Published by Peter Lang in 2007, *The Impact of Hospitals 300–2000* (ed. Henderson, Horden and Pastore) comprised a selection of the papers delivered at two conferences (in 1999 and 2001) that were organised by the International Network for the History of Hospitals (INHH). The present volume, based on the Network's 2009 Barcelona conference, offers a new, wide-ranging collection of papers on the theme of 'Hospitals and Communities'. It discusses a select group of hospitals and communities, including those based in Europe and the Americas, from three main perspectives: isolation and disease, communities and the poor, and war and hospitals.

The subject of community has been researched extensively by sociologists and anthropologists, less so by historians. The 2009 conference challenged participants to consider the idea of community in relationship to the hospital and, particularly, to reflect on how historians should approach the wide range of communities that continue to be shaped by the work of these institutions. Collectively, the case studies in this volume demonstrate that navigation of the history of hospitals requires an understanding of the societies in which these institutions operated. In other words, hospital histories are not just stories about medical institutions; they offer considerable insight into the communities in which they were situated and with which they intersected.

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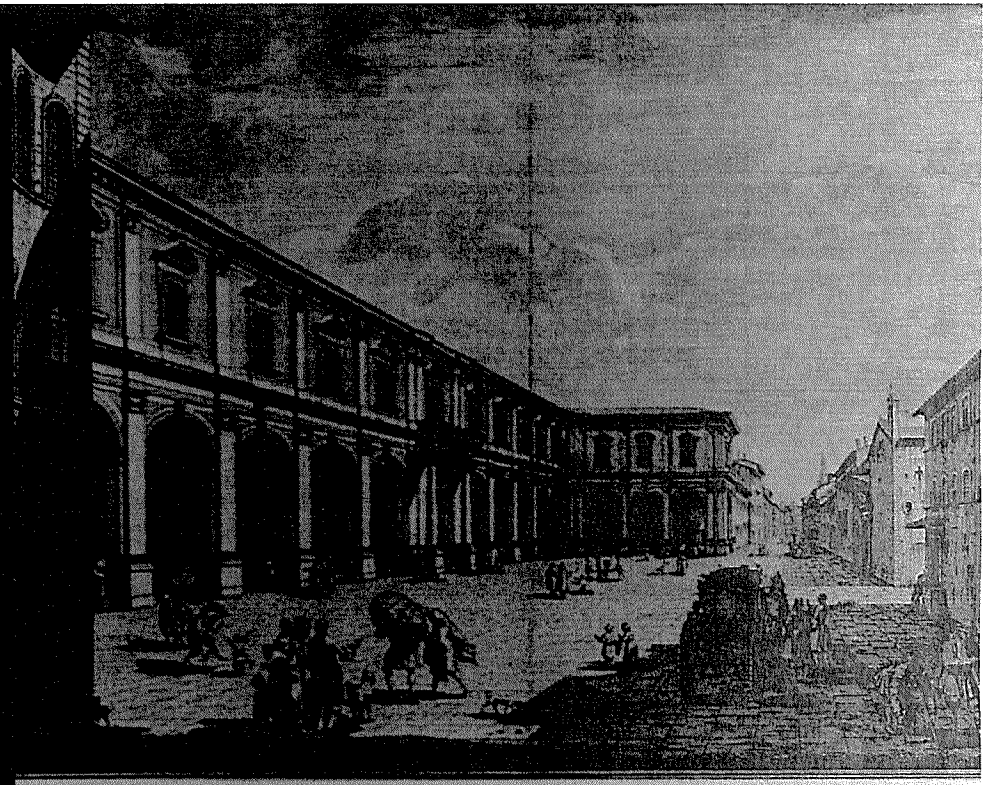

HOSPITALS AND COMMUNITIES, 1100–1960

Edited by Christopher Bonfield, Jonathan Reinarz and Teresa Huguet-Termes

LAURINDA ABREU

The Portuguese Hospitals under the *Misericórdias'* Confraternities (16th–18th Centuries): Community or Crown Control?[1]

Introduction

By the end of the fifteenth century, in line with events that were unfolding throughout the rest of Europe and in response to the emerging concept of the 'deserving poor', Portugal had not only undertaken a systematic reform of its hospitals, but had also developed novel formal arrangements for charitable and welfare provision. Framed by the religious values of charity and mercy, these measures established new patterns of social welfare, aimed at responding to the new socio-economic conditions, the nature of poverty and political concerns. The defining element of the Portuguese experience was the dominant role played by a new lay confraternity – the confraternity of the *Misericórdia* – proclaimed by the crown from the outset as the main pillar of this untried charitable framework. The first Portuguese *Misericórdia* was officially created in Lisbon on 15 August 1498, under the patronage of the king, D. Manuel I. It was composed of members of the city elite, such as nobles and wealthy merchants, and those among the higher guild orders of tradesmen and skilled artisans. The model of the Lisbon *Misericórdia* spread rapidly throughout the country; by the time of the king's death in 1521, there were seventy-seven *Misericórdias* in Portugal and its empire. They increased in number to more than 200 by 1580 and, by 1640, there were more than 300. All of them followed the same set of

1 I would like to thank Jill Francis, University of Birmingham, for having translated this paper and for offering suggestions.

rules (*compromisso*) and ordinances, and had identical social aims. Mainly, these corresponded to the fourteen works of mercy (seven spiritual and seven corporal), and especially favoured the general care of the poor and, in particular, prisoners and the sick.[2]

From the establishment of the *Misericórdias* up to the point that they were transformed into the most important institutions of health care and poor relief in the second half of the sixteenth century, two interconnected events were of particular importance. The first was that the *Misericórdias* were recognised by the Pope at the Council of Trent in 1563 as confraternities under royal patronage, and that they were outside the jurisdiction of the Church, except in matters that directly concerned religion.[3] The second event was the crown's decision, in 1593, to formalise the quasi-monopoly of the *Misericórdias* regarding the administration of institutional poor relief and health care practices. This involved a very strong component of outdoor relief, including administering medical services to the deserving poor. Once the Papacy at the Council of Trent had made *de iure* what was already *de facto*, the crown, either through its own initiative or at the request of the confraternities, systematically transferred the administration of the civil hospitals to the *Misericórdias*. The handover of the Lisbon central hospital, the *Hospital de Todos os Santos*, to the Lisbon *Misericórdia* in June 1564 was the defining moment of the process initiated by D. Manuel I.[4] In contrast to events that had occurred in other countries such as France, there was no opposition in Portugal, either from the local church or from Rome, to impose the canons of the Council of Trent relating to the bishops' authority over the hospitals.[5] At the same time as the hospitals were being transferred to the *Misericórdias*, legislation was introduced that permitted the incomes allocated for the celebration of perpetual masses and other pious legacies to be used to support the care of the poor and sick. Further, it is important to note that the Council of Trent reaffirmed the doctrine of purgatory, thereby increasing the wealth of the institutions responsible for this act of intercession, once the masses were paid. In Portugal, the crown, supported by the papacy, tried to direct the investment in the doctrine of purgatory to the *Misericórdias*, establishing an economically sustainable provision of poor relief and health care in the country.[6] In fact, this was probably one of the most important effects of the Counter Reformation as related to health care and poor-relief in Portugal.

The royal document of 1593, which confirmed the 1591 bull from Pope Innocent IX that had accepted the Portuguese crown's request for the concentration of charitable works in the *Misericórdias*, represents not only a moment of consolidation for the *Misericórdias*, but also a reaffirmation of crown authority over them.[7] From this point onwards, as far as the institutional administration of poor relief resources was concerned, the role of all the other confraternities and the religious orders in Portugal was marginalized.[8] In short, by the time that Portugal was governed by the Habsburgs (1580–1640), all of the circumstances set out above led to a new chapter in the history of Portuguese early-modern health care, and poor relief strategies.

Having set out the broader picture, this chapter will now focus on the particular relationships between three specific communities: the crown;

2 *Compromisso da Misericórdia de Lisboa*, de 1502, in I. Carneiro de Sousa, *Da fundação da Misericórdia à fundação das Misericórdias (1498–1525)* (Porto, 1999), p. 241.

3 L. Abreu, 'Defining the Poor: Between Crown Policies and Local Actors (Évora, 16th–17th Centuries)', in P. Bourdelais and J. Chircop (eds), *Vulnerability, Social Inequality and Health* (Lisbon, 2010), p. 78.

4 The central hospital – Hospital de Todos os Santos – was Lisbon's main hospital, created by royal order in 1492, by the amalgamation of the small hospitals and hospices existing in the city. In 1564 it was transferred to the Misericórdia administration.

5 The conflicts that developed in France, and for the same reasons, resulted in a different response to the council canons. In this context, the Portuguese situation deserves being analyzed further. See J. Imbert, 'Les prescriptions hospitalières du Concile de Trente et leur diffusion en France', *Revue d'histoire de l'Église de France*, 42 (1956), pp. 5–28.

6 L. Abreu, *Memórias do Corpo e da Alma. A Misericórdia de Setúbal na Modernidade* (Viseu, 1999), pp. 153–72.

7 L. Abreu, 'Misericórdias, Estado Moderno e Império', *Portugaliae Monumenta Misericordiarum* (forthcoming).

8 L. Abreu, 'As Misericórdias portuguesas de Filipe I a D. João V', *Portugaliae Monumenta Misericordiarum* (Lisbon, 2002), pp. 47–77; eadem, 'Misericórdias: patrimonialização e controle régio (séculos XVI e XVII)', *Ler História*, 44 (2003), pp. 5–24.

the *Misericórdias'* hospital administrators; and the *Misericórdias'* hospital patients. It is important, however, to point out that this approach is different from that adopted by others, notably Léon Lallemand and Christian Paultre.[9] In their study of hospital politics in seventeenth-century France, they set out the case by which an all-powerful and almost absolutist crown was able to deeply transform both the nature of poor relief and the provision of health care resources. Further, it differs too from that advocated by Jean-Pierre Gutton or even by Jean Imbert.[10] Instead, my approach, which is based on extensive empirical evidence, will argue that the crown in sixteenth-century Portugal was able to create a whole welfare *system* based not only on the support of the popes, but also on the deep involvement of the local elite, based on an elaborate process of negotiation. The way this process was directed strengthened the authority of the royal government by reinforcing its presence in local communities.

In order to better illustrate my central argument, it is first necessary to address the issue of how the hospitals fitted into the general structure of the organization of poor relief and formal health care in this period; in other words, how they were integrated into the social and institutional framework gradually transformed by the Portuguese crown between1498 and 1593. I will briefly set out the chronology of the most important events relating to this topic, starting with the hospitals themselves. This is not only because the hospitals were the most numerous charitable institutions in existence at the beginning of the early modern period (as well as being the most important suppliers of institutional aid until the eighteenth century), but also because as soon as the political authorities began to tackle the relief of the poor as a political issue, they became the first targets of such intervention.

9 Cited by T. McHugh, *Hospital Politics in Seventeenth-Century France: The Crown, Urban Elites and the Poor* (Aldershot and Burlington, 2007), pp. 2–3.

10 Jean-Pierre Gutton, *Société et les pauvres: L'exemple de la généralité de Lyon, 1534–1789* (Paris, 1970). See also J. Imbert, *Les hôpitaux en France* (Paris, 1996).

The Crown as Main Organizer of the Portuguese Poor Relief and Health Care *System*

The way in which Portugal provided hospital care in the first decades of the fifteenth century was similar to that experienced throughout Europe. The first official information on the subject appears in a book written by king D. Duarte's brother, D. Pedro, following his journey around Europe between 1425 and 1428.[11] Almost certainly influenced by the examples he observed, the prince suggested to the king that he should assume some responsibility in the field of poor relief, drawing his brother's attention to the need of hospital reform. Part of D. Pedro's advice was taken into account by the crown in the demands put forward in Rome in 1432: the reform of hospitals was not only highlighted, but so too was the importance of having new forms of hospital administration, which included self-management and local administration free from interference from the local bishops. In fact, this proposal had been already implicit in the final text of the Council of Vienne of 1311, and was also later applied by the Portuguese crown in the *Regiment of the Hospitals and Hospices of Évora* in 1470.[12] This resulted in the complete reorganization of the governance of the health care and poor relief institutions in Portugal's second largest city.[13]

From then onwards, several attempts were made by the crown to disseminate the same policy throughout other cities, but this was often met with strong opposition from the local members of the clergy. It was only after the bull dated 21 February 1486, which enabled the king to implement hospital reform on a national scale, that the process actually started.

11 *O Livro da Virtuosa Bemfeitoria do Infante Dom Pedro*, ed. Joaquim Costa (Porto, 1940), Book. II, cap. IX, p. 86.

12 A. de Gusmão, *Subsídios para a história da Santa Casa da Misericórdia de Évora* (Évora, 1958), first part, pp. 25–9.

13 This subject is developed in L. Abreu, 'As crianças abandonadas no contexto da institucionalização das práticas de caridade e assistência, em Portugal, no século XVI', *Seminário A Infância no Universo Assistencial no Norte da Península Ibérica (séculos XVI–XVIII)* (Braga, 2008), pp. 31–49.

Indeed, the expression of the mutual interests of the monarchy and the papacy, which clearly marginalized the Portuguese prelates, led to its success. What is more, the king argued that he was responsible for the interests of the poor as well as the souls of his dead subjects; yet both were mistreated by the hospital administrators. This was a strong argument that convinced Rome to allow the king to intervene in a subject what was previously under canonical jurisdiction.

Finding themselves accused of jeopardizing the souls of the dead and the expectations of the poor as related to care and relief, several hospital overseers were dismissed and the crown assumed control of the institutions concerned. In a very similar process to that which was unfolding in France, at least from 1496 onwards, the overseers of hospitals and other religious and charitable institutions in Lisbon and its municipality were forced to prove the privileges for which they claimed, a course of action extended to the whole country at the beginning of the sixteenth century. In 1498, a central body – the 'Judgment of the Chapels' (*o Juízo das Capelas*) – was created, with extensive executive powers over the religious foundations, thereby institutionalizing royal control over them. Meanwhile, the crown was sending officials with legal training throughout the country to inquire into the state of these establishments, taking with them jurisdictional authority to act over irregular situations.

Such an active intervention resulted in four main consequences: first, a vast inventory of hospitals' properties; second, a wide movement towards hospital centralization; third, the appointment of new hospital supervisors; and, finally, the reform of hospital ordinances or the obligation to use the statutes of the first Portuguese central hospital, the Lisbon *Hospital de Todos os Santos*, which had been created through a substantial process of consolidation of smaller hospitals, initiated in 1492. Integrated into the new national laws that began to be published in 1512 (*Ordenações Manuelinas*), these reforms, and the associated capacity of the crown to intervene in Church matters, acquired juridical legitimacy.[14] Two years later, in 1514, a 136-page document clarified the crown's authority over the government of

14 See *Ordenações Manuelinas* (Lisbon, 1984).

chapels, hospitals, shelters, brotherhoods and leper houses, among other charitable resources and institutions.[15] Its implementation was assigned to the king's representatives in the provinces (*contadores das comarcas*). Among their new responsibilities was the assessment of the behavior of everyone involved with hospitals, whether as administrators or medical practitioners.[16] Consequently, in the interests of proper administration, most of the medieval hospitals under private patronage disappeared, without, as far as is known, any resistance from their overseers.

Thus, from the beginning of the sixteenth century there was obviously a clear desire on the part of the crown to endow the country with specialized medical institutions organized along the same lines as the main Lisbon hospital,[17] which in turn followed the principles of the Santa Maria Nuova Hospital in Florence.[18] Moreover, this ambition was not without precedence: in 1514, when the *Regimento* (Ordinances) of the *contadores das comarcas* was published, at least 37 *Misericórdias'* confraternities had already been created under the king's directive, providing the crown with a clear indication that it was possible to promote uniform poor relief policies at a national level. Would not the same thing, therefore, be possible with the hospitals? Although hospital reform followed a separate path from the *Misericórdias*– in line with the directives from D. Manuel I – it

15 For religious institutions, see *Regimento de como os contadores das comarcas hã de prover sobre as capellas, ospitaes, albergarias, cõfrarias, gafarias, obras, terças e resídos* (Lisbon, 1514).

16 The French resistance to a similar process is explored by D. Hickey, *Local Hospitals in Ancien Régime France. Rationalazation, Resistance, Renewal, 1530–1789* (Montreal and Kingston, 1977), pp. 17–44.

17 Several similarities are found between the 1543 edict from François I (in Ibid., p. 21), and the ones from D. Manuel I from the end of the fifteenth century and 1502.

18 As Katharine Park and John Henderson point out in the case of the Santa Maria Nuova hospital, Florence, we can not assume that the ideal order presented in the hospital statutes 'corresponded in every detail to acute practice': '"The First Hospital Among Christians": The Ospedale di Santa Maria Nuova in Early Sixteenth-century Florence', *Medical History*, 35 (1991), pp. 164–88. For the medical attributions of this hospital, see J. Henderson, *The Renaissance Hospital. Healing the Body and Healing the Soul* (New Haven and London, 2006).

was nevertheless the same king that started to hand over some hospitals to the *Misericórdias*, clearly considering them to be appropriate institutions to manage the hospitals. As mentioned before, this movement gathered momentum after the 1560s, when the local elite, initially reluctant to become involved in the royal confraternities, became convinced of their social and political importance.

The hospitals and the *Misericórdias* were not, however, the only charitable institutions in which the crown intervened directly. Apart from the institutionalization of civic responsibility towards the care of foundlings, as stated in the 1512 Ordinances that were first implemented during the reign of D. João III (1521–57), other welfare policies were also initiated by the royal household or by the king. One example was the setting up of wheat granaries during the 1570s in rural areas in the south of the country. This was based upon the Italian example of the *Monti di Pietà* of loans of cereals to the poor, and predated the French *Mont de Grain* based on the same model.[19] In Portugal, this policy attempted to force rich landowners to lend their cereal to the poor. The second example, further implemented under the auspices of the crown in 1568, the academic training, in the University of Coimbra, of doctors (thirty per year) was extended in 1604 to apothecaries, granted from the rates (the so-called 'doctor's tax') imposed on seventy-four municipalities, with the objective of providing medical support for the benefit of the poor. Within the very complex and elaborate processes developed in order to establish and activate what I have identified as a *medical network*, some features deserve to be highlighted. First, the compulsory taxation set up by the central government in some municipalities, which imposed a contribution towards the academic training of health professionals; second, the establishment of a specific service under the responsibility of the University of Coimbra to collect and administrate these taxes (the *Doctors and Apothecaries' Fund*) and, also, to select the students according to crown directives – that is to say, privileging the applications coming from the tax-paying municipalities. Finally, the appointment of doctors, surgeons and apothecaries who, in the municipalities, were initially involved in the taxation process was also extended to other regions, including several in

19 See Hickey, *Local Hospitals in Ancien Régime France*, pp. 106–7.

the poorest communities.[20] In almost 70 per cent of cases, the salaries of these medical practitioners were paid by royal taxes resulting from local economic transactions; around 20 per cent were paid through municipal incomes, and around 10 per cent by an extraordinary tax (*finta*) from which the privileged groups were exempted.[21] Charging only the poor who were, in fact, the ones that needed free medical support, the *fintas* were avoided both by the central power and the local authorities trying to prevent the lowest social groups from being penalized twice.

Taken together these various manifestations of formal care, including institutions such as hospitals, the *Misericórdias* and the wheat granaries, as well as formal agencies such as the foundlings' support and the academic training of health professionals, made up a consistent network of care marked by one major characteristic: they were all under the auspice of the crown. However, two further important elements have to be introduced into this analysis. The first is the permanent support received by the crown from the Papacy, as already mentioned. This can be explained, on the one hand, by the contemporary political culture, and, on the other, by the fact that in the second half of the sixteenth century, the throne was occupied by a cardinal who was also the 'Inquisidor-*mor*' (Chief of Inquisition) and the Pope's representative, cardinal D. Henrique.[22] However, whether as governor or king, the cardinal D. Henrique did not mix his religious and political functions, and these interventions simply resulted in reinforcing political power over the charitable system. The second point is related to the implementation of royal charitable ideas. In Portugal, as elsewhere, poor relief policies were rooted in the local community: it was the local dominant groups who put into practice the crown's ideals. They did this voluntarily, contributing towards the creation of a national *system*, based on the same institutions, similar practices

20 This 'doctors' tax' was distributed through scholarships granted to the students of the Faculty of Medicine according to a system that compensated commitment and effort, and penalizing those students who failed to attend the classes: L. Abreu, 'Assistance et santé publique dans la construction de l'Etat moderne au portugal', *RHMC* (forthcoming).

21 As this research is a work in progress, these percentages are not yet fixed.

22 The cardinal D. Henrique was acted in regency. He also was the maximum responsible for the Inquisition (Inquisidor-mor).

and pursuing identical objectives. How then was such a broad consensus, and such an efficient mobilization of the local elite, possible?

The Socio-Political Impact of Crown Poor Relief Policies

As mentioned above, the Lisbon *Misericórdia* was established in August 1498 and, in the following months, the king introduced various economic benefits, tax exemptions and other privileges, thereby asserting royal protection over this new confraternity. Some months later, royal emissaries were sent to important urban centres, compelling the municipalities to create their own *Misericórdia* with the same ordinances and similar privileges of the Lisbon *Misericórdia*. At the same time, the intervention of the latter into the prisons and hospitals, among other sectors, was legitimized through a specific charter that later would be reproduced for other *Misericórdias*. In addition to the strong institutional support for the *Misericórdias*, people in charge of their administrative bodies received identical privileges to those attached to local governance positions. This prerogative had not been provided for in the original manuscript of the *Misericórdia Regiment* (1498), but was included in the first version to be published in 1516, representing an extra benefit which may well have worked as a factor to speed up the establishment of new *Misericórdias*.[23] The same seems to have occurred with the policy of social mobility implicit in the *Misericórdias' Regiment*: by determining a numerical parity between the noblemen and representatives from lower social groups, the possibility was opened up for certain individuals to be appointed to the necessary elite status. This should be normal practice, for instance, when not enough noblemen were in a given community to maintain the required social balance within the *Misericórdias* (the most common situation, in fact). Those wealthy or with university training or military service were directly integrated into this category, but

23 See *Compromisso da Confraria da Misericórdia*, Lisbon, Valentim Fernandes e Hermão de Campos, 1516.

the level of flexibility and possibility of such social promotion was entirely dependent on the make-up of individual communities. This privilege was of crucial importance because the possibility of promotion to the ranks of the elite could be a strong factor behind people establishing a new *Misericórdia* within their own locality.

In this way, the *Misericórdias* were endowed with an institutional capacity to promote social mobility or, at the very least, social differentiation and to recognize some groups as members of the local elite. Being a member of the local elite, according to the national laws in force at the time, was the principal condition which had to be met in order to secure a position in municipal government. In other words, in functioning as places of local social promotion, the *Misericórdias* provided a way for people to meet the necessary conditions required for participating in the local political centres of power. Thus, for some people, entering the *Misericórdias* became an end in itself, providing, as it did, a platform from which a position in local government could be reached. In many cases, such a purpose assumed the character of a *cursus honorum*, starting from the less important confraternities up to the *Misericórdias*, a route that simultaneously offered both social promotion as well as economic and political empowerment.[24] The time it took to make this journey was, of course, dependent on the initial social status of the individual, as well as on his ability to capitalize on this and establish relationships with other individuals who were already better socially positioned.[25] Once admitted to the *Misericórdias*, they acted in such a way so as to be able to exert their influence in both the *Misericórdias* and the municipal government. Although unable to accumulate the privileges inherent to both institutions, by placing different members of their families in *Misericórdias* and municipal governments, individuals could attempt to both control them and prevent the admission of hostile groups or those competing for the same positions.

24 L.Abreu, 'The Crown and Poor Relief: Structuring Local Elites (Early Modern Portugal)', in A. Sandén (ed.), *Demografi – hälsa – rätt. En vänbok till Jan Sundin. Demography – Health – Justice. A festschrift to Jan Sundin* (Linköping, 2008), pp. 161–9.

25 See S. Szreter, 'The State of Social Capital: Bringing Back in Power, Politics, and History', *Theory and Society*, 31 (2002), pp. 573–621.

During the first decades of the sixteenth century and encouraged by crown support, the close links that developed between the *Misericórdias* and the local government resulted in an apparently unique social and political organization of local communities. To be able to act as an intermediary between central government and the local elite in the implementation of a new charitable enterprise was an enormous privilege for the *Misericórdias*, which at the same time provided the king with an extremely important and effective means of communication. Indeed, in the 1560s, when the central government decided to transfer the hospitals to the *Misericórdias*' administration, the privileges were already 'at work' in some communities. From then on, and in contrast to what had happened at the beginning of the century, it was the local groups of small and medium-sized communities that requested the establishment of the *Misericórdias*. On the other hand, in large urban centres, where the social hierarchy was dominated by noblemen and even by the aristocracy, the social advantages provided by the *Misericórdias* had little or no impact.[26]

Yet, how significant was the crown's political action on the availability of public relief and allocation of resources? From my point of view, it acted in two distinct ways: even before the Ypres reforms, the creation of the Lyon's *Aumône Générale* and the Catholic Reformation, the Portuguese crown created a *system*, based on the principles of humanist reform, which accorded to a very precise model. It institutionalised dispersed and selective individual charity practices and called upon the local elite to implement this new model, permitting them to direct the communities' charitable donations towards the *Misericórdias* which were then distributed, according to their own principles of eligibility that, not surprisingly, excluded the undesirable beggars and vagrants. On the other hand, the crown's policy conceptualized itself as the tutelary power, but without any financial commitments, since the system itself was based on private charity such as donations made for religious purposes (*doações pias*) and local taxes for the care of foundlings.

From these two circumstances resulted a third that was of great importance in political terms: the strengthening of crown authority at a time which coincided precisely with the emergence of the early modern state.

26 Abreu, 'Misericórdias, Estado Moderno e Império'.

This was not only because the new poor relief system allowed for the promotion of a new elite, which was theoretically closer to the central government, but also because the crown succeeded in implementing a national structure that basically respected the same regulations, abided by identical policies and aimed for similar social objectives.[27] The crown was a distant power – and not just in geographical terms – with limited physical and human resources. Its power was based more on negotiation than on authority itself, but, as long as it was kept informed, it was able to intervene when the rules were not respected.[28] Its best allies were the *Misericórdias* and the rival groups fighting for their control and for the opportunities to create and feed powerful family dynasties, able to monopolise important local political positions and economic resources, namely the ones belonging to the charitable institutions. Quick to denounce the irregularities (or the supposed irregularities) and to ask for the mediatory power of the central courts, they enabled the crown to become more heavily involved in local affairs than just in the areas of administration and taxation, traditionally appointed as the privileged spheres for early modern state intervention.

It has been demonstrated that ways in which the hospitals were managed and controlled were crucial to the political process in Portugal. The question remains, however, to what the hospitals functioned within the general framework of the whole system of charity provision; this is an issue that is also directly related to the daily life of the hospital patients and their communities.

Early Modern Hospitals: Diversity and Realities

As the recent historiography has shown, early modern hospitals were very complex institutions, which require in-depth analysis in order to present an accurate picture of daily life within their walls, and their relationships

27 See L. Abreu, 'Limites e fronteiras das políticas assistenciais entre os séculos XVI e XVIII: continuidades e alteridades', *Varia História*, 26 (2010), pp. 347–71.

28 Abreu, 'Misericórdias, Estado Moderno e Império'.

with the wider community.[29] Developed within a framework of similar religious, cultural and political values, the European hospitals went through an extended process of transformation in late medieval times, and were characterized by the political, social and even professional contexts in which they were established.

From the case studies already known, there is strong empirical evidence indicating that the early modern hospitals were assumed, from their very early days, to be spaces of progress and 'cure'. Portuguese examples confirm this situation: they excluded, as elsewhere, patients with contagious and incurable diseases. Yet, they also went further, as expressed for instance in a royal letter dated 23 May 1502, which determined that the *Hospital do Espírito Santo* in Évora should be just for the care of the sick.[30] The admission of beggars and vagrants was forbidden, the king ordering that the hospital should be used only for the sick and not as a shelter for the poor.[31] General rules registered in the *Hospital de Todos os Santos* Regiment of 1504, expressed this increasing medical focus, based, as Risse claims, 'on more optimistic notions of health and illness'.[32] Such notions are also clearly revealed in the royal confidence of the *Hospital de Todos os Santos*' capacity, in the first years of the sixteenth century, to cure syphilis, or, later in the 1530s, to cure lunacy. The same optimism was shared by economically advantaged patients, prepared to pay for private rooms inside the hospital in the hope of being cured.[33] New architectural designs and conceptions of space also convey this new approach to sickness adopted by these institutions. Going further than dividing the hospital into separate spaces based on gender

29 'Large and complicated' are the adjectives used by J. Henderson, P. Horden, and A. Pastore to qualify the hospitals' history in *The impact of hospitals 300–2000* (Oxford, 2008), pp. 15–56.

30 Arquivo Distrital de Évora, Arquivo da Câmara Municipal de Évora, *1º Livro dos Originais da Câmara de Évora*, no. 72.

31 Arquivo Distrital de Évora, *Livro I dos Originais*, No. 71, f. 251.

32 G. Risse, *Mending Bodies, Saving Souls. A History of Hospitals* (New York and Oxford, 1999), p. 7.

33 See L. Abreu, 'A Misericórdia de Lisboa, o Hospital Real e os insanos: notas para uma introdução', in Álvaro Lavarinhas (ed.), *Museu S. João de Deus. Psiquiatria e História* (Lisboa, 2009), pp. 109–14.

and medical and surgical functions, the new hospitals invested in specialized infirmaries for particular illnesses in order to avoid mixing the care of the roaming poor with those who were sick. For example, in Lisbon, as in many other places, at the beginning of the sixteenth century the hospital incorporated 'tumor houses' for the treatment of patients suffering from the Great Pox, 'lunatic houses' to treat the insane, the 'children's house' for the care of foundlings and the 'house of beggars', where beggars, pilgrims and poor who were in transit could stay for a maximum of two nights. Two other elements also contributed to the hospital's modernity: its function as a training centre – already provided for in the 1504 Regiment and which evolved into a so-called surgery school for the training of surgeons and bleeders, and the large number of workers employed there: in 1504, there were fifty-six workers (for one hundred beds), of whom forty-eight were residents. From the beginning, twenty-five of these workers were nominated as health professionals; although this did not necessarily imply any academic training, it nevertheless did indicate a certain level of practical training and expertise. Indeed, all of the workers had their activities regulated by a daily routine. For instance, the medical routine, which also applied to outpatient consultation, consisted of two daily medical visits to the inmates, evaluation of their pulse and urine, individual prescription of food and medicines and a major preoccupation with the hygiene of the patient and the infirmary.

The *Hospital de Todos os Santos* began as a multifunctional space where the medical functions prevailed, despite being described by the 1758 administrator as a 'public hotel'.[34] Although the hospital was ruled (from 1530 to 1564) by a number of clergymen, until it was transferred to the *Misericórdia* administration in 1564, they always had to *report* to the crown and could not take on any responsibility in regards to therapeutic or medical tasks, or in respect of the admission or discharge of patients.[35]

34 When he used the hospital revenues to compensate people that had served the royal family, for instance, references such as 'food, shelter and bedding', for men and women, are frequently found in the hospital documents at the same level as any other expenses. See L. Abreu, 'O que ensinam os regimentos hospitalares? Um estudo comparativo entre os Hospitais das Misericórdias de Lisboa e do Porto (sécs. XVI e XVII)', in *A Solidariedade nos Séculos: A Confraternidade e as Obras* (Porto, 2009), pp. 267–85.

35 See Abreu, 'O que ensinam os regimentos hospitalares?'.

Described as one of the most modern hospitals of its time by the foreigners that visited it, the *Hospital de Todos os Santos* was, however – and contrary to the strategy advocated by king D. Manuel I – a rare example in the national context. The problems brought about by financial constraints, limited resources and a lack of health care professionals who were academically trained (despite these same problems being reported by the *Todos os Santos*) made the other hospitals in Portugal pale imitations of the Lisbon *Hospital de Todos os Santos*.

In spite of the absence of systematic research on the early modern Portuguese hospitals, existing studies do uncover scenarios very close to those already known for other countries: in general terms, the hospitals' structures and category of patients were determined more by the social and economic contexts than by political directives. However, the importance of an existing common organizational framework, responsible for similar administrative procedures, and even for the structure of medical care provision and healing practices, cannot be underestimated. For instance, the majority of *medicalised* hospitals were endowed with at least a physician, either permanent or upon request, a surgeon and a bleeder (*sangrador*), although in some cases a barber could assume the functions of both bleeder and surgeon.[36]

In contrast, in small, rural communities, *Misericórdias* and hospitals could exist as a single institution: a place where poor relief was distributed and managed and where the poor could obtain a variety of different forms of assistance. In these cases, the hospitals assumed the classic double function of poorhouse and infirmary. The characterization described by Hickey in respect to some French hospitals applies here also: non-specialized institutions, able to provide what was expected from them, notably 'shelter, health care, food or grain distributions, and aid to poor girls and members of the elite who had fallen on hard times'.[37] In these situations, even when medical care was available, it was of little relevance. Although the majority of

36 On the medicalization concept, see note 45 and C. Jones, *The Charitable Imperative: Hospitals and Nursing in Ancien Régime and Revolutionary France* (London and New York, 1989).

37 See Hickey, *Local Hospitals in Ancien Régime France*, p. 26.

the hospitals' patients were local people, the institutions were also open to travelers and pilgrims. An examination of the hospitals' admission records reveals something of the social profile of the community in which it was situated: in areas of high percentage of male emigration, women were left as householders and formed the majority of patients, whereas in the opposite situation, where worker immigration was more prevalent, men were far more numerous than women in the hospitals. This latter scenario has been shown to be the case in most urban hospitals.[38]

Generally speaking, the demand for the city hospitals far exceeded their capacity to respond to the demand, and control of their expenditure was of utmost importance. During the eighteenth century, a medium-sized urban hospital could treat between 600 and 2,000 patients per year (34,000 in 1734 in the Lisbon *Hospital de Todos os Santos*), which could well represent more than 70 per cent of the total budget of the institution. Why was it that the urban hospitals were under such great financial pressure?

Several explanations have already been presented, but the first to be noted from the admission records relates to the very specific way in which institutional charitable practices were organized during the early modern period: that is, they were centered on the community, and based on networks of relationships and knowledge. By contrast, the hospitals were open welfare institutions and this explains why the great majority of the *medical* hospital patients were not local, regular, residents.

Many were certainly beggars and vagrants because, unlike in France, England and other countries, Portugal had not invested in the systematic confinement of its roaming population.[39] The inefficiency of the policing policies based on physical punishment and expulsion from the concerned communities is well known.[40] Beggars and vagrants were perceived to be

38 This confirmed by our ongoing study on the Évora hospital, see, Abreu, *Memórias do Corpo e da Alma*, pp. 400–10.

39 For a broad approach, see C. Jones, 'Some Recent Trends in the History of Charity', in M. Daunton (ed.), *Charity, Self-Interest and Welfare in the English Past* (London and New York, 1996), pp. 51–63.

40 See L. Abreu, 'Beggars, Vagrants and Roma: Repression and Persecution in the Portuguese Society (14th–18th Centuries)', *Hygieia Internationalis*, 6 (2007), pp. 41–66.

everywhere, and some of them may well have asked for institutional support. However, these same hospital records also demonstrate that these groups were only marginally represented in their wards, indicating perhaps a respect for crown orders and the subsequent restriction of the hospitals' regulations in terms of admissions. Nevertheless, the answer is far from being simple: when examining the clothes that the patients wore on their arrival, the secretary responsible for admissions used phrases such as 'came in rags' or 'brought very old clothes', which could indicate that they belonged to social group different from 'workers' as they were registered.[41] This evidence appears to present a major contradiction and begs the question as to why the hospital administrators were prepared to accept this situation. Was it to prevent social problems that beggary and vagrancy could create in the communities? In part it would seem that this was indeed the case. The testimony of Nicolas Versoris, lawyer in the Parlement of Paris in 1524, cited by Daniel Hickey, is very similar to one presented in Lisbon some decades later, or in Venice, some years earlier: escaping from the rural areas, the young became urban delinquents, committing 'innumerable minor crimes, stealing all they could, and major crimes such as murders, illegal assemblies, looting'.[42] Overseas exile, specific military training or skilled boat training were some of the solutions proposed by the Lisbon municipality in 1599 to resolve the problems created by the unemployed masses. Alternatively, a more radical, but less expensive, proposal recommended enclosing them in specific parts of the city, temporarily transforming these areas into large prisons.[43] In this case, the essential problem was the incapacity of the *Hospital de Todos os Santos* to absorb these people, creating an urgent need to find solutions to the threat of potential public health problems.

So, perhaps the question should in fact be reformulated: why did the hospital administrators admit so many so-called workers knowing full well that many of these paupers were not, in fact, workers? Clearly, it would seem that the answer is because the urban elite who were running the hospitals

41 See, Abreu, *Memórias do Corpo e da Alma*, pp. 409–10.
42 Hickey, *Local Hospitals in Ancien Régime France*, pp. 15–16.
43 Abreu, 'Beggars, Vagrants and Roma', p. 53.

were aware that their income depended on seasonal, unskilled, roaming labourers, usually moving as large groups from rural areas to the cities. But they also knew that the boundaries between the social strata – between worker and beggar – were thin and that these fragile groups needed to be protected in order to guarantee both the maintenance of social order and the availability of manpower.[44] In other words, with no capacity to test the patients' eligibility, the hospitals preferred to support those who asked for assistance rather than practice truly restrictive admission policies. In the same way, although perhaps defending different social philosophies and social values, other countries throughout Europe relied on general hospitals and workhouses.[45]

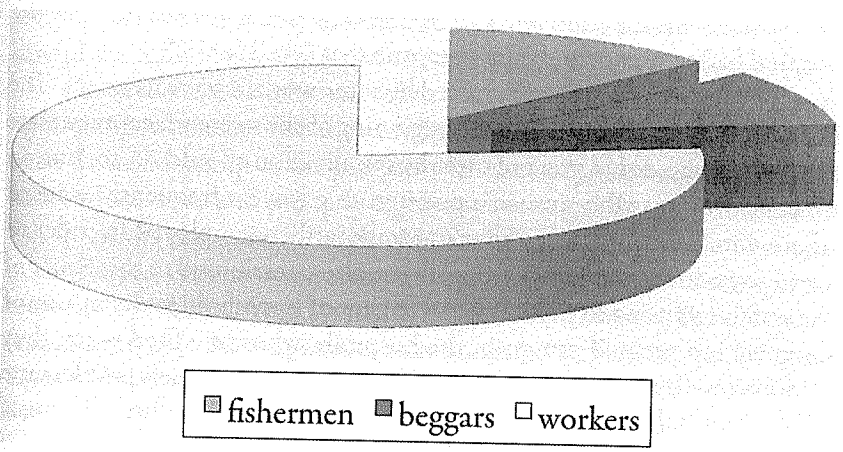

Figure 8.1 Occupations of the *Hospital do Espirito Santo* Patients (Setúbal 1781–1836).

44 For the social function of the early modern hospitals, see C. Jones and M. Sonenscher, 'The Social Functions of the Hospital in Eighteenth-Century France: The Case of the Hôtel-Dieu of Nîmes', *French Historical Studies*, 13 (1983), pp. 172–214.
45 A similar situation occoured in Spain. See T. Huguet-Termes, 'Madrid Hospitals and Welfare in the Context of the Hapsburg Empire, in Hospitals', in *Medical History Supplement Health and Medicine in Hapsburg Spain: Agents, Practices, Representations* (Medical History Supplement), T. Huguet-Termes, J. Arrizabalaga, H.J. Cook (eds), 29, (London), 2009, pp. 64–85.

Young workers, mainly migrants, made up the bulk of patients at the *Hospital do Espírito Santo*, in Setúbal, the biggest salt centre in early modern Portugal. Short stays (between 10 and 11 days) and a low level of mortality (around 11 per cent) would lead us to conclude that a considerable number of patients sought to restore their health and vitality in order to return to work or home. This vision of hospitals as a space of recovery and care gives another, more practical, sense to the application of charity, such as was found in many other European hospitals.[46] Nonetheless, statements from the Setúbal and Lisbon hospital administrators, dating from the mid-late eighteenth century, plainly demonstrate that they were conscious of these social uses of the hospitals' resources, accepting them in spite of recurrent complaints, but justifying them, as a Setúbal hospital administrator affirmed, on the principle that 'the general and generous use that the hospital had to accept and cure everyone that asked for it'.[47]

References to abuses committed by some workers were frequent. The hospitals' statutes, dating from the beginning of the sixteenth century, state that those who could pay for their hospitalization should do so, but, in practice, workers who were in a position to pay were frequently accused of presenting themselves as poor or temporarily unemployed in order to avoid payment to save money. Employers also contributed to this abuse of the system, refusing to pay for the treatment of household servants, one of the most represented groups in the hospitals, who were fired when they were hospitalized and re-employed once they were cured. Less problematic for the hospitals was the treatment of the slaves, since usually the hospital regiments stated that they could be sold for the benefit of the hospital if their expenses were not paid by their owners.

46 That is, obviously according to the medical knowledge of the time, but in a more assertive way than the one pointed noted by Risse: in other words, more in the sense that Jones has defended the concept of medicalization when applied to early modern hospitals. See also L. Granshaw and R. Porter (eds), *The Hospital in History* (London and New York, 1989).

47 Arquivo da Santa Casa da Misericórdia de Setúbal, *Livro de Termos*, Book 445, ff. 69–70v.

If we assume that the hospital overseers had a direct interest in maintaining the workers productive capacity and social status, it is not implausible that they consciously contributed towards the workers' well-being by preventing them from slipping into more vulnerable situations. For certain, it is possible to identify the health of the population as an economic and political issue, existing, as it did, within the framework of a mercantilist state and facilitated by the active participation of the hospitals. And yet, it was more than this: not only did these hospital policies benefit beggars and vagrants by treating them for free, but some workers, who could afford to pay but avoided doing so, were also using the charitable system to their own advantage. In this sense then, and in this specific context, the concept of 'actors with interest', as defined by Van Leeuwen, can be more appropriately applied to the reality of Portugal than the early Foucault theories of discipline, submission and social control.[48]

Given that the hospitals were known as centres for the social and economic empowerment of their controlling authorities, what then might have been the relationship of the patients with the hospitals between the early sixteenth century and the early eighteenth century? In order to examine this question, the example of the *Hospital do Espírito Santo* in Évora has been selected as there is an extant and relatively continuous documentary record of admissions from 1535 up to the twentieth century. For the period from 1555 to 1755, 88,501 patients were admitted to the hospital, of which 84,266 had their birthplace identified and of these, 6,204 were born in Évora, in the southern region of the country and 78,062 in the northern and central regions. The series of figures indicating annual hospital admissions shows a 90 per cent linear correlation between both these geographical points of patient origin, meaning that both groups had the same pattern of demand for hospital support.

48 M.H.D. Van Leeuwen, 'Logic of Charity: Poor Relief in Preindustrial Europe', *Journal of Interdisciplinary History*, 24 (1994), pp. 589–613.

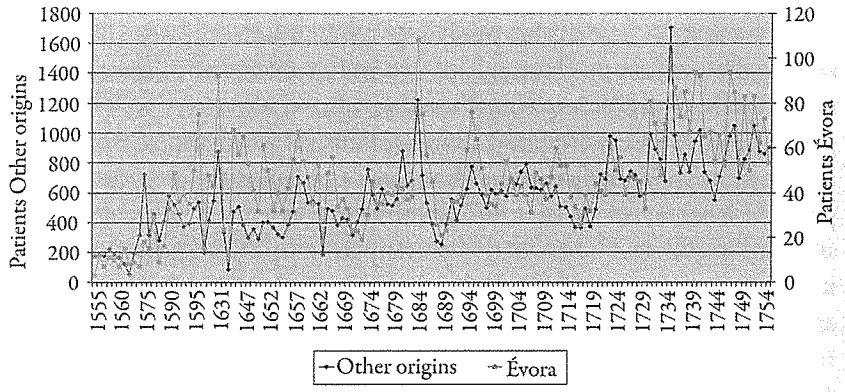

Figure 8.2 *Hospital do Espírito Santo.*

However, when the figures are examined more closely on a monthly basis, as in figure three, this similarity in patterns of behaviour is lost between July and October, the traditional season for hospital admittances.

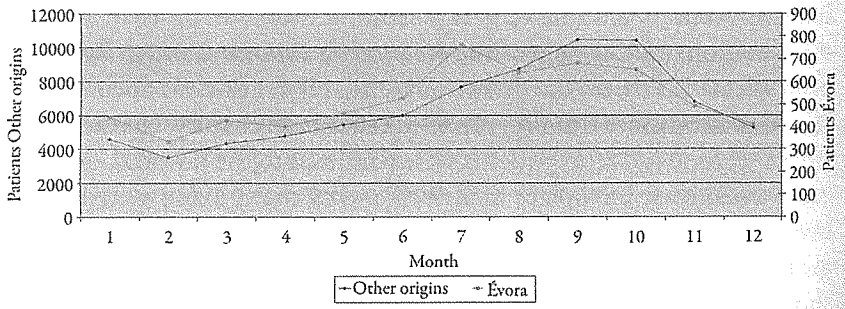

Figure 8.3 *Hospital do Espírito Santo.*

So what conclusions can be extracted from this data? The most obvious is that the hospital clientele was mainly composed of people not born in the city, and this could indicate one of two situations: either extreme variations in population movements throughout the year, or very precarious residence conditions for those who temporarily settled in Évora, leaving them vulnerable and, therefore, reliant on the hospital for temporary

respite to their daily difficulties. However, there is one possible explanation for this apparent difference which will only be able to be confirmed once the on-going study of the city demographic database is concluded, thus corroborating, or not, what the current disparate evidence is revealing, namely that marriage in the city allowed outsiders to be integrated into the community which was then able to provide the kind of support previously only available in the hospital. In practical terms, it could be that, once they married in Evora, outsiders disappeared from the hospital statistics as they transferred to other forms of charitable relief based on residence.

On the other hand, the comparison of the death rates between the natives of Évora and those born elsewhere illuminates a significant trend: that the mortality rate of the outsiders was, in relative terms, lower than the resident ones. This could indicate that the former more commonly used the hospital for cases of acute diseases and specifically for medical purposes. However, what is of significance in this graph is the enormous disparity between the summer and autumn months, when the difference among the Évora patients and those from other origins more than tripled. Does this mean that the latter were more sensitive to the weather conditions of these months and the health problems traditionally associated with them? The separate analysis of the patients' hospital histories reveals a high tendency towards a regular pattern of yearly hospital entrances, concentrated in the same months.

Figure 8.4 *Hospital do Espírito Santo.*

Patient	Father	Mother	Origin	Hospital Entries
Miguel Rodrigues	Miguel Rodrigues	Isabel Monteira	Ferreirim	24–09–1700
				02–09–1704
				31–08–1705
				27–10–1706
				15–10–1707
				26–10–1711
				10–07–1726
				26–08–1726
				21–09–1730

Bento da Silva	Bento da Silva	Maria Antunes	Coimbra	17–12–1725
				15–07–1726
				20–10–1730
				26–08–1734
				01–07–1736
Lucas Pires	Manuel Pires	Francisca Vaz	Teixeira (Miranda)	12–11–1691
				02–11–1692
				21–06–1698
				04–08–1701
				02–10–1701
				19–07–1704
				02–10–1704

Analyzing such data alongside the economic characteristics of the city – agricultural production of corn, wine and olive oil – it is likely that hospital admissions increased during times of intensive work activity and during the breaks between the different activities, but significantly decreased after that. Returning to figure 8.3, the changes in hospital admissions start with the 'June harvest', and will have marked the arrival of labour migrants to the town from the north and centre of Portugal, in line with already known migratory movements. In September, the grape harvests began, early autumn was sowing time and, in November, the olive harvest took place, the Évora region being the second largest oil-producing centre in the country. The end of the year saw the conclusion of intensive agricultural activity. At this time, it is likely that the majority of the seasonal workers retreated home, returning to Évora the following year. Some of them repeated this seasonal mobility for several decades, probably throughout their entire working lives, effectively maintaining a foothold in two communities.

The pattern of the utilization of hospital resources illustrated by figure 8.4 reveals a pattern of behaviour that allows us to re-think not only the concept of poverty when applied to the workers, but also the hospitals' role in the productive system. This is not to say that the poor were not present in the hospitals, only that, since the sixteenth century, the space was shared between them and a large population of migrant workers. Further, although this may not be completely new information, it is confirmed here through

very precise extant evidence and it anticipates the theoretical approaches that defend the eighteenth century as the moment when relief, health and work capacity developed together. Since the 1980s, the new historiography has been uncovering proof that early modern hospitals were more than simply institutions devoted to care and providing religious support and the study of the records of the *Hospital do Espírito Santo de Évora* confirms this.[49] Yet even more than that, this empirical evidence allows us to take our thinking one step further. Following the skepticism introduced by authors such as Jean-Pierre Gutton and Colin Jones, among others, after the theories formulated by Foucault on the early modern hospitals and welfare provision in general, and after the criticism of Tim McHugh of the interpretations of Gutton, Imbert, Jones and even Hickey on the real role of the central government on the French hospitals, maybe it is now time, as pointed out above, to introduce the concept of 'actors with interests' into the context of the hospitals.[50] Regarding the ruling of the hospitals by the urban elite, one could argue, following Emanuel Chill,[51] that what was at stake was a necessity to cure the poor, not as an answer to the problem of poverty, but in order to maintain their ability to work.[52] However, and as Sandra Cavallo has demonstrated in the case of Turin, archival evidence in Portugal also reveals that at least some of the patients were clearly able to manipulate the system to their own advantage, thus influencing the subsequent actions of the elite members in charge of the hospitals.[53] In a way, since they totally controlled its distribution, the elite had much more freedom running the outdoor relief than the hospitals,

49 Risse, *Mending Bodies, Saving Souls.* pp. 237–8.

50 McHugh, *Hospital Politics in Seventeenth-Century France*, mainly chapter two.

51 Cited by McHugh, *Hospital Politics in Seventeenth-Century France*, p. 4.

52 In this sense, it can be assumed that the authorities were aware of the general vulnerability of the workers and the necessity to protect them when the idea emerged that the wealth of nations was dependent on the freedom of the work, even in pre-industrial societies, as was the case in Portugal at that time. See R. Castel, *Les métamorphoses de la question social* (Paris, 1995), pp. 255–87.

53 S. Cavallo, 'Family Obligations and Inequalities in Access to Care in Northern Italy, Seventeenth to Eighteenth centuries', in P. Horden and R. Smith (eds), *The Locus of Care. Families, Communities, Institutions and the Provision of Welfare Since Antiquity*

where their logistical incapacity to identify the deserving poor somehow pressured them to support those who, in fact, they would rather not have supported.[54]

The Portuguese hospitals under the *Misericórdias*: Community or Crown Control?

This question in this concluding subheading has several possible answers. Probably the most convincing one is to admit that both the crown and the communities exerted influence over the hospitals at different times and different levels of control. With regard to organization, as demonstrated the power clearly belonged to the crown. At the same time as administrative, economic and political reforms were carried out, the central government assumed this role as its obligation. Not surprisingly, these reforms and obligations were framed by religious contexts and values and their implementation was dependent on the direct support, and even engagement, of the papacy and the local elite. The crown was aware of its limited capacity to reach the whole country and to impose authoritarian measures over the local dominant groups – it was all about co-operation. In fact, this spirit of co-operation was so beneficial for the local elite that they did not introduce any significant changes to the system until the nineteenth century. The main reason for maintaining such a conservative position was the flexibility of the structure, which allowed the dominant groups to mould it to their own interests, capitalizing on the social, political and economic opportunities offered by the central government to their own

(London and New York, 1998), pp. 90–110. See also, C. Stein, *Negotiating the French Pox in Early Modern Germany* (Burlington, 2009).

54 A study on the logic of the local elites' choices, in terms of distribution of outdoor relief, is being developed by Rute Pardal, in her PhD thesis, entitled, *Práticas de caridade, assistência e controlo social, em Évora, no período moderno.*

advantage. Accused of misusing the *Misericórdias'* patrimony, for instance, they are only seldom found among the *Misericórdias'* benefactors. Following the example of the crown, the elite in charge of the poor relief structures used them to finance their own interests.

Another explanation for the longevity of the system was the attitude assumed by the crown: since the early seventeenth century it took on the role of a distant mediator, only intervening when called upon to do so and punishing transgressions when they were known. Distracted by other preoccupations, the presence of central government was felt less and less, in effect allowing the local elite complete control of the system. As in other countries, the main concern of the political power was the maintenance of the poor relief and health care system – the day-to-day administration being left to local authorities.

Obviously, despite the original ambitions of the crown, it is not possible to analyze the entire country as one homogenous unit. The example of the Lisbon hospital, for instance, with its multiple functions and dimensions under the same authority – not a place, not a building, but an administration managing several places, buildings, functions, types of people, for different reasons – was a unique case that serves to emphasize the point that, as everywhere, the Portuguese hospitals were representative of the societies and communities to which they belonged and it is within this context that they should be viewed. In the end, and despite the best efforts of the crown, the model of the Lisbon hospital could not be applied directly to other hospitals throughout the kingdom, because, ultimately, it was the ethos of the dominant local elite and the communities economic capacity that prevailed.