the wine. His treatment, at any rate, could not be faulted now. In other cases, one could blame a patient who did not recover completely by saying, “You went outside too soon”. On one occasion, he was able to defend himself well by pointing out that the patient had rejected taking the prescribed soporific because of its unpleasant camphor smell.

Physicians could even plan ahead and use a patient’s predictable recalcitrance to serve their own purpose. When he gave opiates, one of Handsch’s cautelae ran, he would tell patients not to eat or do certain things that he knew they would find difficult to resist. When the pain came back – the way it usually did because the measure in question was only a “cloaking” treatment ("cura palliattiva") – he would blame the patient for not doing as he was told. In another entry, he explained that a physician could resort to a mere “cura palleativa”, when he felt unable to heal the patient, and when the patient relapsed, he could claim that the patient had not respected his dietetic instructions.

**Undesirable Effects**

If a patient got significantly worse under treatment or the treatment produced major undesirable effects, a physician could count on the patient’s resistance to continuing with the treatment and could expect to be fiercely reproached. This could happen to any physician. Handsch, too, encountered bitter complaints, for example, when he treated someone suffering from the French disease with mercury fumigations. The patient was faring worse than he ever had, and stated that he would rather die, and he never experienced the flow of saliva that was supposed to take the morbid matter out of his body. Afterwards, Handsch’s own brother reprimanded him and told him that he should not pursue a treatment like this if he did not know what he was doing.

Especially with the widely used herbal remedies, the action of a medicine could vary widely, even if it had been carefully dosed. Factors such as the plant’s quality, age, place of origin, as well as the plant parts that were used, along with the patient’s physical constitution could make a difference. Mistakes could easily

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348 Cod. 11205, fol. 298v.
349 Cod. 11206, fol. 171r.
350 Cod. 11205, fol. 300v.
351 Ibid., fol. 306r.
352 Ibid., fol. 223r.
353 Cod. 11183, fol. 254r.
happen. Especially when it came to evacuating morbid matter, the right choice and the dosing of the remedy was very much a balancing act. Patients and their relatives expected and asked for a strong, noticeable effect, and from a medical perspective, too, a drastic evacuation in many cases was considered essential to curative success. However, the effect could also be all too powerful.

Patients were willing to accept some quite unpleasant attending symptoms. Time and again, without giving any indication that there was dissatisfaction or protest, Handsch noted down cases like that of the sick wife of a chancery scribe, who passed twelve large, mucous stools following the administration of a laxative, and felt weak. An acquaintance told him that he had passed fifty stools after a barber had given him a purgative to prepare him for treatment with mercury. He had discharged blood and been so faint and tired that he had to rest for eight days. Yet, he continued the treatment.

When, however, the negative attending symptoms predominated from the perspective of the patient, physicians had to be prepared to face resistance and criticism. A phrase Handsch wrote down in this context was, “The doctor has ruined him”. The wife of a man called Baptist cursed the remedy she had been given (or the physician who prescribed it), because she felt bad (“male sensit”) after taking a mixture of rhubarb powder and “opening” roots for her white discharge; even so, she had praise to spare (“laudavit”) for other remedies. Handsch’s colleague Willenbroch brought upon himself the “great indignation” (“magnam indignationem”) of a noble female patient – which, Handsch thought, was perhaps not entirely unjustified – when he applied a poultice with Spanish flies to her feet. It seems he meant only to warm the feet, but blisters formed and the woman experienced severe pain. In other cases, the response from patients and their relatives is not documented but is easy to imagine. Fröhlich, for example, was given cassia by Handsch when he was sick. The patient subsequently had close to fifty bowel movements and died several days later. A young nobleman produced close to thirty stools after taking a powerful laxative. This left him very weak and he soon died. An old woman even had close to a hundred stools after taking cassia. She

354 Ibid., fol. 458r.
355 Cod. 11205, fol. 244r.
356 Cod. 11206, fol. 185r: “Der Doctor hat in verterbt”.
357 Cod. 11183, fol. 399r.
358 Ibid., fol. 6v.
359 Cod. 11207, fol. 202v.
360 Ibid., fol. 214v; the physician in charge was a certain Dr Kunstat, whom Handsch mentioned repeatedly.
ultimately died as well. In retrospect, it cannot be said whether the medical therapy contributed to or even caused death in these cases, but the physicians could hardly blame the bereaved if they held them at least partly responsible.

In one of his more detailed entries, Handsch described his unfortunate encounter with the sick Baron von Meseritz. The old gentleman suffered from severe febrile attacks. He complained of a great heat and in his layman’s ignorance (“imperitia laicorum”), as Handsch wrote, he wanted something to be done about it right away. But Handsch was unwilling to even let him be fanned by a boy. The next morning the patient said that he had sweated so much that he had to change his shirt twice. He developed a piercing pain in his knees, as if the morbid matter had moved there, as Handsch remarked. But then Handsch found a murky deposit in the urine, which he interpreted as indicative of a “critical” transformation and excretion of the morbid matter. He therefore believed the disease was subsiding and predicted a marked improvement for the following day. But he was wrong. The old man sent for him and complained vehemently. Handsch wrote, “I had assured him that he would be quite fresh that day but he was very faint, had not slept at all, and his head was like an empty pumpkin”. He criticized Handsch for not giving him any medication, instead “feeding [him] hope about his strong nature”. But now one could see just how strong he was, he said. He had not had a moment’s peace in the night and he claimed he had “become run-down due to negligence”. He demanded a tonic but Handsch did not have any with him, “so now he was breathing anger”. Handsch sent a messenger to fetch a soporific from an apothecary in a nearby town, but the apothecary did not send anything good. The following day, the sick man was weak, and angrily discontinued treatment with Handsch. Handsch learned later that he went to Prague, had himself treated by Mattioli, and recovered but his wife succumbed to a terminal disease. In his final conversation with the patient, Handsch defended himself. If he had promised him that he would be better the following day, he had only done what all physicians do. It was only proper to give a sick person hope, “because this is how he can take heart, can endure the disease with more cheer and overcome it”. He had not given him medication, for one thing because this was to be avoided during the dog days, and for another because he had wanted to first get a better idea of the disease, and when there were signs of a critical excretion, he did not want to get in the way of nature. Handsch admitted in his personal notes that he had made mistakes. He should not have prematurely assured the patient that he would get better and fully recover. If, against all expectations, this turned out not to be true, it diminished the authority of the physician (“diminuitur authoritas

361 Ibid., fol. 152r.
medici”). So as not to avoid accusations of neglect, he decided that he would always give medicines in the right order and according to the rules of the art (“canones”) and make sure to give medicine at the right time. In future, he also wanted to ensure that he always had tonics with him, since he had been trusted less because he did not have one with him.\textsuperscript{362}

**The Sense of Shame**

People’s modesty or sense of shame posed another challenge especially when the patients were women. As Handsch suggested repeatedly, even talking about menstruation was a source of embarrassment for women, which was also reflected in the widespread use of metaphors, euphemisms, and roundabout expressions. With their patients, the physicians used expressions like “time of the month” or simply “your time”\textsuperscript{363} or they even took recourse to poetic turns of phrase like “roses” or “time of the roses”.\textsuperscript{364} Handsch’s colleague Merla wanted to know from a patient “whether she had her justice”.\textsuperscript{365} Handsch noted down some suitable expressions for his own use, such as “your attribute”, “she has come into her time” or “the roses are not going at the right time”, and “she does not have her justice”.\textsuperscript{366} He could explain complaints by saying, for example, “The disease often occurs in women because they do not have their roses in the right way.”\textsuperscript{367}

Numerous entries in Handsch’s notebooks as well as case histories in published *observationes* show at the same time that physicians certainly did ask women about their menstruation, regardless of the feelings of shame this could prompt, and that women on their own initiative sought physicians’ advice when they thought their menstruation was not right. Menstruation was considered too important for women’s health to be hushed, at least when it had

\textsuperscript{362} Cod. 11205, foll. 226r-229r: “Ich hett ym zugesagt, er solte den Tag gar frisch seyn, so er doch gar mattlos were, hette die gantze Nacht nicht geschlaffen, der Kopf were ym wie eyn lediger Kurbiß”; “vertröstet auff seyne starcke Natur”; “durc Nachlessikait verwarlost wor-\textsuperscript{363} 2\textsuperscript{nd} Cod. 11206, fol. 627r, copy of a *consilium* bei Johann Neefe.
\textsuperscript{364} 2\textsuperscript{nd} Cod. 11206, fol. 503r and fol. 547v.
\textsuperscript{365} 2\textsuperscript{nd} Cod. 11206, fol. 36r, “ob sie ire Gerechtikeit hett”.
\textsuperscript{366} 2\textsuperscript{nd} Cod. 11206, fol. 39v, fol. 126v, fol. 176v and fol. 183v; Cod. 11207, fol. 189r: “Euer Eygenschaffit”; “Die Rosen gehen nicht zu rechter Zeit”; “sie ist in ire Zeit kommen”; “Sie hat nicht yr Gerechtkait”.
\textsuperscript{367} 2\textsuperscript{nd} Cod. 11206, fol. 179v: “Die Kranckheit tregt sich ofte zu bey Weibspersonen, darumb das sie ire Rosen nicht zu rechte haben.”
become “disorderly”. It is clear that husbands and wives talked about these things, so that men were able to tell the physician when their wife was expecting her next period, or could pass on their wife’s request to the physician that he do something to encourage her menses. However, Handsch also mentioned a woman who at first did not tell him that her menstruation had stopped. And he wrote that when a woman’s husband was present, he could not ask her questions about menstruation. In his experience, dealing with young women was especially delicate. He wrote about one case in which he had not dared, for reasons of shame (“propter verecundiam”), to ask about menstruation or bowel movements, or to palpate the upper abdomen. This was because young, unmarried women (“virgines”) felt especially bashful in front of young physicians. In the end, he had to leave her uncured.

Handsch’s records further tell us that, even more so than with menstruation, genital discharge was associated with shame. He found that women kept the common experience of white or yellowish discharge to themselves. They concealed it “out of shame” or “admitted” it, if at all, only when the physician inquired. Possibly there was a confluence here of notions of impurity – as were connected to menstruation – and ideas of incontinence, that is an insufficient control over one’s excretions in general. Despite her severe illness and her repeated miscarriages, the wife of a private tutor also kept an ugly anal growth to herself at first.

This woman, like many others, did seek medical advice in the end. In the final reckoning, the desire to be healthy often seems to have outweighed shame. What is more, Handsch’s notebooks clearly disprove the commonly held belief that physicians left the visual examination and the touching of female genital organs to midwives and other female healers. He described at great length, for example, how he personally attempted to inject warm wine into the uterus of the sick Baroness of Hungerkasten, whom his famous colleague Neefe had diagnosed with a “bad cold moisture”. Handsch used a catheter (“syphon”) for the purpose, which he had received from Ulrich Lehner. He gave a close description of the long, round-tipped tube featuring a slit-shaped opening at its end, which,

368 Cod. 11183, fol. 82r.
369 Cod. 11205, fol. 490r.
370 Cod. 11206, fol. 35v.
371 Cod. 11183, fol. 10v, “propter praesentiam mariti”; similarly Cod. 11207, fol. 111r, “propter praesentiam viri”.
372 Cod. 11207, fol. 210r.
373 Cod. 11183, fol. 460r; Cod. 11206, fol. 33r; ibid., fol. 107v.
374 Cod. 11183, fol. 368r.
remarkably, he compared to that found in the male glans. He added in his entry that he had read in a surgery book written in German that a “uterine clyster” should have two holes on the side, which is to say not at the tip. He further described how the woman had to lie on a table with her legs spread and afterwards lie in her bed for two hours. The attempt failed, however, and the wine flowed back out. The patient stated that, by feeling for it (“ex tactu”) one could tell that the uterus was closed but it remains unclear whether Handsch was allowed to verify this.375

To the extent that learned physicians also did surgical work, we may even more safely assume that, if it was necessary and if the patient agreed, they did not refrain from treating the genital area of their female patients. When he died in 1643, Johann Georg Wirsung, who practiced medicine and surgery in Padua, left behind not only a “speculum anni [sic!]” for the examination of the anus but also a “speculum uterinum”.376

When it comes to male patients, Handsch’s notes give no indication that they showed signs of a pronounced sense of shame when they disrobed in front of the (likewise male) physician. With great matter-of-factness, he described, for example, how he palpated a man’s groin and scrotum.377 He treated a man presenting with small ulcers on his penis and a swollen lymph node in his groin by injecting white wine mixed with several drops of sulfuric acid under his foreskin.378 And when mercury unctions were used to treat patients suffering from the French disease, a complete disrobing could hardly be avoided. Handsch gave an exhaustive description of a Jewish healer applying mercury unction to the different body parts of a naked patient, using his own hands to rub it into the gluteal fold, and on the genitals.379 Only when a seriously ill man exposed his genitals for no discernible reason did Handsch explicitly note down that the man had not “blushed”, which apparently could be expected under normal circumstances; the absence of blushing here seemed to indicate to him mental confusion due to the illness.380

Reading Handsch’s notes, it becomes clear that a male sense of shame could primarily be witnessed in medical practice when the patient’s virility or sexual morals were at issue. The merchant Fabian had waited six months before

375 Ibid., fol. 7r-v.
376 List of Wirsung’s estate, edited in the appendix to Ongaro, Wirsung (2010), here foll. 14v-15r.
377 Cod. 11205, fol. 259v.
378 Cod. 11183, fol. 142v.
379 Ibid., fol. 117* r.
380 Ibid., fol. 106v.
he “confessed” to him (“confessus est mihi”) that he also had an ulcer on his
penis and a swollen lymph node in the groin, as Handsch added in the margin.
He had sought treatment from a Jew and had recovered, but then he went back
to the prostitutes. Shame and honor had to be considered when treating a pa-
tient. A cure with guaiacum or mercury over the course of several weeks in a
“French house” was hardly a possibility for men from higher classes. Thus, Mattioli
treated a private tutor with a guaiacum decoction that he prepared at home.
The position of a teacher of boys from the aristocracy, wrote Handsch, did not
allow for his treatment to become public knowledge (“manifeste”).

Shame and injured manliness also seem to have played a role with an older
male patient who complained that he could no longer contain his winds. Espe-
cially when he was walking, they escaped him with a loud “purz, purz, purz” –
presumably audible for everyone around; and sometimes his urine also flowed
against his will.

Even the sexually impotent sought the advice of physicians in spite of – or
sometimes perhaps precisely because of – the fact that impotence was mortify-
ing and shameful and could have serious consequences at the time, in the
worst case the scandal of public legal proceedings for the annulment of mar-
riage. Handsch mentioned a number of impotent men who approached him
and other physicians, along with some he had heard about in private conversa-
tions. Some newly-wed men – here he gave their names – had difficulties dur-
ing the first weeks of their marriage. A certain Hans Ferber, according to
Handsch, did not dare get married a second time, even though he already had
two daughters with his former wife. Other men suffered from impotence for
years and tried all kinds of things to overcome it, taking medicines or visiting
healing springs. Inguinal or scrotal hernias were feared in this regard because
they were linked to the danger of impotence and infertility. Repairing hernias
posed a great risk, because a testicle was often removed in the process. After he

381 Ibid., fol. 177r.
382 Ibid., fol. 222v.
383 Darmon, Tribunal (1985); Ründal, Mannschaft (2011).
384 Cod. 11183, fol. 87r.
385 Ibid., fol. 222v.
386 Cod. 11205, fol. 108r, among others on Hoddeiovinus who fathered children inspite of his hernia.
had undergone the procedure, one young husband mentioned with great relief that intercourse was diminished only a little or not at all.\footnote{387}{Cod. 11183, fol. 451r.}

Some men expressed concerns not only about their male honor and their ability to have children but also acknowledged their obligation to satisfy their wives’ desires. In a letter to Mattioli, an approximately forty-year-old nobleman wrote that he had begun early with “the work of the flesh” and had “practiced it much” as well. Starting twelve or fourteen years ago, however, his ability had declined more and more. His “male member had become unwilling to stand” and if it did, the semen had run out forthwith. He had tried many medicines and consulted various physicians in vain. Mattioli was to please help him “now that he had taken a young wife”, so he may father children and “the wife’s lust may be given its due”. Mattioli prescribed him herbal baths, electuaries, powders, and other remedies. The outcome remains unknown.\footnote{388}{Cod. 11183, fol. 158v and fol. 185r, with a partial transcription of the patient’s letter; “das fleischliche Werck [. . .] viel geübet”; “ime das männliche Gliedt nicht mehr stehen wöllen”; “dem Weib ir Lust auch gebust werde”.

“Bystanders” and Caregivers

It is with good reason that, in the preceding chapters, I have often referred to patients as well as to their families or more generally to the “bystanders”. When a physician made a sick call, he normally met not only the patient but family, friends, and acquaintances, all of whom took an interest. He might even find them standing around the sickbed when he arrived.

This “sickbed-society”\footnote{389}{Lachmund/Stolberg, Patientenwelten (1995), p. 124.} could help the attending physician by providing additional information. For example, he could learn from them that the patient was hardly eating anymore\footnote{390}{Cod. 11207, fol. 65r.} or that his sweat reeked and stained the bedding yellow.\footnote{391}{Ibid., fol. 92r.} They could describe the quality of the sick person’s stool for him\footnote{392}{Ibid., fol. 226r.} or corroborate Handsch’s explanation that the cloudiness in the urine of a patient meant “much phlegm” by pointing out that the siblings were “all phlegmy”, which suggested a certain predisposition.\footnote{393}{Cod. 11205, fol. 293v.} If the patient was a child, the parents and the other bystanders were commonly the most important source of
information. It was they who let the physician know, for example, about a three-year-old girl, that “she has a head cold and toward the evening she runs hot”.\(^\text{394}\) They might also describe an epileptic seizure for him which they had witnessed.\(^\text{395}\) Or they might tell him that a little boy sometimes started to scream all of a sudden, and smelled “strange from the throat”, adding, when Handsch’s asked them, that he often rubbed his nose, which, for Handsch, was an important indication of a worm infestation.\(^\text{396}\) Sometimes bystanders also lent a hand with the treatment. The wife of Adam Zyma, for example, held the clyster in her husband’s anus, while an apothecary – apparently in Handsch’s presence – poured in the liquid.\(^\text{397}\)

The frequent presence of relatives and other bystanders undoubtedly had an impact on the quality of the physician’s visit. Intimate, personal conversations between physician and patient were probably the exception rather than the rule. It also put more pressure on the physician to assert his authority. He had to win over not only the patient but also the whole “audience” with his demeanor, his explanations, and his recommendations. He had to stage himself and his abilities appropriately if he wanted to gain the trust of both the sick person and the bystanders.\(^\text{398}\)

Frequently relatives, especially spouses, would even want to have a say in the choice treatment. In the case of a sick woman called Watzarka, for example, it was her husband who rejected Handsch’s prescription of a purgative and a tonic along with the herbal footbath.\(^\text{399}\) At another occasion, this husband also refused the use of an emollient, soothing remedy for his wife. He explained that he had no trust in Handsch, because Handsch had wrongly promised that an external treatment of the feet would draw the heat down.\(^\text{400}\) In the case of the feverish Johann von Meseritz, it was the father who criticized Handsch because his son was doing worse and Handsch was not giving him any tonics.\(^\text{401}\) When treating the widow of a certain Kneysel, who was suffering from suffocation of the womb, Handsch did not even dare to do cupping on the vulva to draw down the rising uterus “because of the women”.\(^\text{402}\) In another case, an old woman

\(^{394}\) Cod. 11207, fol. 168r “Sie hat den Schnupffen und gegen dem Abend hizet si.”
\(^{395}\) Ibid., fol. 169r, “selzam aus dem Hals”.
\(^{396}\) Ibid., fol. 180r.
\(^{397}\) Cod. 11183, fol. 44r.
\(^{398}\) On the importance of theatrical elements at the patient’s bedside see Lachmund/Stolberg, Doctor (1992), drawing on eighteenth- and nineteenth-century sources.
\(^{399}\) Cod. 11205, fol. 287r.
\(^{400}\) Cod. 11205, fol. 276r.
\(^{401}\) Cod. 11183, fol. 114r.
\(^{402}\) Ibid.
(“vetula”) prevented a young man with a swollen knee from taking the syrup a physician had prescribed.  

Among the “bystanders”, those who were directly involved in the nursing care and who looked after the patient’s wellbeing played a special role. Little is known to date about nursing care in the sixteenth century, which largely took place in private homes rather than in hospitals. Handsch’s notes tell us about sick-nursing and the relationship between physicians and nurses only occasionally, in no more than a few dozen entries, but they do help illuminate some aspects.

We know very little about the people who did the nursing or caregiving, the “adstantes” as Handsch sometimes called them. Sometimes, they were relatives, wives and mothers but also husbands. In the case of more affluent patients, Handsch frequently also mentioned men and women of lower social status who were presumably in the employ of the patient’s family or were hired specifically as sick nurses. He sometimes referred to them only in general terms as servants (“servus”, “puer”), maids (“Magdt”, “ancilla”, “puella”), but sometimes also spoke more specifically of “female helpers” or “by-standing women” (“mulier administra”, “mulier adstans”), and in some cases of a “nurse” (“mulier curatrix”), who was appointed to help a sick official or whose help a certain patient had to do without.

The contemporary medical literature, for example Oetheus’s deliberations on nursing care, emphasized the importance of good nurses who helped ensure that the physician’s orders were carefully followed, prepared medicines and food according to his instructions, and informed him about changes in the patient’s condition. Oetheus and other authors contrasted this idea with the
poor training, negligence and disobedience of those who were usually given that task. Not only “the strangers who were ordered to care for the sick person”, they claimed, “do so with great annoyance and reluctance”.\footnote{Ibid., fol. 119r.} Even relatives occasionally longed for nothing more than for the sick person to die so they would be relieved of the trouble of attending and came into an inheritance. It was no wonder then that even by “their closest friends, they are moved closer to death than to health”.\footnote{Ibid.} Oetheus complained that nurses in their ignorance quite often “turn and pull the patient away from obeying and doing the proper and necessary things as ordered by the physician”.\footnote{Ibid., fol. 122r, “den Krancken vom gebürlichem und notwendigem Gehorsam der jenigen Dinge, welche von dem Artzet geordnet, abziehen und abwenden”.} He vehemently condemned their ignorance and their inability to “give the sick person even the least bit of useful advice”. “Wantonly and impudently” they proclaimed that the patient should eat and drink what he liked and not take not what the physician ordered and toss it out.\footnote{Ibid., fol. 122v, “fräventlich und unverschampt”.} Some even denigrated the physician so that the patient took “to disliking the physician, losing all trust in him, and becoming unwilling to obey and duly follow.”\footnote{Ibid., fol. 123r, “ein Widerwillen gegen dem Artzet fasset, und das Vertrawen zuo ihm gänzlich fallen lasset, auch zuo dem Gehorsam unnd gebürlicher Volge unwillig wirdt.”} According to Oetheus it also often happened that patients were “so delicate and soft or rebellious” that they would not tolerate anything, leave alone allow any pain to be inflicted on them. In such cases, those who nursed them were not to “pay court to the sick at all times” but if necessary “find some hard words”. For if, for the reason that the patient was unwilling to have something or other done and complained of suffering, one were to forgo useful and necessary remedies, this would be doing the patient a great disservice.\footnote{Ibid., fol. 126r-v, “jederzeit dem Krancken hofieren”; “mit Worten hart sein”.} In the seventeenth century, this criticism culminated in the accusation that sick nurses sometimes even sought to accelerate the death of seriously ill patients out of impatience or greed by pulling the pillows out from under their heads and backs or abruptly putting them in a horizontal position by other means.\footnote{Questel, De pulvinari (1678); cf. Stolberg, Active euthanasia (2007).} Under the heading “removing the pillows” (“Die Kussen wegnemen”), Handsch already mentioned such practices in the mid-sixteenth century, without reproach, however, describing them simply as a means to literally help people with dying.

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412 Ibid., fol. 119r.
413 Ibid.
414 Ibid., fol. 122r, “den Krancken vom gebürlichem und notwendigem Gehorsam der jenigen Dinge, welche von dem Artzet geordnet, abziehen und abwenden”.
415 Ibid., fol. 122v, “fräventlich und unverschampt”.
416 Ibid., fol. 123r, “ein Widerwillen gegen dem Artzet fasset, und das Vertrawen zuo ihm gänzlich fallen lasset, auch zuo dem Gehorsam unnd gebürlicher Volge unwillig wirdt.”
417 Ibid., fol. 126r-v, “jederzeit dem Krancken hofieren”; “mit Worten hart sein”.
418 Questel, De pulvinari (1678); cf. Stolberg, Active euthanasia (2007).

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Someone – he forgot who – had said during a meal: “When they struggle with death and cannot die, one should take their pillows away to make them lie suddenly; then they will die.” Handsch added without any undertones of indignation that this had been done similarly with an old and dying tutor; he was laid down on a straw mat on the floor.\footnote{419 Cod. 11207, fol. 182r: “Wenn sie mit dem Tod ringen, und nicht sterben können, so sol man yn die Kussen weg nemen, das sie gleich liegen, so sterben sie.”}

Handsch, too, occasionally criticized caregivers. For example, he upbraided a wife for her “negligence” when she did not get someone to give her paralyzed husband the prescribed enema. He acknowledged, however, that giving an immobilized and greatly overweight man an enema was difficult.\footnote{420 Cod. 11205, fol. 268r.} He also thought it was a poor decision when the mother of a severely ill, delirious young man suffering from a fever cooled her son’s face with rose vinegar. In his view, it was essential not to drive the morbid matter back into the body with cooling remedies but instead it should be allowed to evaporate. Accordingly, he was surprised when the patient was back up on his feet again only three or four days later.\footnote{421 Cod. 11183, fol. 417r.}

The case of Virginia von Loxan, a cousin of Philippine Welser, even led to a dramatic argument between the attending physicians and the “bystanders”. Virginia had the measles, which were going around in Innsbruck at the time. As was common to promote sweating, the physicians advised keeping the woman as warm as possible in a heated chamber. Yet, Virginia complained about the great heat and wanted to cool down. She even asked the Archduke himself for a sip of beer and got it, “in the name of God” (“propter Deum”). Handsch learned that she also put her feet down on the cold floor and leaned with her bare back against a wall. The measles rash was visible only briefly and quickly faded – too quickly, thought the physicians. The young woman found it increasingly difficult to breathe and became delirious. She died one week after the onset of the disease. Now the physicians were faced with the harsh reproaches of the women who were present who blamed them for doing nothing to counter the great heat of the fever, for even increasing it and for giving the sick woman nothing as refreshment and nothing to fortify her. The physicians, on their part, claimed that the women’s disdain for their advice was at fault. Presumably they thought that the external cold had made the skin and pores contract and had thus prevented the morbid matter from exiting; it had been driven back to the inside of the body and to the vital organs. This was the reason why the rash had gone away too quickly. They went on to say that all the other young women who came down with the measles around that time had recovered because they did not
have so many and such “compassionate” caregivers (“adstantes”). The bystanders replied that these women had not been kept in such a hot chamber.\(^{422}\)

In most of his notes on the subject, Handsch did not pass negative judgment. Rather, he expressed a certain esteem for the adstantes and the work they did: “Good care and a cheerful disposition”, were central to a favorable healing process.\(^{423}\) He even discontinued the treatment of a sick nobleman “because he had no one to attend to him.”\(^{424}\) In the case of a court chamber’s messenger, he decided against a more intensive treatment and instead prescribed an oil because the man did not have a nurse (“curatrix”).\(^{425}\)

It was furthermore Handsch’s experience that the information he could obtain from caregivers was helpful for his diagnosis, prognosis, and treatment. Caregivers could describe, for example, a patient’s black colored urine,\(^{426}\) or foul, sanious stool\(^{427}\) when he was unable to see for himself. They could tell him the observations they had made while he was away, for example, a patient’s vomiting and shortness of breath,\(^{428}\) the approximately forty stools another patient produced in two days,\(^{429}\) or the terrifying epileptic seizure a sick woman had had the moment the nurse sat her up. It had lasted the length of two Sunday prayers and she had flailed her arms enough to make the bed shake.\(^{430}\)

Handsch went even further. He also appreciated the practical knowledge, the experience of the caregivers, noting down in many entries how they proceeded at the bedside. These notes evidently served the same purpose as his many entries on the effect of certain medicines or treatment methods, that is to say they could be useful in his own practice in the future. He wanted to be able to introduce with future patients those nursing procedures he considered helpful. He described, for example, how the adstantes put a wooden spoon between the teeth of severely ill and dying patients, presumably to facilitate airflow.\(^{431}\) He even made an entry on the preparation of meat dishes for old patients who

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\(^{422}\) Ibid., foll. 356v-357v.

\(^{423}\) Cod. 11206, fol. 124v: “Gutte Wartung, und ein fröhlich Gemüt”.

\(^{424}\) Cod. 11205, fol. 258v: “Dieweil er keyn Aufwartung hett”; the reason why the man was hospitalized is not known.

\(^{425}\) Cod. 11183, fol. 329r.

\(^{426}\) Ibid., fol. 223v.

\(^{427}\) Ibid., fol. 424v, “mulier administra dicit fuisse quasi saniosas”.

\(^{428}\) Ibid., fol. 28r.

\(^{429}\) Cod. 11205, fol. 298v.

\(^{430}\) Cod. 11183, fol. 423v.

\(^{431}\) Cod. 11205, fol. 236v; apparently this was not done as a means to prevent an injury to the tongue as it could easily happen in epileptic fits.
did not want to chew anymore.\textsuperscript{432} He described with particular attention to detail how the caregivers worked to protect Christoph von Gendorf from “raw skin from lying”, that is from bedsores. The sick man had become emaciated and was unable to move in bed due to his pain. They put a linen cloth under his hips, which helped collect his feces, but above all allowed them to turn him by holding on to the fabric on either side of his body. They also put soft deer leather down on the bed for him.\textsuperscript{433} Handsch learned at another occasion that the white ointment used by a barber for injuries was useful in treating skin that had opened up from lying.\textsuperscript{434}

Based on their observation, caregivers sometimes offered a specific diagnosis or a prognostic judgment, which the physician could adopt for similar cases he might encounter in the future. Handsch found it noteworthy that with the sick Schrenck, for example, the nurse (“mulier curatrix”) suspected an “epileptic disposition”, because he had shaken his head and rolled his eyes.\textsuperscript{435} It was “as if the fit was approaching her”, stated a caregiver (“mulier adstans”) in another case.\textsuperscript{436} From the vomiting and the “sandy” urine of one of Handsch’s adolescent patients, “the women” (“mulieres”) concluded that he had stone disease.\textsuperscript{437}

\section*{The Incurably Ill and the “Cura Palliativa”}

A great challenge that physicians encountered regularly in their practice was the treatment of incurably ill patients. Over and over again, physicians had to experience how their medicine sometimes reached its limits.\textsuperscript{438} An oft-quoted couplet, which Handsch wrote at the beginning of one of his notebooks was “Contra vim mortis non crescit herba in hortis” or “No herb grows in the gardens against the power of death”.\textsuperscript{439} In many of his notes, he wrote down words he could use to explain to patients, relatives, and bereaved family members why even the best medical help could do nothing at a certain point. “When the hour has come, no

\footnotesize{\textsuperscript{432} Cod. 11183, fol. 34v. \\
\textsuperscript{433} Ibid., fol. 33v, “er möchte die Haut rohe liegen”. \\
\textsuperscript{434} Ibid., fol. 40v, “ad excoriationem a iactura”. \\
\textsuperscript{435} Ibid., fol. 418v. \\
\textsuperscript{436} Cod. 11207, fol. 114v, “gleich wie sie das Fressl wolt anstossen”. \\
\textsuperscript{437} Cod. 11183, fol. 277v. \\
\textsuperscript{438} Cod. 9821, fol. 91r: “Non omnes medici possunt depellere morbos. Plus, quam fatorum vis, medicina nequit.” \\
\textsuperscript{439} Cod. 11210, fol. 1r; as the words the physician could use when his patient died: Cod. 11205, fol 212v.}
medicine will help",\textsuperscript{440} was one of the phrases, or “If God is unwilling, I have no means”,\textsuperscript{441} or, in Latin, under the heading “When your patient is dying”, “The physician is nature’s servant, not Her master”.\textsuperscript{442}

Handschi learned early that certain diseases were usually incurable and that with them a radical cure that addressed the cause of the disease was essentially ineffective or even dangerous. Included here were most notably protracted stone and kidney complaints, consumption, cancer, dropsy, and long-standing gout, and with the elderly hectic fever, quartan fever,\textsuperscript{443} asthma, and paralysis.\textsuperscript{444}

In such cases, the physician was not condemned to doing nothing. Galen had already elaborated on a merely palliative treatment – aimed at pain and other subjective complaints and not at their causes – as an independent form of therapy.\textsuperscript{445} Denoted as “mitigating” (“cura mitigativa”), “flattering” (“blan-
ditiva”)\textsuperscript{446} and most widely as a “cura palliativa” – literally, a “cloaking treat-
ment”, understood here in a positive sense – this approach was firmly established
in the medical literature of the Renaissance.\textsuperscript{447} In fact, the notion of “palliative”
treatment is much older than generally assumed. As early as the fourteenth
century, the French physician Gu
dy de Chauliac had recommended a “broadly
conceived, preventive, and palliative treatment” for incurable diseases, or for
when a causal therapy was too dangerous or was refused by the patient.\textsuperscript{448}
In 1543, the English edition of the well-known surgical work by Giovanni da Vigo ex-
plicitly juxtaposed the “palliatyue” with the “eradicatyue cure”\textsuperscript{449} Handschi, too,
in his notes used terms such as “cura palliativa”, “cura pal[l]eativa” and “palliare
several times.\textsuperscript{450} Sometimes a “merely palliative” treatment was mentioned in a
negative, derogatory sense, when the treatment did nothing but literally cover up
the symptoms. “If one only pretended to heal”, is what Handschi called this.\textsuperscript{451} But

\begin{itemize}
\item \textsuperscript{440} Cod. 11206, fol. 116r: “Wenn das Stündle do ist, hilfft kein Arztney.”
\item \textsuperscript{441} Ibid., fol. 126r: “So Gott nicht wil, kan ich nicht.”
\item \textsuperscript{442} Ibid., fol. 115v.
\item \textsuperscript{443} “Hydrops et quartana medicis sunt scandala plana”, Handschi noted (Cod. 11206, fol. 105r).
\item \textsuperscript{444} Cod. 11240, fol. 42r.
\item \textsuperscript{445} Galen, Opera (1822), vol. 18, pp. 59–61.
\item \textsuperscript{446} Cardano, De malo (1536), pp. 8–9.
\item \textsuperscript{447} For a detailed study see Stolberg, Cura palliativa (2007); Stolberg, Geschichte (2011),
\item \textsuperscript{448} pp. 21–42.
\item \textsuperscript{449} Chauliac, Chirurgia (1559), foll. a2(v)-a3(v), “cura larga, praeservativa, et palliativa”; cf.
\item \textsuperscript{447} Chauliac, Inventarium (1997).
\item \textsuperscript{449} Vigo, Workes (1543), fol. 43v, “we wyll speake of his cure aswel eradicatyue as palliatyue”.
\item \textsuperscript{450} Cod. 9666, fol. 43v; Cod. 11205, fol. 223r; Cod. 11206, fol. 135v; Cod. 11207, fol. 32r.
\item \textsuperscript{451} Cod. 9666, fol. 43v: “Wenn man ym Scheyn heylet”.
\end{itemize}
if a causal treatment that attacked the root of the disease was not possible, a “palliative” treatment became the means of choice, a duty even.

According to Vigo, there were some cases in which powerful remedies that targeted the disease cause would potentially kill the patient, while mitigating, flattering remedies – these were usually called “paregorica”\textsuperscript{452} or “mitigantia”\textsuperscript{453} – could prolong his or her life and take the pain away.\textsuperscript{454} Especially for patients with a cancerous ulcer, forgoing a causal treatment – here usually a dangerous and rarely successful surgery – was recommended.\textsuperscript{455} But also with consumption, with indurated tumors, with hidden cancer that had not yet penetrated the skin, and similar illnesses, the well-known Italian physician Girolamo Cardano cautioned that a causal treatment would do more harm than good and came with the great risk of ending patients’ lives before their time. Vehemently, he denounced the “not so few” physicians who attempted a curative treatment here in spite of the danger. Some, he said, acted in this way because they did not want to believe that these diseases were incurable or at least hoped to bring about an improvement. But others, which was worse, were guided by their thirst for glory or by greed. He concluded that in such cases a mitigating treatment was indicated instead, one that did not weaken the patient, did not advance the disease and instead calmed the pain.\textsuperscript{456}

The concept of the “palliative” treatment allowed physicians to continue attending to patients in good conscience and, though this might not be their primary goal, they could still count on being rewarded, even when the prospect of a successful outcome was remote. Yet, in practice physicians were often faced with a dilemma. With a palliative treatment that focused on the symptoms, they were able to reduce patients’ suffering and ideally even prolong their lives. Yet, in a world in which the success and the reputation of a physician hinged on the outstanding cures attributed to him, treating incurable patients was fraught with risk. Even if the physician, speaking frankly at least to the relatives, conveyed the impossibility of curing the patient or even predicted imminent death, he always had to be prepared for the possibility that people would lay part of the blame on him and would believe that another healer might have been able

\textsuperscript{452} Cf. Houllier, De morborum (1572), fol. 136r.
\textsuperscript{453} Cf. Castelli, Lexicon (1598), p. 307.
\textsuperscript{454} Vigo, Workes (1543), fol. 43v.
\textsuperscript{455} Arcaeus, De recta (1574), pp. 99–101 and p. 102; Staatsbibliothek Bamberg, Ms. JH msc. med. 9, Nr. 8, undated account of a consultation by Venetian physicians and surgeons on a 83-year-old patient with a (presumably cancerous) tumor on his nose.
\textsuperscript{456} Cardano, De malo (1536), pp. 8f; in his notes, Handsch quoted from this work (Cod. 11205, fol. 405r).
to avert the unfavorable outcome. This danger was especially great for younger physicians who still had to establish a good reputation for themselves. They could almost count on having patients come to them who were more likely to do badly or indeed die in their care, after they had already tried their luck with other physicians in vain.

The radical solution to this dilemma was to refuse these patients as a matter of principle. “Do not accept incurable patients if you want to protect your reputation”, Handsch wrote after reading the famous Giovanni Manardi. Giovanni Battista da Monte likewise cautioned his students not to accept desperate cases in the early days of their medical practice. Both were leading proponents of medical humanism, which held the classical authorities in great esteem, and in fact they were able to refer to them in this point. The position that physicians should not treat incurable patients had already been stated in the writings of Hippocrates and the Roman encyclopedist Celsus, who enjoyed great currency in the sixteenth century.

However, when Hippocrates and Celsus voiced these concerns, it appears they mainly had the wellbeing of the patients and their relatives in mind who would be spared senseless interventions and expenditures. And early modern physicians could also find passages in the Hippocratic writings in which the treatment of incurable patients was not rejected but was rather explicitly deemed the task of the physician. Not only this: the classical physicians were heathens. For a Christian physician, it would have been all the more unseemly to abandon the incurably ill to their fate. Leading physicians at the time, including Guido Guidi (1509–1569), Baptista Codronchi (1547–1628), and Orazio Augenio, declared it a high duty to assist patients even if their disease was incurable and death was on the doorstep. As Laurent Joubert in Montpellier admonished his students, physicians lacked humanity if they believed that desperate cases should be left alone: love and piety, not striving for fame and money should guide their actions. Certainly, they were to forego powerful remedies like purgatives and bloodletting so as not to create the impression that they had hastened the death of the patient, which would discredit the medical remedies that helped so many. But Joubert

457 Cod. 11200, fol. 126r: “Ne suscipias morbos incurabiles, si famae tuae consultus esse cupis.”
458 Da Monte, Consultationum (1565), col. 458.
461 Guidi, De curatione (1626), p. 121; Codronchi, De christiana ratione (1591), p. 24; Augenio, Epistolarum (1602), fol. 87v; on Codronchi see also Bergdolt, Gewissen (2004), pp. 173f.
held that nothing could be said against mild remedies that alleviated the disease and supported nature, all the more so as often one could never be completely certain about an infaust prognosis.\textsuperscript{462} Several decades later, Paolo Zacchia, personal physician to two popes, summarized this position when he wrote that humanity and Christian piety did not permit the physician to disregard people who asked for medical help by categorizing them as desperate cases. Rather, the physician had to take care of them and give them hope. If he could not cure the disease, he must at least fight its progression and alleviate the complaints that commonly made such diseases unbearable, through the use of medicines or at least by prescribing a suitable diet.\textsuperscript{463}

We have little knowledge of how physicians in daily practice dealt with the dilemma sketched out above, how they dealt with incurably ill people. But the problem must have come up frequently. Illnesses like consumption and dropsy were widespread. Not surprisingly, Handsch brought up the subject repeatedly in his notebooks, and his notes about specific cases show which course of action he and his colleagues adopted with incurably ill patients. The resulting picture is complex and in some respects contradictory.

Whenever Handsch wrote explicitly about the treatment of incurable patients, his position was unambiguous: his concern about damaging his reputation and medical authority prevailed. As a student, Handsch had already noted down the cautionary words, “Do not take on incurable illnesses”,\textsuperscript{464} and he would remind himself of them often in subsequent years,\textsuperscript{465} in part made wiser by painful experience.\textsuperscript{466} His teacher Lehner, Handsch found, followed the same principle and never accepted someone as a patient when he knew that the person suffered from an incurable disease.\textsuperscript{467} Lehner had treated the above-mentioned old man called Hosska, who suffered from asthma; but then he discontinued treatment, true to his guiding principle.\textsuperscript{468} In the case of a man called Wisktanski, who suffered an acute stroke and was gasping for air, Lehner deliberately did not follow what would have been considered proper medical protocol (“secundum artem”) for patients suffering from acute shortness of breath; he did not bleed

\begin{footnotes}
\item\textsuperscript{462} Joubert, Oratio (1580), p. 15.
\item\textsuperscript{463} Zacchia, Quaestiones (1651), p. 393.
\item\textsuperscript{464} Cod. 11240, fol. 42r: “Incurabiles morbos non suscipere.”
\item\textsuperscript{465} Cod. 9666, fol. 27r: “Deplorata non sunt curandi”; Cod. 11205, fol. 268r: “Morbos incurabiles noli suscipere, ne merearis nomen mali medici”; similarly ibid., fol. 528v and fol. 690v.
\item\textsuperscript{466} Cod. 11205, fol. 690v.
\item\textsuperscript{467} Ibid.; see also ibid, fol. 236v and fol. 255v.
\item\textsuperscript{468} Ibid., fol. 255v.
\end{footnotes}
him, because the relatives would have blamed him for the predictably unfavorable course. Struggling for air, the sick man suffocated within a day.\(^{469}\)

As we begin to see here, a physician who needed to decide whether a disease was in fact incurable usually had to see the patient or follow the patient for a certain amount of time. It was therefore unavoidable that he would accept some patients whose disease ultimately proved to be incurable. But his guiding principle told him that when it became obvious that the disease was incurable, it was time to part company with the patient. It appears this happened regularly. Again and again we read of patients who were said to have been “abandoned” or “given up on” by their physicians or other healers. Sometimes such accounts refer to cases in which the author himself did not give up. By underlining the unfavorable prognosis given by his colleagues, he was all the more able to demonstrate his own therapeutic ability.\(^{470}\) But there are also other examples, including in Handsch’s private case notes, that show how physicians did in fact leave incurably sick patients to their fate at some point.

This was primarily the case for people suffering from the symptoms of consumption or, closely related, of an empyema, a collection of pus in the lungs. Considered by many to be consumptive, a young man from the accounting office at the Angel’s Garden in Prague, for example, was abandoned by the physicians after months of unsuccessful treatment. However, when Handsch saw the pale and emaciated patient, he suspected nothing more than an obstruction of his entrails, especially the spleen. He gave him some medicinal herbs and the young man recovered.\(^{471}\) When the consumptive wife of Korzaur, a mother of four, was being treated, all other physicians gave up hope when she began coughing up blood. Handsch continued to see her for several more weeks, but then he too “abandoned” her and she died soon after.\(^{472}\) He likewise “abandoned” – as he put it himself – a chef who had been suffering from an empyema or consumption for three months. Handsch’s experienced colleague D. Kunstat also did not expect that the man would recover.\(^{473}\) Gallo, by Handsch’s account, did not leave a severely emaciated dropsical man by the name of Gregor to his

\(^{469}\) Ibid., fol. 236v.
\(^{470}\) See also Cod. 11238, fol. 97v, on a poor patient in the hospital in Padua whom Trincavella treated by dietetic means only, after he had been “relinquished” by other physicians (“ab aliis medicis relictus”) and Cod. 11251, fol. 37v, on the report of a physician by the name of Florianus who successfully cured a boy with dysenteria in the hospital in Bologna, whom all physicians had “relinquished”.
\(^{471}\) Cod. 11183, fol. 136r.
\(^{472}\) Cod. 11183, fol. 81r, “postea reliqui ipsam”.
\(^{473}\) Ibid., fol. 80v; after several months, the patient was still suffering but when Handsch encountered him again, three years later, he appeared to be cured.
fate, but he visited him infrequently and neglected to administer his medication properly. He, too, ultimately died.\textsuperscript{476} In the case of an old peasant woman who developed a large, festering tumor, it was the barbers who refused to give her what would have been primarily a surgical treatment.\textsuperscript{475}

At the same time, Handsch repeatedly documented the continued medical treatment of patients for whom there remained no realistic hope for a cure, revealing contradictions in the approach to incurable patients. The dropsical Moritz, for example, had a bloated belly, a sunken-in face, discolored yellow eyes, and a cough. Gallo stated that the cough was a bad sign as it indicated water in the lungs. Gallo, who had been seeing Moritz for four weeks with Handsch, gave him juice of iris despite the grim situation and on the following day merely expressed his regret that the remedy had only shown a mild evacuative effect. The patient died in the night.\textsuperscript{476} Neither did Handsch relinquish his treatment of a dropsical man called Krafft until the patient died, even though he was coughing up blood and evacuating great amounts of blood with his stool and in the end needed to be sitting upright to breathe properly.\textsuperscript{477} Handsch also helped the severely ill Balthasar Hirschberger until the man was prepared to reconcile with his brother and could receive his last rites.\textsuperscript{478} And Willenbroch continued to treat the little son of Kaspar von Müllenstein with arum root when the patient was no more than skin and bones, his belly swollen, his face sunken in, and his breath stinking. The boy’s death struggle went on for a day, and then he died in convulsions.\textsuperscript{479}

One reason to continue treatment with patients who were by all appearances incurable, and even with the obviously moribund, was the possibility of misjudgment. “Nota bene: many emaciated [patients] healed”, we can read in Handsch’s notes.\textsuperscript{480} He was telling himself that if he saw the signs of emaciation or dropsy, he was not to give up hope too soon. He then listed examples of patients who recovered against all expectations, like a dropsical postmaster whom Gallo had cured.\textsuperscript{481}

\textsuperscript{474} Cod. 11207, fol. 214r.  \textsuperscript{475} Cod. 11183, fol. 22r.  \textsuperscript{476} Cod. 11207, fol. 70r-v.  \textsuperscript{477} Cod. 11183, foll. 394v-395r; Handsch stopped visiting him for eight days but the reason was apparently not that he had given up hope.  \textsuperscript{478} Cod. 11183, foll. 108v-110v.  \textsuperscript{479} Ibid., fol. 479v.  \textsuperscript{480} Cod. 11205, fol. 265v: “Merke: viele Abgezehrte geheilt”.  \textsuperscript{481} Ibid., fol. 266r.
In other cases, the main reason why physicians continued their visits was a different one, and they sometimes stated it explicitly: they pursued a palliative treatment to relieve the patient’s suffering. “With diseases that are difficult to treat, do a palliative treatment,” we read in Handsch, who pointed to how Galen approached consumption.482 When the “whore” (“meretrix”) who lived next door vomited feces – this was called miserere and still today is known as the dramatic sign of an often fatal bowel obstruction – Ulrich Lehner stated that she would die but nevertheless gave her an enema.483 Handsch himself praised a salve “for the palliation of leprosy”.484 And to the terminally ill young Friedrich von Kunritz suffering from heavy dysentery he gave common hound’s-tongue (cynoglossum) for the pain, the insomnia, and the diarrhea.485 For a sixteen-year-old severely dropsical boy in Bruderhaus in Innsbruck, Handsch prescribed antimony and a diuretic remedy. The boy’s legs became less swollen and he felt “lighter in the chest”. But then he no longer wanted to take the somewhat oily diuretic. His condition worsened and he died several weeks later.486

The most important palliative was opium, used as an analgesic and, depending on the case, as an antidiarrheal. Even if it amounted to no more than a “cura palleativa”, wrote Handsch, the physician could sometimes give an opium preparation “for his own honor”.487 Using such a preparation, called philonium, Mattioli was able for a while to mitigate the pain of Hieronymus, who was suffering from severe colics. The pain returned, and the sick man wrote his last will and prepared himself for death but after a second dose of philonium the pain receded and he recovered.488 Handsch gave a dropsical patient who already had water running out of his legs a remedy with opium for the pain; he died soon after.489 Gallo had told Handsch that he had done a “curam palliatiavam” in dysentery cases (“dysenteria”) and had received “much praise” (“multam laudem”).490

From the study of Handsch’s notes, the question of whether physicians at the time took on incurably ill or terminal patients or continued treatment when patients turned out to be incurably or indeed terminally ill can thus not be answered with a clear yes or no. Rather, what emerges is that even one and the same

482 Cod. 11240, fol. 36r.
483 Ibid., fol. 37r.
484 Cod. 11200, fol. 4v, “ad palleationem leprae unguentum”.
485 Cod. 11183, fol. 106r.
486 Ibid., fol. 443r.
487 Cod. 11205, fol. 223r.
488 Cod. 11183, fol. 322r.
489 Ibid., fol. 46r.
490 Cod. 11207, fol. 32r.
physician attended to some of these patients, hoping to heal them or mitigate their agony, while with others he discontinued treatment and “abandoned” them.

At the Deathbed

As we see from some of the aforementioned cases of chronic, incurable illness, death had a strong presence in quotidian medical practice, a very strong presence even, not only in times of plague. In this respect, the collections of published medical curationes and observationes paint a picture that is substantially removed from reality. They report fatal outcomes only very exceptionally. This was a deliberate choice. Understandably, their authors or publishers selected cases for publication which allowed the reader to learn about the successful treatment of even serious diseases and which at the same time shone a light on the exceptional ability of the attending physician. Handsch’s personal notes, by contrast, paint a different, much more differentiated picture. When treating patients with serious, acute illnesses, physicians frequently had to expect fatal outcomes.

To be sure, Handsch had decided that, as a matter of principle, he would not treat patients who were close to dying, so people would not attribute the cause of death to him.491 They might otherwise say, “No sooner did he give him the medicine, he died”.492 Gallo had advised him early on that when the physician, realized that the illness was stronger than the body, than nature, he should hand the case over to the clergyman.493

However, this assumed that the physician could be certain that the patient would succumb to his disease, and in many cases, it was hardly possible to attain this certainty. Physicians could consult the vast medical literature written since antiquity, which named the characteristic signs of approaching death. In 1601, Prosper Alpinus (1553–1616) dedicated an entire volume to them.494 There was the above-mentioned miserere,495 and the famous facies hippocratica,496 the sunken-inface of the dying. Pointed and cold was the nose of the dying Frau Lehner, Handsch learned from her son who was a physician himself. Her upper lip was pale, her lower lip reddened.497 Medical laypeople, too, were familiar with some

491 Cod. 11240, fol. 42r: “Item extreme affectu propinquum morti non medicatur, ne deinde mortis causam tibi ascribunt.”
492 Cod. 11205, fol. 202r: “So bald er ym die Ertznei geben, ist er gestorben.”
493 Ibid., fol. 271r.
494 Alpinus, De praesagienda vita (1601).
495 Cod. 11210, fol. 93r; Cod. 11240, fol. 37r.
496 Cod. 11205, fol. 301v.
497 Cod. 11183, fol. 47v.
characteristic signs. Handsch found them noteworthy, writing for example, that bystanders at the sickbed interpreted the rattling breath of a severely ill person as a deadly sign,\(^498\) as they did with sustained hiccoughing: “[when] a person is sick and gets a hiccough that lasts twenty-four hours or longer, it is a true sign of death”.\(^499\) When a young nobleman was dying, the wife of Handsch’s mentor Collinus even believed that she was able to feel how his breath was cooler than usual when she put her hand in front of his mouth.\(^500\) In several instances, Handsch wrote down the popular belief that someone who started to pluck non-existent crumbs from the bedspread was close to dying.\(^501\) From Archduke Ferdinand II he heard, however, that “picking at the bedding” was not a sure sign.\(^502\)

As aware as a physician might be of such signs in theory, it remained difficult or even impossible to predict death with certainty at the sickbed, let alone determine the likely time of death. Mattioli was still treating an archducal preacher with antimony two days before the man’s death, and only when he saw him with Handsch on the evening before his death did both physicians predict the fatal outcome. The patient made his confession and died that same night.\(^503\) Sometimes, the physician was called only when the patient was already in the throes of death. Handsch described repeatedly how he arrived at a patient’s home and the patient was agonizing or already breathing his last breath. The old Baron von Meseritz had been lying in bed with his eyes closed for days when Handsch and a colleague – likely the Prague physician Thaddeus Hagecius of Hajek\(^504\) – were called to see him. He was wheezing and his feet were twitching, and he died that same night.\(^505\) Handsch also found Kekeritz, who was suffering from fever and pleuresia, with his eyes already half closed, “as if the light had gone out of them”. Struggling for air, he lay in agony. Handsch stayed with the sick man who was not ready to accept that he had to die. Finally, he “took a deep breath” and they brought him the light – evidently the sacramental candle. He was dead a short while later.\(^506\)

Accounts like these also illuminate how, in the care for the dying, spiritual and physical support were connected and the lines between the two were blurred.

\(^{498}\) Ibid., fol. 454r; the patient ultimately survived.
\(^{499}\) Cod. 11240, fol. 108v, “[wenn] eyner die Krankheit hett, unnd kem yn ein Kluxen an unnd werete 24 Stunden aber [oder, M.S.] mehr, das ist ein gewarlich Zeichen des Todes.”
\(^{500}\) Cod. 11205, fol. 270r.
\(^{501}\) In the case of sick Kretzel, for example, a certain Hensel said, “when he starts picking at his bed, it is over” (Cod. 11205, foll. 127v-128r, “wenn er wirt am Bette klauben, so ist es aus”).
\(^{502}\) Cod. 11183, fol. 350v, “am Bette klauben”.
\(^{503}\) Ibid., fol. 196r-v.
\(^{504}\) Handsch recorded only the first name, Thaddeus.
\(^{505}\) Cod. 11183, fol. 259v.
\(^{506}\) Ibid., fol. 27r and fol. 28r, “wie sie ym gebrochen weren”; “eynen grosen Athemzug”.

The Physician-Patient Relationship
In historical research it has often been assumed that the physician yielded the floor to the clergyman when things came to an end – as we saw with Gallo’s advice. Handsch’s notes and other contemporary sources tell a different story. They show that it was not uncommon for physicians to continue their treatment until the very end, and that sometimes they even stayed at the deathbed when the clergyman came to administer the last rites. The reasons are plain to see. If one wanted to prevent a severely ill patient from dying without receiving his last rites and spiritual support, it was essential to call the clergyman, even if one was not sure that the patient would actually die soon. At the same time, given this prognostic uncertainty, especially with acute illness, it was certainly possible that the medical treatment would show a positive effect after all. Simply breaking it off would have been irresponsible. In striking contradiction to his plan to treat incurable patients, Handsch even declared that one should “not abandon a person as long as he is still breathing because spiro, spero, and thus we want to do our best and send to the apothecary”. He may have found such words useful, of course, to convince the bystanders of the necessity of continuing treatment, which in their eyes had become meaningless and therefore an unnecessary expense. Even in the case of the dying Hosska, whose death he did not predict, a case in which Handsch was cursed for his luckless efforts, he argued that he was not allowed to leave him, because as long as “he breathes, one is not to abandon a person”. To make sure that the patient “was not robbed of human help”, Handsch, Andrea Gallo, and Adam Lehner treated an apoplectic man according to the rules of the medical art (“quae praescribit ars”), though they had little hope. The man died as expected.

Handsch witnessed several times how a sick person ate what was believed to be his last supper, received his last rites, and then lived on. After a girl, in Ambras, who was expectorating blood had received her last rites, they had already opened the windows to make it easier for her soul to leave the house. Handsch, too, had given up hope. And yet, the girl recovered.

With dangerously ill princes and other important figures, whose death would have far-reaching consequences for numerous people, even for an entire territorial dominion or a religious movement, it seems that physicians routinely left nothing

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507 E.g. ibid., fol. 47v, on Mattioli’s treatment of the dying wife of Ulrich Lehner.
508 Cod. 11205, fol. 420v, “einen Menschen nicht verlassen, weil [dieweil, solange, M.S.] er Athem hat, denn spiro, spero, darumb wollen wir thun das best, als wir können, wollen ynn die Apothekenn sennden”; similarly ibid., fol. 213r.
509 Ibid., fol. 255v, “er Athem hat sol man keynen verlassen”.
510 Cod. 11183, foll. 245v-246r; Handsch recorded only his colleagues’ first names, Adam and Andreas.
511 Ibid., fol. 448v.
untired to keep them alive as long as possible, even when they were clearly dying. The death of Philipp Melanchthon offers a vivid example. According to the account written by his personal physician, the sixty-three-year-old was close to dying. His pulse was becoming weaker, his extremities cold. He lost consciousness several times and the physicians tried, successfully at first, to bring him back using quickening, stimulating agents. When he regained consciousness, he said, as was later reported: “Ah, what are you doing? Why do you hinder my gentle peace? Just leave me my peace until the end, it won’t be long now.” He died soon after.⁵¹²

Sometimes physicians and clergymen worked amicably together in attending to the spiritual and physical needs of the dying. A good example here is the deacon Johann Altenburger’s detailed description of the death of Countess Anna von Sachsen, who was only forty-five years old. When the deacon was called to Coburg eight days before Anna’s death to see the severely weakened woman who was plagued by coughing and vomiting, he came with the physician Michael Schön. Schön prescribed various medicines but then had to leave to attend a wedding. Anna took the medicines when they arrived from the apothecary’s shop. But an hour later her face changed color and she became very fearful; she lost her speech and believed she was suffocating. When she recovered, she asked the deacon whether she should take the remaining medicine. He advised her to wait until the following day. This was when Schön came back and prescribed her different remedies, “which she praised highly, because they did her good”. She had told the deacon several times that she would not “refuse proper remedies, so people could not say she was headstrong”. And she stuck to this position. “If it helps, I will have God to thank, if not, I can hope for better things to come.” When she was given a syrup to soothe her, she was unwilling to drink it. Now her condition deteriorated. She developed a strong sense of pressure in her chest, had several convulsive fits, and said things like, “I wish I were dead” or “Dear God, come and take me now”. When the physician and the deacon spoke to each other in Latin in her presence, she asked them to speak openly: “I won’t live long now”. She died the following night. As is clear from this, the physician in no way gave up his place for the clergyman. He remained at the bedside until the sick woman finally rejected his medicines.⁵¹³

⁵¹² Müller, Philipp Melanchthons letzte Lebenstage (1910), with an edition of this account, ibid., pp. 47–87: “Ah, was macht ir, warumb hindert ir mich in meiner sanfften Ruhe? Lasst mir doch mein Ruhe bis an mein End, es wird nicht mehr lang weren.”
⁵¹³ Thüringische Universitäts- und Landesbibliothek, Jena, Ms. Prov. fol. 26 (16), foll. 375v-392v.