Sabine Jesner / Matthew Neufeld (eds.)

Military Healthcare and the Early Modern State, 1660–1830

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Herrschaft und soziale Systeme in der Frühen Neuzeit

Band 30

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des Arbeitskreises Militär und Gesellschaft
in der Frühen Neuzeit e. V.
von Matthias Asche, Horst Carl, Marian Füssel,
Bernhard R. Kroener, Stefan Kroll, Markus Meumann,
Ute Planert und Ralf Pröve

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Management – Professionalisation – Shortcomings

With 8 figures

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Umschlagabbildung: A badly wounded soldier being carried off the battlefield on a makeshift stretcher made of bayonets, eighteenth century. Quelle: Wellcome Collection, CC-BY.

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Sabine Jesner / Matthew Neufeld

Introduction: Military Health Care and the Early Modern State, 1660–1830

In October 1715, a few months before the Habsburg Monarchy and the Republic of Venice entered the war against the Ottomans, the Habsburg *General-kriegskommissar* (general war commissioner) Graf von Thürheim promulgated an instruction concerning the prescription of medicines in garrisons. It was instructed that sick soldiers should receive their medicines free of charge, and that they should be observed and regularly visited by the *Guarnisons Medico* (garrison physician), who was to inform the authorities about the course of diseases every fourteen days. Enclosed with the instruction was a list of selected medicines, remedies, and substances for the special needs of the military units stationed in Hungary for whom the doctor should offer a proper cure. Should unforeseen medical emergencies such as epidemics (*ansteckende Morbis*) occur, the physician was to act prudently so as not to impose additional costs on the treasury (*das Ararium mit keiner Unnothwendigkeit zu beladen*).[1]

These instructions highlight the many and varied components that were necessary to make military healthcare work in peacetime, and also foreshadows how much more complex it must have been in war time. Military administrative personnel with the duty to oversee and steer medical care, as represented by a general war commissioner or a military physician whose work was dedicated to sick and wounded soldiers, represent just two professions of a broad spectrum of practitioners whose efforts were the fulcrum of effective medical care in public service. The interest of the state in military healthcare can be observed clearly from the use of 'paper technology' and the required fortnightly reporting. The consideration of unpredictable events, such as disease outbreaks, suggests an intention to reflect on medical risks by taking a forward-looking perspective. The instructions cast into relief two key aspects of the modern state: demands for austerity measures and a drive to acquire control over subordinated admin-

1 Instruction for garrison physician Sutter from 22nd October 1715. See OeStA [Österreichische Staatsarchiv] KA [Kriegsarchiv] ZSt [Zentralstellen] HKR [Hofkriegsrat] HR [Hauptreihe] Akten 129, Exp/JAN-APR, 1716-Jan-192.

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istrative bodies or actors. While at the same time as insisting that resources not be wasted, it maintained a prudent concern for the well-being of its army.

The role of early modern European states as managers of military healthcare is at the centre of this collection. It is a book about governmental policies, the strenuous strivings to establish new institutional frameworks, and individual 'healthcare workers' in a broader sense who shaped and created medical spaces through their activities. Initiated by Sabine Jesner, this book began as a third-party funding research project at the Section of Southeast European History and Anthropology at the University of Graz in Austria. The project funded by the Austrian Science Fund (FWF) has set itself the goal of investigating Habsburg military healthcare in the Habsburg–Ottoman Wars during the long eighteenth century.[2] Together with Matthew Neufeld, a leading expert in early modern naval healthcare and project partner, the present collection seeks to put the early modern Habsburg Monarchy military medicine case study in a larger framework.

This volume demonstrates novel and innovative ways to study military healthcare from the 1660s to the 1830s. The collection draws attention to different epistemological interests and applies a sociocultural approach to demonstrate how medicine and war were intertwined with numerous different facets of human society and culture.

In spring 2022, after a rather long period of peace for most generations of living Europeans, the "Face of Battle"[3] reemerged on European soil. The war in Ukraine reinforces the need to turn the spotlight on the medical dimension of war. Unfortunately, the ongoing conflict reveals sobering casualty numbers. This implies that medical treatment is still insufficiently organised and gives the impression that the suffering of soldiers is unnecessarily great. The ethical dilemma of the word pair "war" and "medicine" is part of an ongoing debate on the obligations placed upon physicians by the state in times of war.[4] We are reminded that medical healthcare for both war participants and the affected civilian population can never be good enough as long as the wounded are dying or lacking sufficient medical care. This fact collides with how we apprehend our 'modern world' where medical progress is often unreflectively assumed and shortcomings are partly perceived as belonging to the distant past.

That prompts us to raise new questions on this 'distant past', at a point in time when military healthcare became more deeply involved in governmental policies

2 Austrian Science Fund [FWF], "Habsburg Battlefield Medicine in 18th Century", T 1108 Firnberg Programme.

3 John Keegan, The Face of Battle, London et al. 1978.

4 Rajesh Vaidya, Saurabh Bobdey, Medical ethics during armed conflicts. Dilemmas of a physician soldier, in: Medical Journal Armed Forces India 77, 4 (2021), pp. 377–381; Fred Rosner, Ethical dilemmas for physicians in time of war, in: The Israel Medical Association Journal 12, 3 (2010), pp. 133–135.

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and contributed to a broader awareness for the well-being of soldiery.[5] The studies presented in this collection have a strong focus on this development and the consolidation of new strategies. But it also refers to the shortcomings of early modern states. Within the scope of this collection, caring for the intact male soldiers' bodies—while the wounded were recognised as incomplete—became a key task for the state. Military medicine became increasingly a purpose-built instrument to select physically fit people for military service, to monitor their state of health, provide them with medical assistance in the event of wounding and make them fit for service again. The volume considers a sociocultural mode of inquiry as it is grasped by scrutinising the impact of values, habits, and behaviour on the quality and effectiveness of military healthcare. It seeks to understand the personal contributions of military medical professionals whose work saved lives or ensured the recovery of the wounded. Fresh light is shed on the improvement of human and veterinary military medical training, and on how competing interests among the scientific community inhibited medical progress and success. Additionally, this collection points toward better understandings of organisations' ethics and moral pluralism in public service. This collection also looks behind the battlefield and considers the consequences of war for military and civil societies, while presenting female and male views. This collection seeks to explore individual performance and the achievements of actors active in civil service, and examines the duality of informal and formal systems of healthcare related to their impact on military health and recovery. The book shows that early modern states heeded the enlightenment ethics concerning 'humanity' and 'philanthropy' which shifted policies and replaced traditional ideas of statehood and Christian charity.

English-speaking researchers and historians studying early modern England have already begun to engage with the broader context underlying this book. In a continental European context, we have identified a notable research gap concerning the functioning of state management in military healthcare. Most case studies presented in this edited volume are geographically focused on Continental Europe which helps to close this research gap. *Military Health Care and the Early Modern State, 1660–1830* is intended for an international (English-speaking) audience, and is targeted at scholars of early modern Europe, military and medicine historians, undergraduate and graduate students of European history, and other interested readers. An important feature of this book is the interdisciplinary nature of it; individual chapters will also be of interest for the history of veterinary medicine, the history of science, gender studies, the history of administration, the history of epidemiology, and the social history of work.

5 Marian Füssel, "Ungesehenes Leiden? – Tod und Verwundung auf den Schlachtfeldern des 18. Jahrhunderts", in: Historische Anthropologie 23 (2015), pp. 30–53.

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1. Sparking (New) Interest in Early Modern Medicine, the War, and the State

In 2018, the historian Michael Brown edited a "Virtual Issue" for the Journal, *Social History of Medicine* on "Medicine and War".[6] Brown chose the renowned journal as an exemplary case to filter out research niches and imbalances. He stated that within the last 30 years, the research on the topic had focused on the modern world and pointed toward an enormous underrepresentation of premodern subjects. He claimed that the First World War was a turning point for intensified research and linked this development with the rating of the First World War "as the first major war of social, cultural and technological modernity" and that this is grounded by "its place in the development of modern ideas about self and psyche".[7] Since this critical analysis, five years ago, not much has changed. The early modern period is still underrepresented in the research on the entanglement of war and medicine and the state.

Fielding H. Garrison is considered one of the pioneers who boosted the interest in the history of military medicine. As early as 1922 he wrote that,

> "in the 18th century the administration of military medicine became a definite function of government, and, in consequence, limited periods of voluntary enlistment, regular medical examination of recruits, regular salaries for officers, government quarters for troops, regular uniforms, a common daily ration, the military regulation of army hospitals, printed orders and bulletins on military medicine (in Prussia and Austria) became part of the established order of things."[8]

Indeed, the long eighteenth century (1660–1830) is seen as a phase where broadly speaking 'basic processes' including 'institutionalisation', 'professionalisation', 'centralisation', or 'medicalisation' started to transform the early modern state into a modern state. The advent of standing armies shortly before forced states to undertake a revaluation of their relations with their naval and military forces and the ways to manage warfare. This resulted in the creation of new or at least reformed sanitary institutions and offices, new professional academic models of military medical training, the introduction of more centralised processes within the military bureaucracy and the medicalisation of civil society and the armed forces.[9] Research has paid attention to the category 'disease', whose conquest was

6 Michael Brown (ed.), Virtual issue of Social History of Medicine on 'Medicine and War': https://academic.oup.com/shm/pages/medicine_and_war, 19.12.2022.

7 Ibid.

8 Cf. F. H. Garrison, Notes on the History of Military Medicine, Hildesheim 1970, p. 137.

9 Recently, in particular, influential Sebastian Pranghofer, The Early Modern Medical-Military Complex: The Wider Context of the Relationship Between Military, Medicine, and the State, in: Canadian Journal of History 51, 3 (2016), pp. 451–472; David J. Appleby, Andrew Hopper (eds.), Battle-scarred: Mortality, medical care and military welfare in the British Civil Wars,

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recognised as a key feature for a prosperous and powerful European early modern state, and an important element of state building.[10] Early modern medical practices were based on ancient ideas concerning the emergence, the transmission, or the diagnostics of disease. Humoral pathology and the miasma theory served as the predominant medical doctrine and shaped the medical treatment of patients. In this period, surgeons started to step out of the shadow of doctors and physicians and improved their surgical methods.

Significant processes of centralisation and institutionalisation taken up by historians using the terms 'medical policing' and/or 'public health' point to more general developments about the interfaces of health, medicine, and the state.[11]

Manchester 2018; Geoffrey l. Hudson, British Military and Naval Medicine, 1600–1830, Amsterdam et al. 2007; Erica Charters, Disease, War, and The Imperial State: The Welfare of the British Armed Forces during the Seven Years' War, Chicago et al. 2014; Matthias König, Blutiges Handwerk. Die Entwicklung der österreichischen Feldsanität zwischen 1748 und 1785, Vienna 2011; Jörg Hoff, Zur Geschichte des Militärsanitätswesens in Hessen-Kassel vom Beginn des stehenden Heeres unter Landgraf Karl (1670–1730) bis zum Übergang Kurhessens an Preußen im Jahre 1866, Marburg, Diss. 1980; Ralf Vollmuth, Die sanitätsdienstliche Versorgung in den Landsknechtsheeren des ausgehenden Mittelalters und der frühen Neuzeit. Probleme und Lösungsansätze, Würzburg 1991; Carl-Hermann Colshorn, Die Hospitalkassen der hannoverischen Armee. Ein Vorläufer der Sozialversicherung seit 1680, Hildesheim 1970; Wolfgang Bühling, Kaserne und Lazarett im Hochstift Würzburg, 1636–1802, Würzburg, Diss. 1997; Colin Jones, The Welfare of the French Foot-Soldier, in: History 65 (1980), pp. 193–213; Monique Lucenet, Médicine, chirurgie et armée en France au sicle des luminéres, Clichy-la Garenne 2006; José Maria Massons, Historia de la sanidad military española, 4 vols., Barcelona 1994; Christopher Storrs, Health, Sickness and Medical Services in Spain's Armed Forces c.1665–1700, in: Medical History 50 (2006), pp. 325–350; Joachim Moerchel, Das österreichische Militärsanitätswesen im Zeitalter des aufgeklärten Absolutismus, Frankfurt/M. 1984; Peter Kolmsee, Das Militärmedizinalwesen in Fridericianischer Zeit – Institution, Personal, Organisation, in: Jürgen Ziechmann (ed.), Fridericianische Miniaturen 3, Oldenburg 1993, pp. 175–201; Salomon Kirchenberger, Geschichte des k. und k. österreichisch-ungarischen Militär-Sanitätswesens, Vienna 1895; Tim Lockley, Military Medicine and the Making of Race: Life and Death in the West India Regiments, 1795–1874, Cambridge 2020; Jim Downs, Maladies of Empire: How Colonialism, Slavery, and War Transformed Medicine, Cambridge, MA 2021; Ute Caumanns et al. (eds.), Medizin und Krieg in historischer Perspektive / Medycyna i wojna w perspektywie historycznej, Frankfurt/M. 2012; Miri Shefer Mossensohn, Medical Treatment in the Ottoman Navy in the Early Modern Period, in: Journal of the Economic and Social History of the Orient 50, 4 (2007), pp. 542–568.

10 Peter Elmer, The Healing Arts: Health, Disease and Society in Europe, 1500–1800. Manchester 2004; Roy Porter, Disease, medicine and society in England, 1550–1860, 2nd edn., Cambridge 2009; Laurence Brockliss, Colin Jones, The Medical World of Early Modern France, Oxford 1997.

11 Patrick E. Carroll, Medical Police and the History of Public Health, in: Medical History 46 (2002), pp. 461–494; George Rosen, History of Public Health, New York 1958; Georg Rosen, From Medical Police to Social Medicine. Essays on the History of Health, New York 1974; Christian Barthel, Medizinische Polizey und medizinische Aufklärung. Aspekte des öffentlichen Gesundheitsdiskurses im 18. Jahrhundert, Frankfurt/M. 1989; Ute Frevert, Krankheit als politisches Problem 1770–1880. Soziale Unterschichten in Preußen zwischen medizinischer Polizei und staatlicher Sozialversicherung, Göttingen 1984; Lukas Lang, Medicinische

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Following in the footsteps of Michel Foucault, scholars often refer to the processes described by the terms 'biopolitics' or 'biopower' which encourage rethinking how the state used the concern for the life of subject populations to increase its capacity to conduct their actions as populations and individuals.[12]

Popular but still underexplored thematic fields in this domain include the analysis of careers and the social mobility of medical professionals,[13] logistical questions,[14] improved training,[15] or facets of 'paper technology' within the research on early modern military healthcare.[16]

For a deeper understanding of this transformation in warfare in the broadest sense, historians developed concepts which have substantially expanded the historical field of inquiry, and they started to ask how the state was able to handle the resource-intensive duties which arose with the maintenance of standing armies.[17] The publication of *The Sinews of Power*, *War, Money and the English State*

Policey in den habsburgischen Ländern der Sattelzeit. Ein Beitrag zu einer Kulturgeschichte der Verwaltung von Gesundheit und Krankheit, Vienna 2021.

12 Michel Foucault, The politics of health in the eighteenth century, in: Michel Foucault: Power. Essential Works of Foucault 1954–1984, London 2000, pp. 90–105, and focusing on early modern naval health, Matthew Neufeld, The Biopolitics of Manning the Royal Navy in Late Stuart England, in: Journal of British Studies 56, 3 (2017), pp. 506–531.

13 Marcus Ackroyd et al., Advancing with the Army: Medicine, the Professions and Social Mobility in the British Isles 1790–1850, Oxford et al. 2006; Sebastian Pranghofer, Zur Anatomie beurlaubt. Qualifizierung und Karrieren von Feldscheren in Berlin und Hannover im 18. Jahrhundert, in: Johanna Bleker et al. (eds.), Tiefe Einblicke. Das Anatomische Theater im Zeitalter der Aufklärung, Berlin 2018, pp. 223–237; Catherine Kelly, War and the militarization of British Army medicine, 1793–1830, London 2011.

14 Matthew Neufeld, Blaine Wickham, The State, the People and the Care of Sick and Injured Sailors in Late Stuart England, in: Social History of Medicine 28 (2015), pp. 45–63; Erin Spinney, Servants to the hospital and the state: nurses in Plymouth and Haslar Naval Hospitals, 1775–1815, in: Journal for Maritime Research 20, 1–2 (2018), pp. 3–19; Lilla Krász, From Home Treatment to Hospitalisation: General Trends in the Development of Hungary's Hospital Network, in: Martin Scheutz et al. (eds.), Europäisches Spitalwesen. Institutionelle Fürsorge in Mittelalter und Früher Neuzeit, Vienna 2008, pp. 455–475.

15 Brigitte Lohff, Die Josephs-Akademie im Wiener Josephinum. Die medizinisch-chirurgische Militärakademie im Spannungsfeld von Wissenschaft und Politik 1785–1874, Vienna et al. 2019; Fritz Dross, *feldtscher*. Zur Professionalität der Versorgung frühneuzeitlicher Kämpfer, in: Nikolas Funke et al. (eds.), Krank vom Krieg. Umgangsweisen und kulturelle Deutungsmuster von der Antike bis in die Moderne, Frankfurt et al. 2022, pp. 77–104; Daniela Haarmann (ed.), 250 Jahre Veterinärmedizinische Universität Wien. Verantwortung für Tier und Mensch, Vienna 2015.

16 Erica Charters, L'histoire de la quantification: la guerre franco-anglaise et le développement des statistiques médicales, in: Dix-huitième siècle 47 (2015), pp. 21–38; Sebastian Pranghofer, States of healing in early modern Germany: Military health care and the management of manpower, in: Axel C. Hüntelmann, Oliver Falk (eds.), Accounting for health: Calculation, paperwork, and medicine, 1500–2000, Manchester 2021, pp. 283–304.

17 Scholars started to relate the formation of states with war and vice versa. "War made the state, and the state made war", suggested Charles Tilly in 1975. Cf. Charles Tilly, Reflections on the History of European State Making, in: Charles Tilly (ed.), The Formation of National States in

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1688–1783 by John Brewer sparked the debates on "fiscal military states":[18] these states were focused on the creation of new fiscal tools to raise revenue, both borrowing and taxation, for military affairs. For the scope of this book, the concept of a fiscal-military state applies to the funding of medical resources, infrastructure, and personnel in war and peace time. However, many historians regard the concept in need of rethinking, since until the nineteenth century, broad sections of the population were agrarian and operated outside the monetary and financial system. Moreover, the formal conclusion of the Napoleonic Wars (1803–1815) with the Congress of Vienna (1814–1815) provoked a caesura in the understanding of 'state power' and pointed to a change in political culture as the 'diplomatic concert' became a vital instrument to ensure peace and balance without a military demonstration of power.[19]

The last decade has spawned another key concept that has greatly facilitated a better understanding of the connections between the early modern state and war. The idea of the 'contactor state' shifts the focus from coercive fiscal power toward the significance of expenditures and the mobilisation of war-making resources. This includes again the crucial question of how states managed warfare, and it became clear that states needed partners for this endeavour. Multi-faceted types of semi-public–private partnerships emerged from that need, whose agreements,

Western Europe, Princeton 1975, p. 42 or recently from a political science perspective Johannes Jüde, Making or un-making states: when does war have formative effects?, in: European Journal of International Relations 28, 1 (2021), pp. 209–234.

18 John Brewer, The Sinews of Power: War, Money, and the English State, 1688–1783, Cambridge, MA 1989.

19 Recently the ERC project "The European Fiscal-Military System 1530–1870" headed by Peter H. Wilson and conducted at the University of Oxford: https://fiscalmilitary.history.ox.ac.uk/home, 20.01.2023; Matthias Meinhardt, Markus Meumann (eds.), Die Kapitalisierung des Krieges/The Capitalisation of War: Kriegsunternehmer im Spätmittelalter und in der Frühen Neuzeit / Military Entrepreneurs in the Late Middle Ages and the Early Modern Period, Münster 2021; Richard Bonney, The Rise of the Fiscal State in Europe 1200–1815, Oxford 1999; Rafael Torres Sánchez, The Triumph of the Fiscal-Military State in the Eighteenth Century, in: Rafael Torres Sánchez (ed.), War, State and Development: Fiscal-Military States in the Eighteenth Century, Pamplona 2007; Margaret Hunt, Women and the Fiscal-Imperial State in the Late Seventeenth and Early Eighteenth Centuries, in: Kathleen Wilson (ed.), A New Imperial History: Culture, Identity and Modernity in Britain and the Empire, Cambridge 2004, pp. 29–47; Christopher Storrs, War and the Military Revolution, in: C. Scott Dixon, Beat Kümin (eds.), Interpreting Early Modern Europe, New York 2020, pp. 244–267 and recently William D. Godsey, Petr Mata (eds.), The Habsburg Monarchy as a Fiscal-Military State, Oxford 2022. In a broader context we have to refer to the "Military Revolution" as a further model contributing to the understanding of the intertwining of state formation and warfare. See Clifford J. Rogers (ed.), The Military Revolution Debate: Readings on the Military Transformation of Early Modern Europe, Boulder 1995.

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contracts, and relationships with the state are central for the contractor state concept.[20]

Research on the management of military healthcare has so far only slightly touched these innovative research approaches. However, they are very promising for further research. Military healthcare can be seen as an enterprise, permitting historians to investigate problems such as how the provision of resources for medical infrastructures like (field) hospitals or lazarettes worked in detail, how the production or distribution of drugs was managed in (field) pharmacies, or by whom all of that was done and financed.[21]

By narrowing the focus, we have to address the entanglement of what Mark Harrison titled *The Medicalization of War – The Militarization of Medicine* in 1996.[22] While the reciprocal relationship of medicine and war is no longer questioned, a closer look at this relationship still reveals unresolved issues. In 1987, Johanna Bleker posited that physicians and surgeons' role in the civil service, underpinned by their professional ethic, may have contradicted with their duties in the wake of war. Bleker cited the influential German physician, Rudolf Virchow, who wrote in 1870: "Medicine is first to be destined to prepare the era of peace. In the midst of the horrors of war, it and essentially only it is officially destined to be present on the battlefields as a representative of humanity, […]".[23] The well-known metaphor of war as a teacher for medical professionals engendered criticism, since civilian medical care in particular rarely profited and war medicine was 'good' only for highly specialised practices that were relevant to the war effort or military resilience.[24]

20 Peter H. Wilson, Marianne Klerk, The business of war untangled: Cities as fiscal-military hubs in Europe (1530s–1860s), in: War in History 29, 1 (2020), pp. 80–103; Rafael Torres Sánchez, Military Entrepreneurs and the Spanish Contractor State in the Eighteenth Century. Oxford 2016; Richard Harding, Sergio Solbes Ferri (eds.), The Contractor States and its Implications (1659–1815), Las Palmas de Gran Canaria 2012; Huw V. Bowen, Agustín Gonzáles Encisco (eds.), Mobilising resources for war: Britain and Spain at work during the early modern period, Pamplona 2006.

21 A particular exception is the study by Matthew Neufeld and Blaine Wickham. See Neufeld, Wickham, The State (cf. note 14).

22 Mark Harrison, The Medicalization of War – The Militarization of Medicine, in: Social History of Medicine 9 (1996), pp. 267–276.

23 The German original by Rudolf Virchow: "*Die Medizin ist zunächst berufen, die Aera des Friedens vorzubereiten. Inmitten der Schrecken des Krieges ist sie und wesentlich nur sie amtlich berufen, auf den Schlachtfeldern anwesend zu sein als Vertreterin der Humanität, […]*". See Medizin im Dienst des Krieges – Krieg im Dienst der Medizin. Zur Frage der Kontinuität des ärztlichen Auftrages und ärztlicher Werthaltungen im Angesicht des Krieges, in: Johanna Bleker, Heinz-Peter Schmiedebach (eds.), Medizin und Krieg. Vom Dilemma der Heilberufe 1865 bis 1985, Frankfurt 1987, pp. 13–25, here p. 13.

24 Leo van Bergen, Eric Vermetten (eds.), The First World War and Health: Rethinking Resilience, Leiden et al. 2020, pp. 4–5; Roger Cooter, Medicine and the Goodness of War, in: Canadian Bulletin of Medical History 7, 2 (1990), pp. 147–159; Shauna Devine, Learning from

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Analysing the broader context of military healthcare evoked further core objectives on what has been called the military medical complex. Roughly since the end of the last century, historiography became enriched by impulses from social and cultural history, as scholars began intensively to examine the impact of war and warfare on civilian populations.[25] The penetration of everyday life by armed conflicts became a factor for the quality of an early modern life. The business of war was recognised as far from being a purely masculine affair, and it has been noticed how it spilled over into the feminine lifeworld. The transformation of this narrative boosted a gendered perspective on the impact of war on womankind.[26] Examining the role of civic participation in the military medical complex reveals different facets of voluntary and involuntary participation, including both 'patients' and 'care workers'. Formal and informal modes of care depended on civil work. Civilian forms of work concerned among others cleaning or cooking assistance and nursing care in governmental steered (field) hospitals and, if the medical infrastructure was not adequate enough, billeting in civilian homes was provided also by the ordinary people.[27]

Research has drawn attention to the significance of war as a phenomenon that requires the consideration of pre and postwar phases. The extension of the temporal and causal scope allows historians to examine the complexity of military healthcare in the early modern period more comprehensively. The medical examinations during the recruitment of troops on the eve of a war or the consideration of 'disability' and 'invalidity' as consequences of war could provide further impulses on the research of military healthcare.[28]

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the Wounded: The Civil War and the Rise of American Medical Science, Chapel Hill et al. 2014 or Ana Carden-Coyne, The Politics of Wounds: Military Patients and Medical Power in the First World War, Oxford 2014, pp. 6–13.

25 Ralf Pröve, Stehendes Heer und städtische Gesellschaft im 18. Jahrhundert. Göttingen und seine Militärbevölkerung 1713–1756, Munich 1885; Jutta Nowosadtko, Stehendes Heer im Ständestaat. Das Zusammenleben von Militär- und Zivilbevölkerung im Fürstbistum Münster 1650–1803, Paderborn 2011; Frank Tallett, War and Society in Early-Modern Europe 1495–1715, London et al. 1992 or Erica Charters et al. (eds.), Civilians and War in Europe 1618–1815, Liverpool 2012.

26 Karen Hagemann et al. (eds.), The Oxford Handbook of Gender, War, and the Western World since 1600, Oxford 2020; Karen Hagemann, Ralf Pröve (eds.), Landsknechte, Soldatenfrauen und Nationalkrieger. Militär, Krieg und Geschlechterordnung im historischen Wandel, Frankfurt/M. 1998; John A. Lynn, Woman, Armies, and Warfare in Early Modern Europe, Cambridge 2008.

27 Eric Gruber von Arni, Hospital Care and the British Standing Army, 1660–1714, Aldershot 2006; Eric Gruber von Arni, Justice to the Maimed Soldier: Nursing, Medical Care and Welfare for Sick and Wounded Soldiers and their Families during the English Civil Wars and Interregnum, 1642–1660, Aldershot 2001; Neufeld, Wickham, The State (cf. note 14); Spinney, Servants (cf. note 14).

28 Ivana Horbec, Dubravko Habek, War Invalids and Disabled Soldiers in the Habsburg Army: The Case of the Đurđevac Regiment in 1860/61, in: RAD CASA – Medical Sciences 540, 48/49

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Krank vom Krieg (sick from war) is the title of a recent published collection by Nikolas Funke, Gundula Gahlen, and Ulrike Ludwig, which explores cultural patterns of meanings of war diseases from antiquity to the present.[29] Bubonic plague, typhoid, dysentery, cholera, venereal diseases, or trachoma, etc. were, and partly still are, in the position to render an army inoperative. However, these diseases also brought war from the battlefield into civilian homes, even though not all of them eroded public health. Some diseases that prompted or legitimise public health measures by the state do not correspond with the urgency that followed from epidemiology. These diseases, e. g., cholera, venereal disease, or trachoma, were classified by Alfons Labisch in respect to their potential to enforce political measures as so-called *skandalisierte Krankheiten* (scandalised diseases).[30] However, the reciprocal influence of waging war and the spread of diseases has been known for a long time.[31] The entanglement has been illustrated by Friedrich Prinzing in his landmark book, *Epidemics Resulting from Wars* in 1916,[32] followed by Hans Zinsser's *Rats, Lice and History* in 1935.[33] The fatal relationship is illustrated, among other things, by the decimation of the armies in the Habsburg–Ottoman War (1736–1739) thanks to a bubonic plague outbreak,[34] the loss of 10 per cent of its maximum effective strength of the French Army to

(2019), pp. 86–91; Julia Heinemann, Geweste Soldaten und Invalide. Die Kategorisierung von Kriegsversehrtheit in der Habsburger Verwaltung (Wien, 1678–1750), in: Nikolas Funke et al. (eds.), Krank vom Krieg. Umgangsweisen und kulturelle Deutungsmuster von der Antike in die Moderne, Frankfurt et al. 2022, pp. 189–215; Martin Winter, Zum Besten der Invaliden Casse. Der Zugriff auf das Vermögen entwichener kantonpflichtiger Untertanen aus Brandenburg im 18. Jahrhundert, in: Markus Meumann, Ralf Pröve (eds.), Herrschaft in der Frühen Neuzeit. Umrisse eines dynamisch-kommunikativen Prozesses, Münster 2004, pp. 195–229; Pierluigei Pironti, Kriegsopfer und Staat. Sozialpolitik für Invaliden, Witwen und Waisen des Ersten Weltkriegs in Deutschland und Italien (1914–1924), Cologne et al. 2015.

29 Relevant for this book is in particular the chapter by Sebastian Pranghofer, Der Umgang mit Krankheit und Seuchengefahr im Kriegsalltag in Nordwestdeutschland, 1757–1763, in: Nikolas Funke et al. (eds.), Krank vom Krieg. Umgangsweisen und kulturelle Deutungsmuster von der Antike bis in die Moderne, Frankfurt et al. 2022, pp. 105–133.

30 Alfons Labisch, Der "öffentliche Werth der Gesundheit". Oder: was bringt eine Gesellschaft dazu, gesund sein und bleiben zu wollen? Die historische Perspektive, in: Heinz-Peter Schmiedebach (ed.), Medizin und öffentliche Gesundheit. Konzepte, Akteure, Perspektiven, Berlin et al. 2018, pp. 29–46.

31 Matthew R. Smallman-Raynor, Andrew D. Cliff, War Epidemics: An Historical Geography of Infectious Diseases in Military Conflict and Civil Strife, 1850–2000, Oxford 2004, and from recent research, see Stuart B. Jennings, Controlling disease in a civil-war garrison town: Military discipline or civic duty? The surviving evidence for Newark upon Trent, 1642–46, in: David J. Appleby, Andrew Hopper (eds.), Battle-scarred: Mortality, medical care and military welfare in the British Civil Wars, Manchester 2018, pp. 40–54.

32 Friedrich Prinzing, Epidemics resulting from Wars, Oxford 1916.

33 Hans Zinsser, Rats, Lice and History, London 1935.

34 Sabine Jesner, Fighting war epidemics: Habsburg strategies of disease management during the Ottoman War 1736–1739, in: Tryntje Helfferich, Howard Louthan (eds.), Beyond the Battlefield: Reconsidering Warfare in Early Modern Europe, London 2023, pp. 228–243.

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epidemics of cholera, dysentery, or typhus fever in the Crimean War (1854–1856)[35] and the 'Spanish flu' pandemic during the Great War in 1918/19.[36]

Early modern societies recognised these threats, although their patterns of meanings corresponded with the zeitgeist (miasma theory) and were far away from micro-biological scientific explanations, which have been efficiently developed since the second half of the nineteenth century, at the beginning of the bacteriological age. However, these threats facilitated the emergence of new policies, and 'prevention' became a public health policy parameter. The idea of prevention had its origin within the complex field of the management of contagious diseases. States tried to prohibit outbreaks of diseases by controlling the mobility of the population. Facing large and seemingly invisible dangers, characteristic of epidemics, state surveillance was accepted by the population, as Michel Foucault described it in his book, *Surveiller et punir: Naissance de la prison* in 1975.[37] Putting people, suspected of an infectious disease, into seclusion is today subsumed under the term 'social distancing' and is, as a medical technique, represented by the method of 'quarantine', part of the medical standard today. The protection of the entire population at risk forms the basis of this policy, and remains a difficult area of governance until today.

The transformation of the army medical systems is fundamental for the thematic focus in this book. It serves as a starting point to demonstrate why and how military medical healthcare has been adapted. Sebastian Pranghofer, examining the early modern German context, argued that "as consequence of this alteration, individual soldiers and their bodies were transformed in populations that could be measured and managed on the large scale" and that "military populations were consider to be assets and their value was primarily based on their utility".[38] Pranghofer further stated that within the context of German cameralism, a drive to enhance the usefulness of military manpower propelled early modern states to improve their military healthcare.[39] It is undoubted that the motives behind governmental actions and behaviour are concentrated on the necessity to strengthen the state. Consequently, early modern states were under pressure to invest in a huge number of healthy soldiers and sailors in order to strengthen this power. Therefore, the governance of military medical health is

35 Smallmann-Raynor, Cliff, War Epidemics (cf. note 31), p. ix; Prinzing, Epidemics (cf. note 32), p. 17; Uğurgül Tunç, Lessons from the Crimean War: How Hospitals were Transformed by Florence Nightingale and Others, in: Infectious Diseases & Clinical Microbiology 2 (2019), pp. 110–118.

36 See for the rich and substantial studies, among others, Mark Osborne Humphries, The Last Plague: Spanish Influenza and the Politics of Public Health in Canada, Toronto 2013; Laura Spinney, Pale Rider: The Spanish Flu of 1918 and How It Changed the World, London 2017.

37 Michel Foucault, Surveiller et punir: Naissance de la prison, Paris 1975.

38 Pranghofer, States of healing (cf. note 16), p. 283.

39 Ibid.

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characterised by a mode of rationality when it comes to the implementation of health policy and the formation of a perfect soldier's body for war (*Kriegskörper*).[40]

A well-organised logistics chain was essential for the success of military healthcare. The provision of troops with foodstuffs and fresh water, or the compliance with hygiene standards was as important as the functionality of medical infrastructures and the availability of healthcare workers. Such fundamental processes were key state responsibilities, instantiated in military administrations, whose efficiency could be determinative for the state's capacity to manage military healthcare. Even with the greatest efforts, military healthcare can never be a full success story and will always be connected to the state's ability to offer sufficient funds and care. Besides high numbers of casualties, a lack of state capacity can be linked to the sociocultural phenomena of desertion and self-mutilation.[41] The abandonment of a military duty in general is still a huge research gap that needs to be filled urgently with new insights on the entanglement of trauma care or the fear of war. In-depth research on the synergy of individuals and their agency within the military medical complex would stimulate further scholarship.

2. Structure and contents

A quarter century has passed since the publication of the book, *War, Medicine and Modernity*, edited by Roger Cooter, Mark Harrison, and Steve Sturdy.[42] The book's editors rightly insisted that historians of medicine needed to take seriously the interweaving of practices of healing with organised violence, within time- and place-specific social and cultural structures. This collection's emphasis on early modern warfare and medicine complements its worthy predecessor with its similar insistence on the cultural and social specificity of state-supervised attempts to respond to the plight of injured and sick servicemen.

Early modern military medicine, like its late-nineteenth- and twentieth-century successors, presented practitioners and administrators with enormous

40 Klaus Wiehl, Kriegskörper. Zur Formation idealer Soldaten in Literatur und Wissenschaft im 18. Jahrhundert, Würzburg 2020.

41 Michael Sikora, Disziplin und Desertion. Strukturprobleme militärischer Organisation im 18. Jahrhundert, Berlin 1996; Ulrich Bröckling, Michael Sikora (eds.), Armeen und ihre Deserteure. Vernachlässigte Kapitel einer Militärgeschichte der Neuzeit, Göttingen 1998; Mathias van Rossum, Jeannette Kamp (eds.), Desertion in the Early Modern World: A Comparative History, London 2016.

42 Roger Cooter, Mark Harrison, Steve Sturdy (eds.), War, Medicine and Modernity, Stroud 1998.

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challenges of human and material resource management. The first section of this book explores closely the careers of several officials entrusted by their governments with the provision of care to wounded and sick soldiers and sailors. Anke Fischer-Kattner's essay examines the actions of the French commissary, Charles Hocquard, who was responsible for the care of those injured during the spring 1734 siege of Philippsburg, a fortress along the River Rhine. This species of slow, drawn-out encounter, in which the outcome depended on the defenders' will to resist and the attackers' willingness to make incremental progress, was a hallmark of early modern warfare. However, little scholarship thus far has attended to the challenges of medical care in the midst of a siege. Fischer-Kattner analyses the siege hospital system erected by Hocquard, and shows how it functioned and how it addressed severe challenges. This essay offers important insight into the ways the emerging French state dealt with the medical implications of war at the local level, and the significance of non-medical officials such as Hocquard in the provision of care for soldiers.

While the French commissary acted primarily for the sake of the men under his care during the siege, a decade later, two officials employed to administer medical treatment for sick and injured British sailors found themselves under investigation for putting their personal interests above that of the patients. Matthew Neufeld's essay examines the cases of Sir James Barclay and John Butler, two agents for the sick and wounded administration at the port town of Gosport, who were both dismissed from their posts on charges of corruption. The investigations suggest that corruption in naval healthcare was partly the product of circumstances in which local agents determined that the navy's ethic of service for the sick and wounded trespassed or threatened to undermine officials' legitimate self-interest or even self-preservation. Thus, the mid-eighteenth-century British naval healthcare administration confronted corruption when its prioritisation of human resources—sick and injured seamen—unduly harmed its officials.

Erin Spinney's essay explores the workings of the Royal Navy's main onshore healthcare institutions, Haslar and Plymouth naval hospitals. She shows the importance of and variability of women's work at these hospitals through an innovative prosopographical analysis of their pay records. Spinney demonstrates that not only did the work of washerwomen and nurses significantly contribute to the hospitals' success, but also were part of a wider network of preferentially treated sailors' wives and widows of seamen. Women workers at the naval hospital formed a kind of auxiliary labour force whom the British fiscal-state regarded as intrinsic to the proper functioning of its healthcare infrastructure.

Early modern states aspired not only to manage men and resources in order to prosecute their wars but also to enhance their capacity to conduct the conduct of their subjects, in part by bringing diseases themselves under a kind of control.

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The second section of this book, which concerns disease management and society, opens with an essay by Sabine Jesner on the Habsburg Army's handling of soldiers with sexually transmitted infections. The medical and social consequences of this class of diseases persisted long after a war's end. Their effects reached deep into the private lives of families and intimate partners, and produce different outcomes for women and men. Jesner's analysis shows that during the last quarter of the eighteenth century, the Habsburg Monarchy began to shift its position on public morality and its thinking about the population. This change was exemplified by new bespoke modes of treatment of sexually transmitted diseases. The conception of venereal diseases shifted from a criminal and moral question toward a demographic and medical one. An important driver of this shift was the government's consideration of the disease's impact on two factors that were of crucial importance for the consolidation of the Empire during the long eighteenth century: its economic prosperity and the military strength of the Habsburg Monarchy. Consequently, the prevention, containment, and cure of venereal disease became an issue for governmental military medicine.

Changing conceptions of disease played an important role in transforming the practice of military healthcare, with important implications for domestic medicine in peacetime. Christian Promitzer and Marcel Chahrour examine in their essay how during the early nineteenth century, ophthalmic diseases played an important part in uncovering the processes of the transmission. An epidemic outbreak of trachoma at the garrison in the town of Klagenfurt in 1822/24 became a matter of serious concern for both the military and the civilian authorities. The authors show how military and general physicians tried to assess the aetiology and pathogenesis of the disease among the soldiers. By localising the illness and focusing on the organ of concern, the diseased eye, physicians rejected disease aetiologies based on the assumptions of Galenic medicine. Postwar military efforts to address the epidemic thus affected the state's approach to public health and physicians' conception of the genesis of disease.

The second section concludes with an essay by Nebiha Guiga, which remains focused on early-nineteenth-century developments. Turning to the period of the Napoleonic Wars, Guiga's essay outlines the interactions of formal and informal modes of care and of various actors taking part in the treatment of wounded soldiers. It highlights the significance of the constant interaction of formal and informal modes of care, as well as the role of both civilians and military officials. Guiga points out that during these campaigns, military health services only worked within the larger background of networks of care based on interactions involving both soldiers and local civilians. The key point is that even during the transformative conflicts of the Napoleonic era, which saw an increased militarisation of medicine, formal and informal modes of care were not sharply separated nor were they always clearly distinguishable.

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The third and final section of the book deals with the transformations of educational and practical sectors of medicine and healthcare. Vojtěch Szajkó's essay challenges suggestions that processes normally associated with the modernisation of medicine first began in the nineteenth century. Szajkó provides a broad overview of professionalisation and institutionalisation, focused on military physicians under the Habsburg Monarchy, Prussia, and the Ottoman Empire from 1500 to 1800. Professionalisation meant the emergence of a distinct professional group of qualified military physicians and surgeons. Institutionalisation involved the establishment of military medical schools and hospitals, which then became enablers of the professionalisation of the military physician or surgeon as an occupation. He argues that the rulers of these very different political communities undertook significant changes in war medicine for broadly similar reasons—to possess armies that were as strong and as numerous as possible.

Brigitte Lohff 's contribution homes in on an institutional context that proved critical for consolidating important trends within early modern military medicine in the Habsburg Monarchy: the *Josephinum* in Vienna. The *Josephinum*, as the premier academy for training military surgeons within the Austrian Empire, witnessed intense debates over the curriculum shortly after its founding in 1785. These vehement discussions ultimately contributed to the improvement of the education. The essay also shows clearly that from an early stage, the institution confronted changing demands and contrasting approaches to the education of military surgeons, which led ultimately to its alignment with university medical training.

The final essay of the third section shifts attention from human to animal medicine. Daniela Haarmann rightly reminds scholars that the history of human and veterinary medicine have a long, if under-explored, connection. Pandemics and epidemics like malaria and monkey pox provide daily proof that healthy animals are an essential and important precondition for public health. Shining a light on the emergence of what in early modern German lands was called the establishment of a functional medical police (*Medizinalpolizey*), Haarmann points to the connection between the increasing interest among the Habsburg authorities in the administration of various kinds of health-related agendas, and the establishment of veterinary medicine's educational and regulatory systems in the Monarchy. This shows the fundamental importance of veterinary medicine for both military and civil society in the seventy-five years following the end of the Seven Years War.

Taken together, the essays in *Military Health Care and the Early Modern State, 1660–1830* testify to the importance of the (very) long eighteenth century for historians of medicine and warfare. Governmental authorities in a variety of European polities strove to respond to short-term medical challenges, such as

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epidemics or deadly sieges, through reasoned-out policies and what they hoped were reasonably honest and dedicated officials. Their attempts to bring order and healing to what were often chaotic and disorienting situations did not always succeed or achieve their intended outcomes. However, falling short of their goals did not stop rulers and administrators from conceiving ways to manage the conduct of soldiers and civilians such that both kinds of subjects would contribute to and enhance governmental capacity, even to the extent of promoting life and health. Additionally, ordinary people continued to form a crucial base of support for the day-to-day care of sick and wounded soldiers, with more or less appreciation and recognition from their governors. Thus, many of the features of the complicated relationship between war and medicine that sparked the curiosity of historians of medicine at the turn of the twenty-first century lie scattered across the eighteenth-century European landscape. This book will have succeeded in its aim if it encourages scholars working outside the German and English-language spheres to gather up and analyse such fragments lying in their fields of study.

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Managing Military Healthcare

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Anke Fischer-Kattner

Commissaire Ordonnateur Hocquard at the Siege of Philippsburg (1734): An Administrative Pivot of Military Medicine in Ancien-Régime Warfare

In our disturbing present, which combines a pandemic with the resurgence of war in Europe, the connection between medicine and the military might appear obvious. Yet in 1993, Roger Cooter claimed that the field of "relations between medicine and war" was "poorly served" by research in the burgeoning history of medicine.[1] Since then, a number of studies on late-nineteenth- and twentieth-century warfare have filled in many of the gaps he diagnosed. Histories that link medicine and war are often interpreted within the scope of modernisation, even though this is no longer necessarily regarded as a unified or positive development —and within such a framework and for this era, the role of the modern (national) state has largely gone unquestioned.[2] According to this view, modern states were external to the institutions of medicine, and they were certainly crucial actors of war.[3]

Yet, from the perspective of the early modern period, when such states cannot be assumed, things look different. The triadic relationship of the military, medicine, and the state is therefore being reconsidered in recent research. Thus, functional alternatives to Weberian bureaucratisation can be detected, for example, in the involvement of English coastal communities in care arrangements for the wounded of seventeenth-century naval warfare.[4] Likewise, a closer look at practices and theoretical writings emanating from eighteenth-century military hospitals reveals the crucial overlap between military and medical 'paper technologies', which eventually permitted bio-political intervention into state pop-

1 Roger Cooter, War and Modern Medicine, in: W. F. Bynum, Roy Porter (eds.), Companion Encyclopaedia of the History of Medicine, London 1993, pp. 1536–1573, at p. 1536.

2 See for a critical account of the pervasive assumptions inherent in modernisation narratives: Wolfgang Knöbl, Theories That Won't Pass Away: The Never-Ending Story of Modernization Theory, in: Engin F. Isin, Gerard Delanty (eds.), Handbook of Historical Sociology, London 2003, pp. 96–107.

3 See, e. g., Daniel M. Fox, Medical Institutions and the State, in: W. F. Bynum, Roy Porter (eds.), Companion Encyclopaedia of the History of Medicine, London 1993, pp. 1204–1230.

4 Matthew Neufeld, The Framework of Casualty Care during the Anglo-Dutch Wars, in: War in History 19, 4 (2012), pp. 427–444.

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ulations.[5] Considering such entanglements between state formation, military, and medical developments, Sebastian Pranghofer has even suggested that a tightly woven 'medical-military complex' awaits detailed studies of the actors and practices.[6]

An investigation into the activities of a French commissary named Hocquard, who was responsible for, among many other logistical issues, the care of those injured in the attacks on the fortress of Philippsburg on the Rhine River (25th May–18th June 1734), highlights a group of actors and an area of practice which has been ignored in histories of medicine and of administration. Enthralled by the set-piece battle, military history has only recently begun to pay closer attention to siege warfare, although sieges actually made up the biggest share of large- to medium-scale operations of early modern war and were often connected to its most prominent form—small-scale skirmishing.[7] Moreover, siege hospital systems, how they functioned, and how they confronted severe challenges, offer important insights into the ways in which the emerging French state addressed the medical implications of its wars at the local level. This achievement certainly deserves closer attention as a pivotal element of the early modern medical-military complex.

1. Forgotten Aspects of the Early Eighteenth-century Medical-Military Complex: Commissaries and Siege Warfare

The history of medicine has analysed important elements of the medical-military complex. Yet, its focus on medical personnel and—more recently—patients, has so far neglected a crucial actor of the state-building process: the commissary.

5 Sebastian Pranghofer, States of Healing in Early Modern Germany: Military Health Care and the Management of Manpower, in: Axel C. Hüntelmann, Oliver Falk (eds.), Accounting for Health: Calculation, Paperwork, and Medicine, 1500–2000, Manchester 2021, pp. 283–304, at p. 298. Cf. for the pioneering study of the connections between imperial military manpower and medicine Erica Charters, Disease, War, and the Imperial State, Chicago, IL et al. 2014.

6 Sebastian Pranghofer, The Early Modern Medical-Military Complex: The Wider Context of the Relationship Between Military, Medicine, and the State, in: Canadian Journal of History 51, 3 (2016), pp. 451–472.

7 Remarks on this could already be found in Frank Tallett, War and Society in Early-Modern Europe, 1495–1715 (= War in context), London 1992, p. 3; as well as Jürgen Luh, Kriegskunst in Europa 1650–1800, Cologne et al. 2004, pp. 10–11. The importance of the siege in the early modern period is substantiated by Jeremy Black, Fortification and Siegecraft: Defense and Attack through the Ages, Lanham et al. 2018, pp. 65–169. Cf. for a cultural-history perspective, Anke Fischer-Kattner, Jamel Ostwald (eds.), The World of the Siege: Representations of Early Modern Positional Warfare (= History of Warfare 126), Leiden et al. 2019; and, most recently, for the experience of sieges in the era of the Napoleonic Wars, with a literature-based retrospection into eighteenth-century practices and legal theory, Gavin Daly, Storm and Sack: British Sieges, Violence and the Laws of War in the Napoleonic Era, 1799–1815, Cambridge 2022.

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This is surprising, considering that pioneering German histories of state building in the early twentieth century, most prominently those by the historian Otto Hintze and the legal scholar Carl Schmitt pointed out the fundamental role played by the *commissarius* as an agent of centralising state power.[8]

From the fourteenth century onwards, officials that came to be labelled commissaries of war, *commissaires des guerres*, were charged with the logistics and administration of the French kings' armies.[9] Their many duties lay at the core of the intimate connection between "war making and state making".[10] These activities have indeed been accorded some historiographical attention in the context of the development of fiscal-military states.[11] Yet, for practitioners of administrative history, concentrating on the commissaries' employment in the expansion of fiscal systems and bureaucratic administration, their responsibility for organising the care of the sick and wounded in war did not count among their key state-building activities. However, the parallel organisation of the war commissariat and the army medical services, marked by important codifications of their norms and regulations in the first decade of the eighteenth century,[12] points to decisive connections worthy of closer investigation.

8 Otto Hintze, Der Commissarius und seine Bedeutung in der allgemeinen Verwaltungsgeschichte, in: Id.: Gesammelte Abhandlungen, ed. by Gerhard Oestreich, vol. 1: Staat und Verfassung, 2nd edn., Göttingen 1962 [originally 1911], pp. 242–274; Carl Schmitt, Die Diktatur: Von den Anfängen des modernen Souveränitätsgedankens bis zum proletarischen Klassenkampf, 6th edn., Berlin 1994 [originally 1921].

9 R. Stiot, Le Commissariat des guerres: Son organisation – Son évolution – Ses attributions, in: La Revue administrative 10, 59 (1957), pp. 454–463; for the origins of the office, see pp. 454–455.

10 See for the origin of this fortuitous phrasing: Charles Tilly, War Making and State Making as Organized Crime, in: Peter B. Evans et al. (eds.), Bringing the State Back In, Cambridge 1985, pp. 169–191.

11 Cf. for the origins of this concept, John Brewer, The Sinews of Power: War, Money and the English State, 1688–1783, London 1988; the debate around it is summarised by Aaron Graham, Patrick Walsh, Introduction, in: Aaron Graham, Patrick Walsh (eds.), The British Fiscal-Military States, 1660-c. 1783, London et al. 2016, pp. 1–26; for a probe into its use as an overarching European model, see Christopher Storrs (ed.), The Fiscal-Military State in Eighteenth-Century Europe: Essays in Honour of P. G. M. Dickson, Farnham et al. 2009.

12 Stiot points to royal ordinances in 1704 as a major organisational step for the commissariat (Stiot, Commissariat (cf. note 9), p. 458), while the foundation of a "corps des officiers de santé militaire" by royal edict in 1708 (Monique Lucenet, Médecine, chirurgie et armée en France au siècle des Lumières, Sceaux 2006, p. 21) has become a topical statement (cf. Jean Guillermand et al., Histoire de la médecine aux armées, vol. 1: De l'Antiquité à la Révolution, Paris 1982, pp. 397–402; Laurence Brockliss, Colin Jones, The Medical World of Early Modern France, Oxford 1997, p. 696, pointing to the precursor of the naval health service introduced in 1689).

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While the connection of early modern state building and military medicine has recently been accorded some attention,[13] the role of the commissaries of war in the medical-military complex is far from clear.[14] This even applies for the well-researched case of early modern France,[15] where the traditional notion that *commissaires* were civilian officials employed by the central government in order to control military administration still overshadows all evidence that points to close entanglements and even partial identification between commissaries and military officers.[16] In the course of the eighteenth century, the commissaries were becoming, as Monique Lucenet diagnoses, "'*l'âme et le moteur' de tout le Service de Santé*" of the French military.[17] Introducing a few examples of commissaries' careers from archival sources,[18] Lucenet's pioneering work—though much more exhaustive on the medical professionals[19]—underlines how much more systematic research needs to be conducted on this group of key actors in the military-medical complex.

The figure of the early modern commissary links military medicine to an important, yet largely neglected component of early modern warfare: sieges. The history of medicine does provide some hints to the fact that the earliest ambulant military hospitals were organised for sieges, whose stable locales made spatial planning possible. While Laurence Brockliss and Colin Jones mention Amiens (1597) as a point of origin,[20] Monique Lucenet places professional medical care

13 Cf. e. g., besides Charters, War (cf. note 5), with its focus on mid-eighteenth-century Britain, for the mid-17th century: Matthew Neufeld, Blaine Wickham, The State, the People and the Care of Sick and Injured Sailors in Late Stuart England, in: Social History of Medicine 28, 1 (2015), pp. 45–63.

14 Collectively, they were discussed almost 40 years ago in a short archival study by Claude C. Sturgill, Les commissaires des guerres et l'administration de l'armée française, 1715–1730, Vincennes 1985, who was stressing the dysfunctional aspects of a system running on debt.

15 A great overview, which still has to be considered the standard introduction in English to the topic of early modern French medical history in its political, social, and cultural contexts, is offered by Brockliss, Jones, Medical World (cf. note 12). From the sheer mass of studies on French absolutism and its administrative developments, important recent overviews stress the connection between state building and the army, e. g., Guy Rowlands, The Dynastic State and the Army under Louis XIV: Royal Service and Private Interest, 1661–1701, Cambridge 2002; Hervé Drévillon, Olivier Wieviorka (eds.), Histoire militaire de la France, vol. 1: Des Mérovingiens au Second Empire, Paris 2018.

16 Cf. e. g. Brockliss, Jones, Medical World (cf. note 12), p. 698. While late-17th-century ordinances had already assimilated the rank of the *commissaires conducteurs*, who were to provide for army units on the march, to "officiers combattants" (Stiot, Commissariat (cf. note 9), p. 456), commissaries received a uniform in 1746 and were officially accorded military status in 1767 (ibid., p. 458).

17 Lucenet, Médecine (cf. note 12), p. 74.

18 Ibid., pp. 74–76.

19 Ibid., pp. 77–91.

20 Brockliss, Jones, Medical World (cf. note 12), p. 253; this is probably based on Colin Jones, The Welfare of the French Foot-Soldier, in: History 65, 214 (1980), pp. 193–213, at p. 194.

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provided for the French soldiers at the siege of Rennes in the late fifteenth century in much longer, ancient, and medieval traditions of military medicine.[21] These were continued and expanded by Henri IV at Amiens, but this had certainly also been the case at the siege of Rouen in 1591.[22]

In 1629, the decrees united in the *Code Michaud* ordered, among other things, that medical professionals be employed with every regiment and fortress. These were to be used for the establishment of temporary hospitals on campaigns.[23] Yet, the existing historiography has tended to focus on the permanent institutions in fortress cities, regarded as the organisational forerunners of modern hospitals.[24] Much less attention is accorded to the 'flying' mobile hospitals prepared for campaigns in the eighteenth century.[25] In between the permanent military hospitals and the short-term care arrangements necessary for the masses of sick and wounded on battlefields, the medium-term establishment of siege hospitals all but disappears from view in most of the literature.

A closer look at a particular commissary and his efforts to organise care for the wounded of a major siege operation thus offers important insights into the functioning of a key area of military medicine in its connection with the emerging state. The campaign records kept at the French Military Archives, established as an official repository by Louis XIV's Minister of War, François Michel Le Tellier de Louvois, in 1688,[26] demonstrate the interest which the French kings and their court took in matters of military medicine. Instead of following a clear, hierarchical chain of administrative command, in which the provincial intendant, turned *intendant de l'armée* in wartime, would supervise the commissaries' activities and report to the Minister of War,[27] commissaries, especially those with responsibility for medical care, corresponded regularly with the court themselves. Louvois' successors in the eighteenth century were consciously following his example in keeping up communications with officers and officials at different levels of the military and administrative hierarchy, as they strove to obtain multifaceted information on the course of the war for the royal cabinet. Thus, Nicolas

21 Lucenet, Médecine (cf. note 12), p. 17.
22 Ibid., p. 19.
23 Brockliss, Jones, Medical World (cf. note 12), pp. 253–254.
24 Ibid., p. 254 and pp. 689–700. See the same general tendency in Lucenet, Médecine (cf. note 12), pp. 52–95.
25 Lucenet, Médicine (cf. note 12), pp. 55–59.
26 For a brief overview of the establishment of the *Dépôt de la Guerre* and its rich archival treasures, see Markus Meumann, Quellen zur Sozial- und Verwaltungsgeschichte der Armee sowie zum Verhältnis von Militär- und Zivilbevölkerung im Frankreich des Ancien Régime. Ein Wegweiser zu französischen Archiven und Bibliotheken, in: Militärgeschichtliche Zeitschrift 64, 1 (2005), pp. 177–200, at p. 184. For Louvois' biography and political role, cf. e.g., André Corvisier, Louvois, Paris 1983.
27 This is suggested by Lucenet's sketch of "la chaîne hospitalière": Lucenet, Médecine (cf. note 12), p. 74.

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Prosper Baüyn, sieur d'Angervilliers,[28] Louis XV's Minister of War for more than a decade during the reign of Cardinal-Minister de Fleury,[29] eagerly received and answered the letters of a man named Charles Hocquard, who was the organising commissary at the siege of the Rhine fortress of Philippsburg in 1734, the main operation in the German theatre of the War of the Polish Succession during that year. The sources preserved at Vincennes offer glimpses into the running of a crucial temporary local institution of the military-medical complex, the siege hospital.

2. Case Study: Philippsburg and the War of the Polish Succession —Hospital Structures in Cabinet Warfare?

The war that broke out over the question of who should rule the Polish–Lithuanian Commonwealth after the death of its Saxon king, Augustus II, in early 1733 is largely disregarded in current historiography.[30] If mentioned at all, it is usually passed over as "the most typical of eighteenth-century wars, a kind of model for the cautious and restricted warfare of the time."[31] Yet, the soldiers at the siege of Philippsburg would probably have disagreed with that judgement. The French besiegers no doubt considered themselves engaged in the most serious of conflicts as they struggled against intricate defensive works, ably manned enemy artillery, and a flood in the Rhine valley, all while fearing the arrival of an imperial relief force commanded by the redoubtable Prince Eugene of Savoy.

28 See for his political role and biography, Guillaume Lasconjarias, Baüyn d'Angervilliers, Secrétaire d'État de la Guerre (1728–1740), in: Annuaire-Bulletin de la Société de l'histoire de France (2011), pp. 79–95.

29 Extremely critical of his administration is Guy Chaussinand-Nogaret, Le Cardinal de Fleury: Le Richelieu de Louis XV, Paris 2002. A more positive impression of the cardinal, mainly in order to rehabilitate the king as a political actor, is offered by Jean-Christian Petitfils, Louis XV, Paris 2014, pp. 159–358.

30 The last academic monograph in English is more than 40 years old: John L. Sutton, The King's Honor and the King's Cardinal: The War of the Polish Succession, Lexington, KY 1980. Operational history is still most reliably depicted, though with dated historiographical concepts, by the Austrian War Archive's overview and general staff source edition: Raimund Gerba (arr.), Polnischer Thronfolge-Krieg. Feldzüge 1733 und 1734 (= Feldzüge des Prinzen Eugen von Savoyen, ed. by the Kriegsgeschichtliche Abtheilung des k. und k. Kriegs-Archivs, vol. 19; 2nd series, vol. 10), Vienna 1891; as well as its successor volume (Id. (arr.), Polnischer Thronfolge-Krieg. Feldzug 1735 (= Feldzüge des Prinzen Eugen von Savoyen, ed. by the Kriegsgeschichtliche Abtheilung des k. und k. Kriegs-Archivs, vol. 20, 2nd series, vol. 11), Vienna 1891). A helpful overview is provided in, e.g., Heinz Musall, Die Feldzüge der französischen Armee am Oberrhein in den Jahren 1734 und 1735 während des Polnischen Thronfolgekrieges. Kriegführung und Militärkartographie am Oberrhein zu Beginn des 18. Jahrhunderts, Karlsruhe-Durlach 2013, pp. 73–88.

31 Sutton, King's Honor (cf. note 30), p. 9.

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Obviously, the royal court at Versailles was of a similar opinion, and it tried to relieve the suffering of its wounded fighters. Even after the death of war-enthusiast Louis XIV in 1715, the French state continued to expend considerable amounts of money from the *Extraordinaire des guerres* on military health services. In peace time, 1.3 per cent of the funds spent in this account (which included common soldiers' pay, lodgings, and food, and the [costly] construction of fortresses) were dedicated to the health of the troops. During the War of the Austrian Succession, this percentage more than doubled, reaching 3 per cent in 1746.[32] Meanwhile, the overall expenditure was also rising steeply as ever more costly campaigns had to be financed. The care of the fiscal-military state for its sick and wounded soldiers was a significant financial factor in war-making during the eighteenth century.

For a French army on campaign, an intendant, a high-ranking official at the head of the provincial administration, was appointed as the army intendant and charged with the overall supervision of the logistics for the war effort. A number of ordinary war commissaries (*commissaires ordinaires des guerres*) formed the executive staff on whom he could rely for various errands.[33] The oversight of military hospitals with the army, however, had been since at least the seventeenth century among the distinctive tasks that were the responsibility of a higher-ranking commissary, the *commissaire ordonnateur*.[34]

For the French *Armée du Rhin* commanded by the Duke of Berwick,[35] it was the intendant of Strasbourg in Alsace, Paul Esprit Feydeau de Brou, who was to organise the logistical side of the 1734 campaign in the Rhineland.[36] During the previous autumn, the French had opened a front against the Holy Roman Emperor, Charles VI, thanks to the quick conquest of the bridgehead fortress of

32 Lucenet, Médecine (cf. note 12), pp. 42–44.

33 Cf. for a schematic depiction of the hierarchies: Sturgill, Commissaires (cf. note 14), p. 15 (yet, with a focus on peacetime, in which provincial war commissaries formed a hierarchical level in between the intendant and his subdélégué, on the one hand, and the commissaries on the other); Lucenet, Médecine (cf. note 12), p. 53.

34 Sturgill, Commissaires (cf. note 14), p. 12; cf. for the complex history of the hierarchy within the commissariat during the (pre-revolutionary) 18th century, Stiot, Commissariat (cf. note 9), pp. 458–460, and for the explicit responsibility of the *commissaire ordonnateur* for military hospitals at p. 459.

35 He was an illegitimate son of the deposed English monarch, James II Stuart, who had risen to the position of a Marshall of France; see for his biography and military career, Alix de Rohan Chabot, Le maréchal de Berwick: Une épée anglaise au service des Bourbons, Paris 1990; Stuart Handley, Fitzjames, James, duke of Berwick upon Tweed (1670–1734), army officer in the French service, in: Oxford Dictionary of National Biography, vol. 19, DOI: https://doi.org/10.1093/ref:odnb/9610, 03.09.2022.

36 See for his career [François Alexandre Aubert] de la Chenaye-Desbois, [Jacques] Badier, Dictionnaire de la noblesse, contenant les Généalogies, l'Histoire & la Chronologie des Familles Nobles de France, […], 3rd edn., vol. 8, Paris 1866, p. 25.

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Kehl, undertaken before an imperial army could even be raised.[37] For the next campaign season, the emperor sent his most famous general to the Rhine, the president of the Aulic War Council, Prince Eugene of Savoy, as commander of the imperial forces. While the latter was still waiting for the different contingents of his army to arrive,[38] Berwick's troops crossed the Rhine on 30th April and proceeded to besiege the imperial fortress of Philippsburg. A modern stronghold in the prince-bishopric of Speyer, it had been hotly contested by the Empire and France ever since the Thirty Years War.[39] When Berwick split his army into besieging and covering forces, intendant de Brou decided to manage the huge effort of supplying them all from Strasbourg.[40] In his stead, commissary of war Hocquard took over the direction of local logistics and supply, in the headquarters of the besieging force, as *commissaire ordonnateur*.[41] By this appointment, Hocquard[42] became responsible, among many other things, for the establishment of a field hospital and care system for those wounded at the siege.

37 Gerba, Polnischer Thronfolge-Krieg, 1733–1734 (cf. note 30), pp. 42–53; Sutton, King's Honor (cf. note 30), pp. 74–78; for the intricacies of the imperial defense organisation, see Peter H. Wilson, The Holy Roman Empire and the Problem of the Armed Estates, in: Peter Rauscher (ed.), Kriegführung und Staatsfinanzen. Die Habsburgermonarchie und das Heilige Römische Reich vom Dreißigjährigen Krieg bis zum Ende des habsburgischen Kaisertums 1740, Münster 2010, pp. 487–514.

38 For an overview of the complexities of the imperial war machine, see Wilson, The Holy Roman Empire (cf. note 37), pp. 487–514.

39 The last major historiographical monograph on this important European fortress dates from the late nineteenth century: Hieronymus Nopp, Geschichte der Stadt und ehemaligen Reichsfestung Philippsburg von ihrem Entstehen aus der Burg und dem Dorfe Udenheim bis zum Anfalle derselben an Baden, Speyer 1881. While it offers a detailed account based on extensive archival work, its narrative and interpretation can no longer be regarded as satisfactory. A new study, taking into account the intercultural entanglements of siege warfare, is being prepared by the author.

40 Looking at an earlier period of warfare, Lauro Martines illustrates the intensity of logistical challenges posed in siege warfare by referring to early modern armies as ambulant cities, which, when forced into a static position besieging a fortress, turned into dying cities (Lauro Martines, Furies: War in Europe, 1450–1700, New York 2013, p. 142). See for an overview of the technical challenges and logistical solutions developed, the early modern contributions in John Lynn (ed.), Feeding Mars: Logistics in Western Warfare from the Middle Ages to the Present, Boulder, CO et al. 1993.

41 Service Historique de la Défence, Vincennes [SHD], Guerre et Armée de Terre [GR] Ancien Régime [A] Correspondance du secrétaire d'Etat de la Guerre [1] 2729, No. 164: de Brou to [Minister of War d'Angervilliers], Camp of Kirloch, 1st June 1734.

42 He is not fully identified by the standard biographical dictionaries, but appears to have been called Charles. German sources used by Heinz Duchhardt, Philipp Karl von Eltz. Kurfürst von Mainz, Erzkanzler des Reiches (1732–1743). Studien zur kurmainzischen Reichs- und Innenpolitik, Mainz 1969, p. 64, identify him by this name. Indeed, an individual dossier on a war commissary named Charles Hocquard exists in SHD, sub-series Ya (Archives administratives du Département de la guerre), Administration militaire et pensionnaires dans les provinces, No. 44. I have unfortunately not been able to consult this in preparation for this

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His commission put Hocquard in direct contact with the minister of war at Versailles, d'Angervilliers, who eagerly demanded reports. As he kept in touch with a large number of correspondents among the armies, d'Angervilliers followed the example set by his famous predecessor, Louvois. During the previous siege of Philippsburg, in 1688, at the beginning of the Nine Years War, the latter was informed about the workings of the siege hospital structure and the health of wounded officers by the intendant, de la Grange, and the surgeon, Bessière.[43] This time, the intendant was not with the besieging force. Taking over his duties on the spot, in the siege headquarters, commissary Hocquard, up until then a lower-tier official in the army administration hierarchy, maintained a communicative link to the court of King Louis XV. His organising activities turned him into a pivotal figure for the French war effort against Philippsburg, which became the main operation in the prestigious Rhenish theatre of war. Hocquard's letters, copied into the official minutes and preserved in the central administration's archives, attest to the increased importance of military medical care in eighteenth-century warfare, and they allow us to follow the activities in this field during the course of the siege. These reports provide insights into the huge siege operation that engulfed the fortress city of Philippsburg between late May and the garrison's capitulation on 18th June 1734. Berwick commanded an army of roughly 100,000 fighting men, divided between a covering force and the actual siege corps under Marquis d'Asfeld.[44] The latter took over the general command of the whole army when Berwick died unexpectedly on 12th June, hit by a cannonball while inspecting the trenches. The intense artillery fighting during these early summer days cost many more lives and limbs among the besiegers and besieged.

Meanwhile, Prince Eugene gathered the imperial army at Heilbronn. Although the size of his force was still smaller than that of his French opponents, the Savoyard veteran general moved his troops to relieve the besieged fortress. The French commander-in-chief pulled his covering army into the fortified lines of circumvallation erected around the siege camp, where an attack could be easily repulsed.[45] The huge structure eventually proved successful, and the daring imperial victor of Zenta (1697), Blenheim/Höchstädt (1704), and Belgrade (1717) declined to give battle to the well-entrenched besiegers. The French conquered

study. Sturgill, Commissaires (cf. note 14), p. 59, lists him (without his first name) as a simple "ordinaire des guerres" at Paris from 1724.

43 Cf. the relevant reports archived for further use in SHD, GR A1 823–826.

44 Cf. for d'Asfeld's military career and service as general director of fortification: Janis Langins, Conserving the Enlightenment: French Military Engineering from Vauban to the Revolution, Cambridge, MA et al. 2004, p. 85. A biographical sketch is also provided in Gerba, Polnischer Thronfolge-Krieg, 1733–1734 (cf. note 30), p. 221 (footnote).

45 Prince Eugene described the difficulties of this situation to the emperor, Charles VI: Gerba, Polnischer Thronfolge-Krieg, 1733–1734 (cf. note 30), No. 159: [Eugen] An den Kaiser. Hauptquartier Wiesenthal, 13th July 1734, pp. 204–205.

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the imperial fortress via a capitulation agreement, while Prince Eugene's forces had to look on. In spite of this disappointment, the imperial army managed to outmanoeuvre the French during the rest of the campaign season, so Philippsburg remained their most prominent conquest. Until the signing of the peace preliminaries in the fall of 1735, there were no more truly decisive actions. The French were unable to follow up on their initial success and did not manage to unite their forces with their traditional ally in the Empire, the Elector of Bavaria.[46]

In the meantime, Russian and Saxon troops had jointly conquered Poland, ensuring the succession of Augustus III to his father's throne by quashing the last pockets of resistance. The downfall of the proud port city of Gdańsk/Danzig after a lengthy siege, from which the unhappy Franco-Polish pretender, Stanisław Leszczyński, had escaped unnoticed, sealed the fate of the latter's supporters. In Italy, the Habsburgs lost the Kingdom of Naples to the Spanish. Their Northern Italian possessions were under pressure from successful Franco-Sardinian operations. However, the outcome of this conflict was not to be settled on the battlefield. In lengthy negotiations begun in the fall of 1734, a French emissary to the Habsburg court in Vienna drew up a complex diplomatic plan to satisfy the conflicting dynastic interests—at least temporarily. On 3rd October 1735, peace preliminaries were signed.[47] While France would have to return all its Rhenish conquests, Philippsburg most prominently among them, the house of Bourbon had won the much-coveted Duchy of Lorraine, accorded to Louis XV's father-in-law, Leszczyński, in exchange for the Polish throne. The young Duke of Lorraine, Francis Stephen, who was to marry the Habsburg heiress, Maria Theresa, would receive the Grand Duchy of Tuscany instead—after the foreseeable death of the ailing and childless Grand Duke Gian Gastone de' Medici (1671–1737).

The lack of prominent battles in this war and the diplomatic intricacies of the peace agreement have (mis-)led military and political historians to regard this conflict as a prototypical example of limited, closely controlled cabinet warfare, in which even a military genius of the capacity of Prince Eugene of Savoy could not demonstrate his brilliance.[48] This interpretation has often implied a lack of seriousness in the fighting and little impact on civil society, yet such a view of

46 See for the end of hostilities on the Rhine front Musall, Feldzüge (cf. note 30), p. 88; Gerba, Polnischer Thronfolge-Krieg, 1735 (cf. note 30), p. 163. An explanation for French readiness to conclude a peace deal is offered (in Russian military aid for the emperor) by Maren Köster, Russische Truppen für Prinz Eugen. Politik mit militärischen Mitteln im frühen 18. Jahrhundert, Vienna 1986, especially at p. 144.

47 Cf. for the negotiations and the detail of their results Sutton, King's Honor (cf. note 30), pp. 191–208; Gerba, Polnischer Thronfolge-Krieg, 1735 (cf. note 30), pp. 244–253.

48 See, e. g., Siegfried Fiedler, Kriegswesen und Kriegführung im Zeitalter der Kabinettskriege, Koblenz 1986, p. 68.

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ancien-régime warfare has rightly been questioned in regard to other conflicts of the period.[49] It should also be discarded for the War of the Polish Succession.

Siege warfare, as happened during the operation against Philippsburg in 1734, affected large numbers of civilians and soldiers alike, destroying property and lives. While its duration was more extended than the compressed time-span of the battle,[50] the total numbers of dead and wounded were frequently of the same order, with the numbers of those struck down and killed by disease in the unhealthy cramped conditions of the opposing camps, even higher. The reports by commissary Hocquard attest to the strains imposed on military medicine by such a large siege, a very serious and deadly undertaking in early modern eyes—and one certainly relevant to the history of warfare and early modern state building.

3. The Bloody Business: Building Up a Siege Hospital System

Within the context of a bloody siege, *commissaire ordonnateur* Charles Hocquard went about his task with a cool professionalism. On 1st June, he took up his duties, organising the erection of the siege headquarters in the village of Oberhausen, roughly four kilometres northeast of Philippsburg and likewise on the Rhine's right bank.[51] He busily prepared the camp, organised provisions and transport, and directed requisitioned draft horses and workers to aid the sappers in the construction of the immense lines of circumvallation, which were to protect the besieging forces against attack by an imperial relief army. Meanwhile, the siege troops moved into their perimeter, which measured more than ten kilometres, surrounding Philippsburg from Knaudenheim, a village about six kilometres upstream from the fortress, all the way to Oberhausen, situated

49 E. g., to some extent by Jeremy Black, Eighteenth-Century Warfare Reconsidered, in: War in History 1, 2 (1994), pp. 215–232; more decisively by Frank Göse, Der Kabinettskrieg, in: Dietrich Beyrau et al. (eds.), Formen des Krieges. Von der Antike bis zur Gegenwart, Paderborn 2007, pp. 121–148; Martin Wrede, "Zähmung der Bellona" oder Ökonomie der Gewalt? Überlegungen zur Kultur des Krieges im Ancien régime, in: Irene Dingel et al. (eds.), Theatrum Belli – Theatrum Pacis. Konflikte und Konfliktregelungen im frühneuzeitlichen Europa (Festschrift für Heinz Duchhardt zu seinem 75. Geburtstag), Göttingen 2018, pp. 207–237.

50 Cf. for the temporality of sieges more generally, Anke Fischer-Kattner, Zeit-Not/Not-Zeit. Temporale Perspektiven auf den Belagerungskrieg im 17. Jahrhundert, in: Achim Landwehr (ed.), Militär und Zeit in der Frühen Neuzeit (Zeitschrift des Arbeitskreises Militär und Gesellschaft in der Frühen Neuzeit, 21), Potsdam 2017, pp. 57–97. See also, for the War of the Austrian Succession: Sven Petersen, Die belagerte Stadt. Alltag und Gewalt im Österreichischen Erbfolgekrieg (1740–1748), Frankfurt et al. 2019. See, in contrast, for battles: Marian Füssel, Michael Sikora, Einführung: Schlachtengeschichte als Kulturgeschichte, in: Marian Füssel, Michael Sikora (eds.), Kulturgeschichte der Schlacht, Paderborn 2014, pp. 11–26.

51 SHD, GR A1 2729, No. 168: Hocquard to [d'Angervilliers], Camp of Oberhausen, 1st June 1734.

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downstream.[52] A hand-drawn contemporary map illustrates how the circumvallation, connected to the Rhine River, enclosed the whole siege operation (Fig. 1). In the immense effort of constructing this fortified camp, the establishment of a hospital was a minor activity, but it was one which Hocquard explicitly detailed in his first report to the minister of war at Versailles.

Hocquard planned to erect the camp hospital in the headquarters at Oberhausen.[53] It was to receive injured officers and up to 200 soldiers. As the fighting of a major siege would certainly produce more victims than that, Hocquard made clear in his account for the minister that the hospital would provide primary care only. Every day, all those among the injured who were fit for transport would be brought to Spires (Speyer), a short distance downstream on the left bank of the Rhine. Marshall Berwick had set up his headquarters there in April in preparation for his army's river crossing,[54] and the post was obviously retained as a relay station. In this major rearward post, a larger field hospital was already established. Patients from Oberhausen would be carried the eight kilometres to Spires on stretchers or by carts. Expert army medical personnel, most probably surgeons, were stationed in both hospitals: A man named Duvivier was to serve in Oberhausen, while his colleague, Petit, was based in Spires. Hocquard had sent commissary of war Boisson to Spires in order to take care of the hospital organisation there.

For the impending night, the French army planned to begin an attack against the Rhine fort, a detached work across from Philippsburg, on the left bank of the Rhine.[55] Hocquard gave orders to Boisson as well as Petit to come near the Rhine fort in the evening, bringing surgery assistants and all necessary equipment in order to provide for the soldiers and officers injured in the attack. This emergency ambulance team was to stay until the conquest of the fort—which would occur after the calculated retreat of the defenders two days later, on 3rd June—and send its patients to Spires for further treatment.[56]

52 See for their importance as the last instance of major circumvallation works in European warfare: Christopher Duffy, The Fortress in the Age of Vauban and Frederick the Great, 1660–1789, London 1985, p. 100.

53 SHD, GR A1 2729, No. 168: Hocquard to [d'Angervilliers], Camp of Oberhausen, 1st June 1734.

54 See Gerba, Polnischer Thronfolgekrieg, 1733–1734 (cf. note 30), pp. 170–171.

55 See for details of the conquest of the Rhine fort: Nopp, Geschichte (cf. note 39), pp. 376–377; a contemporary account from the perspective of the defenders is printed in: Schreiben an eine hochlöbliche allgemeine Reichs-Versammlung zu Regenspurg […], Frankfurt a. M. 1734, containing the siege journal "Diarium eines Staabs-Officiers &c. Was von Anfang der Belagerung der Vestung Philippsburg alltäglich passiret ist", here at fols. Cv–C2r.

56 SHD, GR A1 2729, No. 168: Hocquard to [d'Angervilliers], Camp of Oberhausen, 1st June 1734. Cf. for an overview of the material requirements of the ambulant hospitals provided for the French armies and for their preparation: Lucenet, Médicine (cf. note 12), pp. 39–40, 55–56, and 48–49, specifically for a siege hospital pp. 56–58.

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Fig. 1: Carte de Philipsbourg[57] (North situated on the right-hand side!). Source: Europeana

57 Carte de Philipsbourg avec ses attaques commencée la nuit du 1er au 2 juin et finies le 18 juillet 1734 par M. le M.al d'Asfeld. Avec aussy les inondations produites par les différentes crues des eaux du Rhin. Ainssi que la position du camp de l'armée de l'empereur pendant le

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After the relatively easy conquest of the Rhine fort, the attackers opened approach trenches towards the *corps de place*, the main fortress, on the right bank. The first victims of the defenders' fire arrived at the camp hospital in Oberhausen. It was Hocquard's duty as *commissaire ordonnateur* to send regular reports to the administrative centre in Versailles on the numbers of soldiers and officers who were admitted to the hospital.[58] His letters demonstrate that this task took up an increasing share of his time. On 9th June, Hocquard informed minister d'Angervilliers about his efforts to obtain oats and forage to maintain the French cavalry and draft horses, but his main concern had now shifted to the course of the siege operation and its injured victims.[59] The commissary reported that during the two previous nights, nine and eleven soldiers injured in the trenches had been brought to the camp hospital. While common soldiers were only mentioned collectively in aggregate numbers, all officers received much more individualised attention in the correspondence. Hocquard provided the minister with information on their ranks and regiments as well as details of their injuries —and sometimes ensuing deaths. Hocquard reported that every day, those who could endure transportation were taken to Spire, while those who would suffer excessively if put on a cart were kept in Oberhausen for a few days before eventually being transferred to Spire by boat on the Rhine. This arrangement, which commissary Hocquard worked out in agreement with Duvivier as the medical professional in charge, demonstrated their shared concern for the relief of the injured, which was maintained until the end of the siege.[60]

As the operation progressed and the approach trenches moved closer to the defensive works, the fighting intensified and more victims required immediate care. Before they could be carried from the trenches to the camp hospital at Oberhausen, their wounds had to be dressed for transport. On 19th June, Hocquard informed the minister how the surgeons addressed these medical needs by means of a spatial adaptation: the commissary praised Duvivier for going almost every night to the end of the approach trenches, whence he returned only when the heavy artillery fire, intended to prevent the nightly construction work in the approaches, had ended. As Hocquard testified, whenever on duty, Duvivier personally bandaged the injured and dressed their wounds with great care and success. Likewise, Petit was said to deserve praise for his service at the hospital in Spires for which he was responsible. He was ably supported by Sieurs de la

siège, commandée par M. le Prince Eugène – 1734 – National Library of France, France – No Copyright – Other Known Legal Restrictions. https://www.europeana.eu/item/9200517/ark__12148_btv1b72002128.

58 Cf. Lucenet, Médicine (cf. note 12), p. 74; see also Charters, War (cf. note 5), p. 197.

59 SHD, GR A1 2730, No. 39: Hocquard to [d'Angervilliers], Camp before Philippsburg, 9th June 1734.

60 Ibid.

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Martinière and Garnier,[61] who also made a point of coming to the trenches whenever action was expected.[62]

Two days later, this new spatial arrangement had turned from an instance of remarkable personal engagement into a regular part of the siege hospital layout. Hocquard reported to Versailles that a lively attack against the horn work, the first major outwork of the Philippsburg fortification system towards the Rhine River, was imminent. For this reason, he had asked the commissaries of war to attend every night henceforth at what was now called the "trench hospital". By this means, Hocquard attempted to ensure further relief for the injured officers and soldiers, who were to be carefully transported under the commissaries' supervision to the established camp hospital after having received primary care at the back of the trench. The subordinate commissaries had allegedly accepted the new charge with good grace. M. de Briais, the most senior among them, began regular attendance on the same evening.[63]

Hocquard's premonition that more helping hands would be useful for the trench ambulance station indeed proved well-founded. It was, however, not the hoped-for French attack that would cost many lives that night, but a sally by the imperial garrison defending Philippsburg. On 22nd June, the commissary reported that between noon on the previous day and 24 hours later, 50 soldiers injured in the trenches had been carried to the hospital. Thirty-seven of them had been wounded during the night, but only fifteen of the latter had grave injuries. Besides the 50 hospitalised patients, eight or ten more had returned to their regiments after being treated in the back of the trench. Hocquard had heard of ten or twelve men being killed and of many smaller injuries caused by grenades, which the besieged had thrown in large quantities.[64]

As usual, the hospital admissions and injuries among the common soldiery were only passed on in the form of bare numbers to the court at Versailles, while the fate of individual officers was reported descriptively. For example, Hocquard informed the minister of war that grenadier captain O'Neill from the Clare regiment had suffered a wound on his leg, but it was not considered dangerous. Four more officers and a noble volunteer in the regiment of Provence were also injured, mostly by explosions of grenades. In order to make room in the camp hospital for the large number of new admissions, Hocquard had 42 injured

61 This might actually have been Germain Pichault de la Martinière, who would later become the personal surgeon for Louis XV and director of the Royal Academy of Surgery (Académie royale de chirurgie, established in 1731). (Lucenet, Médicine (cf. note 12), p. 86.)

62 SHD, GR A1 2730, No. 194: Hocquard to [d'Angervilliers], Camp before Philippsburg, 19th June 1734.

63 GR A1 2730, No. 216: Hocquard to [d'Angervilliers], Camp before Philippsburg, 21st June 1734.

64 GR A1 2731, No. 9: Hocquard to [d'Angervilliers], Camp before Philippsburg, 22nd June 1734.

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patients transported to the rearward hospital in Spires. The same number was still lodged at the Oberhausen hospital, awaiting transport as soon as it was possible without danger.[65]

Among the diverse duties and activities of the *commissaire ordonnateur*, the organisation of medical care for soldiers injured at a siege was obviously a matter that required particular attention. Hocquard relied on a well-tested spatial layout: An improvised station at the end of the approach trench offered primary care for those wounded, but not killed in action. All who could not return to service with their units immediately were brought to the camp hospital set up in the siege army's headquarters. They stayed there until their condition allowed for their transport to the rearward hospital set up in Spires. All of this, it is important to note, however, only applied to the injured. For those suffering from diseases, usually a much larger number than those wounded in combat in early modern armies,[66] a different route was taken: Diseased soldiers were to be transported to Landau,[67] a fortress city situated about 30 kilometres west of Philippsburg that had been occupied by the French since the Peace of Rastatt in 1714. This important French post was to receive a permanent military hospital in 1737,[68] but it obviously functioned as a site of army medical care before this.

In theory, everything was now set up for well-ordered medical support of the siege effort. Erected on the bank of the Rhine River, as recommended by contemporary regulations, the Philippsburg siege camp hospital promised excellent care for the injured military men. Under the scrutiny of commissary Hocquard, surgeons and their assistants, as well as an unmentioned crowd of pharmacists, nurses, chaplains, bakers, and cooks, specialised personnel for the preparation of herbal tea and launderers, were to make sure that those who survived injury were not carried off by gangrene or other fatal infections, if possible.[69] Yet, as the experienced military men of the army and the commissariat knew only too well, the incalculable realities of war offered daunting challenges, even for perfect planning. In practice, on the spot, things were always different.

65 Ibid.

66 From summer 1734 until the spring of the next year, a typhus epidemic in the French Armée d'Allemagne would bring more than 40,000 soldiers into 45 different hospitals in Germany (Lucenet, Médecine (cf. note 12), p. 114.)

67 SHD, GR A1 2730, No. 56: Hocquard to [d'Angervilliers], Camp before Philippsburg, 11th June 1734.

68 Lucenet, Médicine (cf. note 12), p. 71.

69 See for the recommended setup and material equipment of a siege hospital: Lucenet, Médecine (cf. note 12), pp. 56–58.

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4. Flooded by Patients and Water: The Demands of Hospital Practice

In the night of 23rd to 24th June, the French besiegers seized the covered way in front of the horn work via a bloody surprise attack.[70] On the following day, intendant de Brou proudly reported this military success, by which 53 enemy prisoners were taken, while at least the same number of imperial soldiers were killed in battle or drowned when trying to swim across the wet ditch. He contrasted this with the numbers of French victims, who had only three officers killed and eleven injured, besides 50 soldiers who had been brought to the hospital. De Brou had heard from the fighting forces that the total number of dead among the attackers was not remarkable, but that there were several men with severe injuries. As the intendant finished his letter, he received the detailed list of all officers and soldiers who had been killed or injured in the trenches during the previous night. He added a copy of it to his own report.[71]

The letter by commissary Hocquard to minister d'Angervilliers revealed the human cost of this operation even more clearly. Writing on 24th June, Hocquard reported on the hospital admissions of the previous two days.[72] Even before the successful attack, the fighting had obviously become more intense. Between 22nd June at noon and the same hour on the next day, 49 injured soldiers had been brought from the trench to the hospital. Hocquard provided some details on the victims of officer rank: Grenadier captain St. Georges from the regiment Bourbonnais had been killed, while two other captains of the same unit had been severely injured. Captain de Lousteau had received a musket shot through his body. Although this had caused a dangerous wound, surgeon Duvivier was reasonably confident of his recovery. Likewise, Captain de la Motte had been hit by a musket shot in the mouth, which had caused, in Hocquard's words, "some disorder". At this moment, he was not yet able to articulate anything clearly, but Duvivier was hopeful that eventually he might likewise be cured. Both of these injured officers were at the camp hospital. The engineers de Clerac and de Perdiguier had received hits in their arms. While the wound of the first was more serious than that of the second, both were not in danger. An officer of the sappers' corps had suffered a contusion.

As minister d'Angervilliers read on in Hocquard's letter, he must have realised why his *commissaire ordonnateur* at Philippsburg made a point of mentioning

70 See for an account of the action from the perspective of the besieged: Diarium eines Staabs-Officiers (cf. note 57), fol. Fv.

71 SHD, GR A1 2731, No. 38: de Brou to [d'Angervilliers], Camp before Philippsburg, 24th June 1734.

72 SHD, GR A1 2731, No. 37: Hocquard to [d'Angervilliers], Camp before Philippsburg, 24th June 1734.

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that the officers injured during the previous night had stayed in the hospital. In the course of the night of the attack on the horn work, 55 of the besieging soldiers were injured in the trenches. Additionally, the hospital received thirteen enemy prisoners requiring medical care as well. Hocquard assured the minister that all injured soldiers who could bear transport would be sent to Spires. At this moment, there were 60 remaining at the camp hospital in Oberhausen, but these, together with the officers, were still too many for the space and personnel available. Therefore, two ships were made to arrive the next day in order to evacuate the largest part of them. Unfortunately, the commissary had bigger problems with the officers. None of them could be brought to leave the cramped camp hospital, even though there was no suitable space for them. Hocquard had been assigned two small houses, where he could place seven or eight; but he sincerely hoped that at least some of those who remained in the hospital would decide to leave for Spires, where they could receive their treatment much more comfortably. The commissary assured the minister that although he personally did not dare to advise them directly, he would try to suggest as much implicitly.

The commissary was deeply troubled, but he was obviously also proud of the achievement of his hospital arrangement. He conjectured that it was mainly trust in the abilities of Duvivier that kept the officers in Oberhausen, besides the fact that they did not lack anything. Just like the injured soldiers, they were being treated very well. Yet, Hocquard emphasised, the same was true in Spires. The very success of the camp hospital threatened its functioning. If officers with light injuries refused to leave for the rearward hospital, the newly injured could not receive the medical care that they needed. As the fighting around the works of Philippsburg intensified, the flood of victims was rising. If the camp hospital housed too many officers who stubbornly refused to leave their preferred surgeon, it could not provide the necessary care for the mass of newly injured.

D'Angervilliers graciously responded to the *commissaire ordonnateur* from Versailles on 28th June.[73] He expressed his regret about the losses in the trench and made a point of his and the king's concern that the injured should receive the best possible care. They were not to lack anything, and the minister was glad to learn that the largest part of them would be saved: "*je vous demande toute vos attentions pour qu'il ne manque rien aux blessés. Je vois avec plaisir que nous en sauverons la plus grande partie.*" Yet, the court at Versailles obviously refused to deal with the issue of overcrowding, since nothing was said about the issue which troubled Hocquard so deeply.

Meanwhile, another flood was rising besides that of injured fighters. In his report on the day after the horn work attack, intendant de Brou mentioned to the minister of war that he had just received word that the Rhine had risen consid-

73 SHD, GR A1 2731, No. 139: [d'Angervilliers] to Hocquard, Versailles, 28th June 1734.

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erably. In consequence, the French army had been forced to increase the number of boats used in the construction of two mobile bridges across the river. Moreover, a *chaussée*, a raised pathway, of fascines had to be built as a connection to the bridges. De Brou had added ominously that, if things continued like this, one had to be concerned for the viability of the siege works.[74]

More than two weeks later, Hocquard's account made clear what the rising waters meant for the logistical efforts of the siege and, more particularly, for the care of the wounded soldiers. In his regular report, the commissary started with an account of the difficulties that the flooding caused for the Rhine bridges, the siege army's lifeline back to France. The connections to the other bank were the last resort for the French troops if Prince Eugene's imperial army was to attack. That army had arrived to relieve the besieged in late June, but had only undertaken minor attempts against the besiegers' lines.[75] Hocquard wrote to Versailles that the Rhine's waters had cut off any connection between the French bridges at Knaudenheim and Germersheim (upstream from the headquarters, on the other end of the circumvallation). The same circumstances made the bridges near Oberhausen extremely difficult to reach. The French pioneers were busy working on their prolongation, and Hocquard believed that they would finish in the course of the day or, at the latest, on the next morning. At least, the weather had been fine for the previous two days, so there was some hope that the river might retreat into its bed. This, according to the commissary, would allow for the siege works to continue without further disturbance, whereas a rising water level would render all efforts just about futile.[76] Obviously, the French army's elite was not quite assured of the outcome of this undertaking. Environmental factors could hardly be controlled, and they might well favour the garrison and imperial relief force.

While Hocquard wrote his letter, he learned that Marshall d'Asfeld and his general staff planned to attack the crownwork, the biggest outwork of Philippsburg's fortifications, on the same evening. The commissary was obviously not completely convinced that this was a good idea under the present circumstances, but he tried very hard to demonstrate unfailing support for the military leadership. He had heard that it was almost impossible to transport injured soldiers to the end of the trench, where the water had risen to such heights that it reached the armpits of the soldiers who were forced to pass through it. Hocquard intended to

74 SHD, GR A1 2731, No. 38: de Brou to [d'Angervilliers], Camp before Philippsburg, 24th June 1734.

75 See for an account of the military (in-)action and its dire consequences for the fortress city: Nopp, Geschichte (cf. note 39), 385–396.

76 SHD, GR A1 2732, No. 155: Hocquard to [d'Angervilliers], Camp before Philippsburg, 10th July 1734.

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go there in person with Duvivier on order to see how this "unpleasant disturbance" of military–medical logistics might possibly be countered.[77]

On the same day, Hocquard also had to deal with the other serious disturbance troubling his hospital system, with the necessity of removing wounded soldiers to Spires in order to make room for new arrivals. In a second letter to minister d'Angervilliers,[78] the commissary expressed his deeply felt regret about the deaths of a number of soldiers, who had undergone amputations of injured limbs, during their transport to Spires. Hocquard mentioned that he had written about this deplorable issue already on 7th July, but after a more detailed inquiry with Seigneur Petit, the surgeon at Spires, he now ascertained that in fact only one soldier had died. All the others were apparently getting better.

The *commissaire ordonnateur* rejected strongly the allegations of mistreatment of the injured in his care. He added in his letter that all the injured officers at present with him in the camp hospital were doing quite well. Hocquard stated that he and the hospital staff were doing their best in taking care of them, and that they assured him every day of their contentment with their treatment.[79] In spite of the problems caused by the tenacious officers, who refused to leave the camp hospital, Hocquard and the medical team could also use them as proof of their effort to provide adequate care for every wounded soldier. The commissary used their presence to refute any allegation of prematurely transporting gravely injured victims of the siege operation.

The next day, Hocquard delineated the measures that he had considered and those actually taken in order to adapt the siege hospital system to the flood situation.[80] As the military leaders contemplated an attack on the crownwork, the commissary made exact plans for medical care during the expected fight (even though it was called off). Hocquard had considered sending the surgeons to the horn work by boat so that they would be able to provide immediate medical care for the wounded. Yet, in the recently conquered outwork, they would have been exposed to enemy fire and so unable to execute their operations. Therefore, the commissary decided that the boats would pick up the injured at the horn work and bring them to the bridges near Oberhausen. Duvivier, the surgeons, and de Morlay, a commissary of war, spent the night there. Since there was no attack that night, however, no injured soldiers arrived. Only four wounded men came to the regular hospital at the end of the trench. Hocquard declared nonetheless that the same precautions for the emergency of an attack would be taken in the coming

77 Ibid.

78 SHD, GR A1 2732, No. 156: Hocquard to [d'Angervilliers], Camp before Philippsburg, 10th July 1734.

79 Ibid.

80 SHD, GR A1 2732, No. 182: Hocquard to [d'Angervilliers], Camp before Philippsburg, 11th July 1734.

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night. If the water retreated, everything could be reunited in the trench hospital station.

A letter by commissary of war de Briais attests to the fact that Hocquard's orders were indeed executed.[81] The subordinate commissary reported to the minister at Versailles that because of the extraordinary rising water along the Rhine, he and his colleagues no longer went to the end of the trench, but took turns spending the night on the bank of the river. They lodged near the two bridges close to Oberhausen, where the hospital magazine had been set up. During the night, the wounded were brought there by ships, which was necessary because of the flooding. The smallest false step by the bearers could be fatal for the injured. A few soldiers had allegedly even drowned while transporting wounded comrades. The dressing station at the bridgehead thus promised a more secure way to medical care. It remained fully staffed, even during nights without major engagements.[82]

While from 13th to 14th July only seven wounded soldiers arrived at the hospital, the successful attack of the besiegers against the crown work in the next night brought large numbers in need of medical attention.[83] Up to 20 French soldiers had been killed and 54 were injured. Hocquard learned that a Marine grenadier lieutenant and a grenadier sous-lieutenant from the Regiment Piedmont had been killed. Among the remaining officers, there had only been slight injuries, none of which had to be treated at the hospital. Yet, another 30 injured enemy soldiers taken prisoner needed care. Together with two non-commissioned officers and 55 healthy imperial soldiers, they were the only survivors of the 300 men, who had guarded the crown work when it was attacked. Hocquard was able to send 35 injured soldiers to Spires in the morning, yet another 100 still remained in the camp hospital, among them the 30 from the garrison of Philippsburg. Hocquard hoped to send all of them off to Spires, but assured the minister that enemy prisoners were closely guarded and that they would be sent to Landau after their recovery. Exact lists of prisoners were kept so that none could enter French service as this was strictly prohibited. While immediate military-medical care for imprisoned enemy combatants was largely the same as

81 SHD, GR A1 2732, No. 190: Sr. de Briais to [d'Angervilliers], Camp before Philippsburg, 12th July 1734.

82 Cf. for another commissary's report from a relatively boring night in the emergency care station: SHD, GR A1 2732, No. 205: Sr. Courdoumer [?] to [d'Asfeld], Camp before Philippsburg, 14th July 1734.

83 SHD, GR A1 2732, No. 211: Hocquard to [d'Angervilliers], Camp before Philippsburg, 15th July 1734.

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that for the French king's own troops, their further treatment was differentiated by the requirements of the developing prisoner-of-war system.[84]

Overall, Hocquard claimed once again, the injured soldiers in the camp hospital were quite well. Nevertheless, he wished for their departure to Spires in order to enable the medical staff to admit the newly wounded for primary treatment. As he still found it difficult to convince officers to leave, Hocquard hoped that the fortress would surrender soon, as this would limit the number of injured soldiers.[85]

While the numbers of patients rose, the waters of the Rhine were at least receding. The roads were still impassable, but the commissary had already begun to prepare everything for their repair. He noted proudly that he had employed boats successfully in the meantime, so the army did not lack provisions. The trenches were almost drained, so the commissary expected that it would be possible to walk through them without difficulty in two to three days, after they would have dried up. Until this was the case, it remained necessary to transport the injured by ship from the horn work to the medical station at the bridgehead. During the previous night, when the fighting at the crownwork had injured so many men, Duvivier and a sufficient number of surgeons were at the horn work in person, offering emergency treatment there. Thus, wounds were immediately dressed before the men were put on the boats to be brought to the camp hospital. Commissary of war de Morlay received the injured as they were shipped to the bridgehead. Hocquard proudly summarised his team's efforts by stating that the king was being served well and that there was no lack of anything.[86]

Hocquard's satisfaction might suggest that he and his fellow officers suspected that the loss of the crown work meant the capitulation of Philippsburg. Indeed, on 18th July, the commissary could report that no more injured had arrived at the hospital since the previous morning of the 17th, when the garrison of Philippsburg asked for a ceasefire and negotiations concerning its surrender.[87] The defenders feared that a prolonged struggle without any hope of a successful relief by Prince Eugene's forces would increase the risk of the French storming the fortress. They agreed to terms and retreated from the fortress on 22nd July.[88]

84 Cf. for the development of legal protection for prisoners of war through cartels in the early modern period, Peter Wilson, Prisoners in Early Modern European Warfare, in: Sibylle Scheipers (ed.), Prisoners in War, Oxford et al. 2010, pp. 39–56.

85 SHD, GR A1 2732, No. 211: Hocquard to [d'Angervilliers], Camp before Philippsburg, 15th July 1734.

86 Ibid.

87 SHD, GR A1 2732, No. 250: Hocquard to [d'Angervilliers], Camp before Philippsburg, 18th July 1734.

88 See Nopp, Geschichte (cf. note 39), pp. 390–394, and, for a contemporary relation, Diarium eines Staabs-Officiers (cf. note 57), fols. Iv–K2v.

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Victorious at the siege of Philippsburg, the French army, and its leaders, and the royal court hoped for further successes against the Empire.

The siege hospital run by Hocquard proved that the French king indeed cared for the soldiers fighting his wars. Morale among the troops, now seasoned by this lengthy operation, was better than before. D'Asfeld planned to attack Mainz next, but Prince Eugene, who had not wasted his army in a major relief attempt at Philippsburg, then manoeuvred successfully against him.[89] Thence until the signing of the preliminary peace agreement in October 1735, the Rhenish theatre of the War of the Polish Succession was dominated by manoeuvring and small warfare.[90] Despite the difficulties encountered at the siege of Philippsburg, the military medical service of the French army on this front demonstrated that the French state could cope very well with the painful consequences of this war. The choice of Charles Hocquard as *commissaire ordonnateur* was a fortunate one for Louis XV's *armée d'Allemagne.*

5. Conclusions

Chevalier de Folard, a veteran soldier and controversial military historian-cum-theorist of the early eighteenth century, gave his advice to the comte de Belle-Isle, lieutenant-general and a rising star in the French general staff of the *armée d'Allemagne* in 1734, on the occasion of the siege of Philippsburg. He recommended that Belle-Isle make himself popular with the troops to motivate them to achieve victory. Military hospitals were very appropriate for this purpose, as Folard instructed his young protector: "*Visitez souvent les hôpitaux, voyez les soldats, caresses-les, cela est digne du general.*"[91] Indeed, following this advice, Napoleon later became famous over his demonstrative care for his soldiers. At the same time, however, he cut the expenses for military medical services.[92] In this light, the "caring fiscal-military state" appears more like a cynical propaganda strategy.[93] Yet, Bonaparte's dazzling example should not blind us to the fact that many eighteenth-century officers and government officials took the task of caring for their monarch's (or republic's) troops seriously. Even before the theoretically grounded reform movement of the 1760s, identified as a "révolution humanitaire" by Jean Chagniot[94] and connected to a broader "Military Enlight-

89 See Gerba, Polnischer Thronfolge-Krieg, 1733–1734 (cf. note 30), pp. 254–273.
90 See for operational details Gerba, Polnischer Thronfolge-Krieg, 1735 (cf. note 30).
91 Quoted by Alix de Rohan Chabot, Le maréchal de Belle Isle ou La revanche de Foucquet, Paris 2005, p. 93.
92 Jones, Foot-Soldier (cf. note 20), p. 209.
93 Charters, War (cf. note 5), p. 4.
94 Jean Chagniot, Paris et l'armée au XVIIIe siècle: Etude politique et sociale, Paris 1985, p. 628.

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enment" by Christy Pichichero,[95] the commissariat's responsibilities and reports reminded different actors in France's military-medical complex of the sensible bodies caught up in wars. Whoever informed him about the workings of military hospitals, faced a panoply of human suffering; commissaries, surgeons, and medical personnel in the field worked hard to mitigate this.

Erica Charters has pointed to the cultural differences between military medical systems in Europe through their conventions in reporting, contrasting British written returns of troop strength with French lists of hospital admissions,[96] the sort of paper forms of which commissary Hocquard sent to Versailles in 1734. The more qualitative French system, with its personalised reports on the injuries and health status of wounded officers, might have offered less statistical oversight to the state, but it brought qualitative successes and problems of military medicine in the field much closer to the centre of power. Thus, "seeing like a state" in eighteenth-century Europe did not only involve the flattened and simplified perspective of numerical legibility.[97] In contrast, state-building practices, even in war, were deeply entangled with local acts and with the humanity of (certain) actors within the system. The reports from the siege of Philippsburg by *commissaire ordonnateur* Hocquard remind us that the early modern state was never an impersonal institution only. Instead, it functioned through a constellation of interactions and interpersonal relationships—a point which has recently been stressed for England,[98] but also applies more generally in early modern Europe. In military medicine, such a perspective reveals the crucial role played by commissaries in the field, whose work linked logistics and care, reporting, and organisational responsibility.

As has become evident, commissary of war Charles Hocquard, the *commissaire ordonnateur* at the siege of Philippsburg, exemplifies the significance of this office in the provision of medical care for the king's soldiers. His reports offer insights into the challenges in local implementation of the established spatial hierarchy of field hospitals in siege operations. Setting up a system that offered

95 Christy Pichichero, The Military Enlightenment: War and Culture in the French Empire from Louis XIV to Napoleon, Ithaca et al. 2017, particularly for the connection of enlightened medical thought with the military: pp. 119–127.

96 Erica Charters, L'histoire de la quantification: la guerre franco-anglaise et le développement des statistiques médicales, in: Dix-huitième siècle 47,1 (2015), pp. 21–38; Charters, War (cf. note 5), p. 197.

97 See for the origin of this much-debated concept: James C. Scott, Seeing Like a State: How Certain Schemes to Improve the Human Condition have Failed, New Haven et al. 1998.

98 See, e. g., for the context of finance, Aaron Graham, Credit, confidence and the circulation of Exchequer bills in the early financial revolution, in: Financial History Review 26, 1 (2019), pp. 63–80; more generally: Michael J. Braddick, State Formation in Early Modern England, c. 1550–1700, Cambridge et al. 2000; for the importance of locality, see also Steve Hindle, The State and Social Change in Early Modern England, c. 1550–1640, Basingstoke et al. 2000.

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immediate emergency care at the back end of the approach trenches, more extended treatment at the main camp hospital near the general headquarters, and a larger, more permanent hospital for longer-term care in the rear of the army's advance, at Spires, Hocquard and intendant de Brou had only slightly modified a proven layout from a previous operation.[99]

Yet, in spite of all the accumulated experience, two factors had threatened to interrupt the smooth running of the medical care operation. Firstly, the camp hospital at Oberhausen was endangered by its own success. Especially officers, who claimed the privilege of deciding where they would undergo medical treatment, chose to remain at the camp hospital, threatening to clog the system. Secondly, the natural environment of the Rhine valley, so prone to flooding, endangered the French siege operation in general and posed particular challenges for the logistics of military medicine. As the rising river drowned the marshy plains and approach trenches around Philippsburg, the soldiers had to carry the wounded through mud and water far beyond the usual trench dressing station. In these critical circumstances, commissary Hocquard responded to the daunting challenges with an alternative spatial layout. Re-location of primary care to the bridgeheads and transportation of the wounded by boat from the conquered horn work kept the system running. The system overseen by Hocquard proved flexible enough for rearrangements which assured its functioning without unduly compromising the wounded men's care. Organising hospital (and general) logistics, collaborating with the medical personnel, and reporting to the court at Versailles, the *commissaire ordonnateur* succeeded in his multiple tasks at the siege of Philippsburg.

More generally, this chapter attests to the developing concern for the welfare of the soldiery among the French elite, up to the minister of war and the king. Officials at the highest levels of government explicitly requested to be informed about wounded soldiers and officers as well as the care provided for them. The French example suggests that the emerging early modern state combined abstract, biopolitical views of its human resources with personal contacts with expert officials on the spot.[100] Attention to this important dimension of state formation will help add nuance to contending metanarratives concerning medicine and political change during the early modern era; the relationship of

99 During the siege of 1688, there had been two rearward hospitals, one at Spires and the other at Germersheim—about 15 km upriver. (Cf. the intendant's report at the time: SHD, GR A1 826, No. 10: de la Grange to Louvois, Rheinhausen, 17th October 1688.)

100 See for the origin of this influential concept in Michel Foucault's lecture at the Collège de France: Michel Foucault, The Birth of Biopolitics: Lectures at the Collège de France, 1978–1979, transl. by Graham Burchell, New York 2008; the original French is offered by Michel Foucault, Naissance de la biopolitique: Cours au Collège de France 1978–1979, ed. by Michel Senellart, Paris 2004.

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the two was neither just cynical *raison d'état* applied to the suffering of soldiers nor the steady and inevitable progress of medical humanitarianism. The pivotal role played by commissaries and siege warfare in the early modern medical-military complex should be considered as a place-bound, yet decisive element in histories of state building as well as of humanitarian efforts. Hocquard's case thus invites further, comparative study.

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Matthew Neufeld

Corruption in the British Naval Healthcare Administration during the War of the Austrian Succession*

An ethic aimed at saving human and material resources animated the administration of British naval healthcare on shore during the 1740s.[1] As much as possible, medical officials and administrators of the Royal Navy's "sick and wounded service" were to act to save seamen's lives, to save money, and to keep men from fleeing the navy. For example, in the spring of 1740, the commissioners for sick and wounded seamen reminded Dr Brady, their physician and victualling agent at the south coast port of Gosport, that his instructions required him to act "not only as contractor for Victualling the sick and wounded but as Physician to them also for their preservation".[2] For the commissioners, and naval officers, sailors were a valuable resource who needed proper care to return to active duty.[3] Officials employed in Georgian Britain's naval healthcare system were expected to prioritise the welfare of the sick and wounded sailors.

However, two investigations into wrongdoing at Gosport reveal a parallel ethic. Regionally based administrators and medical staff, while perhaps motivated to serve the sick and wounded out of real concern for human life and the national interest, also wanted to make a living. Naval healthcare was a vehicle to promote officials' self-interests. Moreover, officials certainly did not want their work for the navy to ruin them financially.

* All dates are given, as in the originals, in the "old style" or Julian calendar, which was ten days behind the Georgian one.

1 Gottfried Niedhart, Handel und Krieg in der Britischen Weltpolitik, 1738–1763, München 1979; Anthony Page, The Seventy Years War: Enlightenment, Revolution and Empire, Basingstoke 2015.

2 The National Archives of the UK [NA], ADM [Admiralty] 1/3528, Commissioners to Dr Brady, 24th April 1740; cf. NA, ADM 1/3528, Extract of a letter from Mr Edisbury to the commissioners from Portsmouth, 16th July 1729: "it would be for the Preservation of the Poor Mens lives if a Physitian were appointed to visit sick men on shore."

3 Prisoners likewise were a valuable resource for the navy: Renaud Morieux, The Society of Prisoners: Anglo-French Wars and Incarceration in the Eighteenth Century, Oxford 2019, pp. 316–318.

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Most of the time, the navy's ethic of preservation and the officials' ethic of self-advancement did not clash. In the cases of Sir James Barclay and John Butler, they did. The latter owed his appointment as agent for "taking Care of His Majesties Sick and Wounded Seamen" to the dismissal of his predecessor, Sir James Barclay, following an investigation into allegations of wrongdoing.[4] A series of enquiries conducted by the commissioners over the winter of 1744/45 likewise resulted in Butler losing his post. For the first time in ninety years of governmentally managed naval medicine in Britain, investigations into wrongdoing successively removed two agents for sick and wounded seamen at the same location.[5] The investigations into their actions as agents for the sick and wounded at Gosport suggest that corruption in naval healthcare was partly the product of circumstances in which local agents determined that the navy's ethic of service for the sick and wounded trespassed or threatened to undermine officials' legitimate self-interests or even self-preservation. In other words, the mid-Georgian naval healthcare administration confronted corruption when its prioritisation of human resources—sick and injured seamen—unduly harmed its officials.

As early as the eighteenth century, European militaries and navies strove to manage the health and conduct of soldiers and seamen.[6] Historians of military medicine link the development of medical administrations with the advent of modern warfare.[7] The medical bureaucracies of armed forces facilitated the rationalisation of military forces by, for example, lowering the number of servicemen lost to disease, and in improving the rate of sick and wounded men able to

4 The National Maritime Museum [NMM] London, ADM/F/2, 14th March 1744.

5 Matthew Neufeld, Early Modern Naval Healthcare in England, 1650–1750, Montreal 2024.

6 Alex Hinrich Murken, Zur Geschichte der Europäischen Marinelazarette – Ihr Einfluß auf das Krankenhauswesen des 19. Jahrhunderts, in: Heinz Goerke (ed.), Geschichte der Schifffahrtsmedizin, Bonn 1985, pp. 93–117; Ole Peter Grell, War, Medicine and the Military Revolution, in: Peter Elmer (ed.), The Healing Arts: Health, Disease and Society in Europe, Manchester 2004, pp. 257–283; Geoffrey Hudson, Internal Influences in the Making of the English Military Hospital: The Early-Eighteenth-Century Greenwich, in: Geoffrey Hudson (ed.), British Military and Naval Medicine, 1600–1830, Amsterdam 2007, pp. 253–272; Erica Charters, Disease, War, and the Imperial State: The Welfare of British Armed Forces During the Seven Years' War, Chicago 2014, pp. 71–75; Cori Convertito, Mending the Sick and Wounded: The Development of Naval Hospitals in the West Indies, 1740–1800, in: Canadian Journal of History 51 (2016), pp. 500–533; Sebastian Pranghofer, States of Healing in Early Modern Germany, in: Axel C. Hüntelmann, Oliver Falk (eds.), Accounting for Health: Calculation, Paperwork, and Medicine, 1500–2000, Manchester 2021, pp. 283–304.

7 Roger Cooter, War and Modern Medicine, in: W. F. Bynum, Roy Porter (eds.), Companion Encyclopedia of the History of Medicine, London 1997, pp. 1536–1573; Roger Cooter, Mark Harrison, Steve Sturdy, Introduction, in: idem (eds.), War, Medicine and Modernity, Stroud 1998, pp. 1–17; Richard A. Gabriel, Between Flesh and Steel: A History of Military Medicine from the Middle Ages to the War in Afghanistan, Lincoln, NB 2016, pp. 193–244.

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return to active duty.[8] Medical officers played important parts in upholding discipline in the ranks and in sustaining their morale.[9] Modern medicine and rationalised medical administrations thus both saved lives and enabled armed forces to wage wars more effectively. In short, bureaucratically organised military and naval medicine was good for war.[10]

However, a number of scholars dispute the importance of warfare for the emergence of instrumentally rational bureaucracies and powerful states.[11] Early modern Britain's "fiscal-military state" was, they argue, effective in fighting wars abroad and suppressing corruption among its officials at home not thanks to bureaucratic forms of administration but rather because of ongoing partisan strife, much of which occurred in the 'public sphere'.[12] Mark Knights similarly emphasises the role of ideological contestation for the rise of a modern idea of corruption in Britain.[13] Between 1600 and 1850, a long series of public discussions, punctuated by scandals and controversies about the conduct of certain domestic and imperial officials, resulted in a normative view of office as a public trust. In this view, an agent occupied a public office, and was expected to perform his duty entirely ("selflessly," says Knights) in the interest of the entrusting

8 Mark Harrison, Medicine and the Management of Modern Warfare, in: History of Science 34 (1996), pp. 379–410; Paul Lerner, Rationalizing the Therapeutic Arsenal: Germany Neuropsychiatry in World War I, in: Manfred Berg, Geoffrey Cocks (eds.), Medicine and Modernity: Public Health and Medical Care in Nineteenth- and Twentieth-Century Germany, Washington 1997, pp. 121–148.

9 Mark Harrison, Medicine and Victory: British Military Medicine in the Second World War, Oxford 2004; Mark Harrison, The Medical War: British Military Medicine in the First World War, Oxford 2010.

10 Roger Cooter, Medicine and the Goodness of War, in: Canadian Bulletin of Medical History 7 (1990), pp. 147–159.

11 John Brewer, The Sinews of Power: War, Money, and the English State, 1688–1783, Cambridge, MA 1989; cf. Stephen Conway, War, State and Society in Mid-Eighteenth Century Britain and Ireland, Oxford 2006; Rafael Torres Sánchez, The Triumph of the Fiscal-Military State in the Eighteenth Century, in: Rafael Torres Sánchez (ed.), War, State and Development: Fiscal-Military States in the Eighteenth Century, Pamplona 2007. Christopher Storrs, War and the Military Revolution, in: C. Scott Dixon, Beat Kümin (eds.), Interpreting Early Modern Europe, New York 2020, pp. 244–267; Aaron Graham, War and Society in Early Modern Europe, in: Matthew S. Muehlbauer, David J. Ulbrich (eds.), The Routledge History of Global War and Society, New York 2018, pp. 91–102.

12 Philip Harling, The Waning of "Old Corruption": The Politics of Economical Reforms in Britain, 1779–1846, Oxford 1996, pp. 8–9; Aaron Graham, Corruption, Party, and Government in Britain, 1702–1713, Oxford 2015; Matthew Neufeld, Parliament and Some Roots of Whistle Blowing, in: The Historical Journal 52 (2014), pp. 397–420.

13 Mark Knights, Trust and Distrust: Corruption in Office in Britain and its Empire, Oxford 2021, pp. 62–63, 7–8, 48, 140–141; Douglass C. North et al., Violence and Social Orders: A Conceptual Framework for Interpreting Recorded Human History, Cambridge 2009; Toon Kerkhoff et al., Corruption and the Rise of Modern Politics in Europe in the Eighteenth and Nineteenth Centuries: A Comparison between France, the Netherlands, Germany and England. Introduction, in: Journal of Modern European History 11 (2013), pp. 19–30.

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authority, to whom he was ultimately accountable.[14] Nonetheless, the legitimacy and effectiveness of governmental administrations depended on the probity of their officials.[15]

In what follows, I examine two investigations into corruption in the eighteenth-century British naval healthcare system. As evaluations of human action, the investigations depended on enabling ethical descriptions, which were (and are) the products of the reciprocal relationship between shared human capacities and the diverse ways that people have reflected on and responded to them across time and space. Thus, the enquiries into the conduct of agents, Sir James Barclay and John Butler, at Gosport in the 1740s, shed light on "the historical cloth of ethical life", woven from concepts and rules and tacit habits and social interactions.[16] The main seam running through the practical ethics of naval healthcare divided agents, for whom the sick and hurt service was a mode of service and a way to make a living, and senior administrators. For the latter, naval healthcare was a way to preserve seamen as valuable resources, while costing the crown as little money as possible.[17] Out of a determination to save lives and money, the navy created conditions that their employees sometimes deemed contrary to their fundamental interests. Corruption in naval healthcare thus emerged partly from the constraints that the navy imposed on the officials who were supposed to care for sick and injured seamen. Additionally, enquiries into wrongdoing afforded accused agents an opportunity to account for their actions within an ethical repertoire that recognised the difference between acting for one's own (self-) interests and the interests of the crown or, in these cases, the Royal Navy's naval healthcare system.[18] By requiring officials to rationalise their deeds from the perspective of the navy's preservative ethic, investigations into corruption such as happened to Barclay and Butler promoted a rationalisation of Britain's naval healthcare administration.

14 Knights, Trust and Distrust (cf. note 13), pp. 417, 433.

15 Joel Hurstfield, Freedom, Corruption and Government in Elizabethan England, London 1973, pp. 137–162, 183–196; G. E. Aylmer, Buckingham as an administrative reformer? in: The English Historical Review 105 (1990), pp. 355–362; Linda Levy Peck, Court Patronage and Corruption in Early Stuart England, Boston 1990, pp. 106–133; Jens Ivo Engels, Politische Korruption in der Moderne, in: Historische Zeitschrift 282 (2006), pp. 313–350.

16 Webb Keane, Ethical Life: Its Natural and Social Histories, Princeton 2016, pp. 161–162, 167; Christian Smith, What is a Person? Rethinking Humanity, Social Life and the Moral Good from the Person Up, Chicago 2010; Douglas V. Porpora, Reconstructing Sociology: The Critical Realist Approach, Cambridge 2015, pp. 129–158.

17 This characterisation of competing ethics within naval healthcare draws on Morieux, Society of Prisoners, p. 318.

18 James J. Gibson, The Theory of Affordances, in: R. Shaw and J. Bransford (eds.), Perceiving, Acting and Knowing: Toward an Ecological Psychology, Hillsdale, NJ 1977, pp. 67–82.

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1. Agent Barclay's Failures

Gosport town lies on a peninsula westward of Portsmouth, a major hub for the Royal Navy since the late seventeenth century.[19] By the second third of the eighteenth century, Gosport constituted one of two major centres for naval healthcare on Britain's south coast. Gosport had both a large contract hospital with room for roughly 350 patients, and many townspeople, known as quarterers, who were willing to provide accommodation and care if needed.[20]

At the beginning of the War of Austrian Succession, the Royal Navy employed two medical officials, a physician and a surgeon-agent, at Gosport, along with several clerks to keep records of the men in care and to maintain the financial accounts of the service.[21] The surgeon-agent, former ship's surgeon, Sir James Barclay, appointed since August 1739, soon confronted a massive health crisis.[22] A fever epidemic that contemporaries called "The Great Sickness" lasted from late 1739 to early 1742. In June 1740, almost 1,900 sick seamen were in care at Gosport. By the end of August 1740, Gosport's naval hospital and town quarterers had hosted just over 8,300 sailors in less than twelve months.[23] To say that the circumstances at Gosport made surgeon-agent Barclay's work very challenging would be to say the least.

Sir James Barclay faced questions about his conduct from the commissioners within months of his appointment. However, a formal investigation into his actions as agent began in the autumn of 1740. By early April 1741, the Admiralty decided to dismiss Barclay from his post. The enquiry unfolded as a single process that produced an uncontested outcome and an attempt at structural remediation. Unfortunately, the navy' efforts to combat corruption at Gosport prepared the ground for the next enquiry into an official's wrongdoing.

19 Michael Duffy, The Establishment of the Western Squadron as the Linchpin of British Naval Strategy, in: Michael Duffy (ed.), Parameters of British Naval Power, 1650–1850, Exeter 1992, pp. 60–81; N. A. M. Rodger, The Command of the Ocean: A Naval History of Britain, 1649–1815, London 2006, pp. 188–189.

20 Neufeld, Naval Healthcare in England.

21 NMM, ADM/E/7, Admiralty to Commissioners, 22nd November 1935; NA, ADM 1/3528, 2nd July 1735; Richard Harding, The Emergence of Britain's Global Naval Supremacy: The War of 1739–1748, Woodbridge 2010.

22 NMM, ADM/E/7, Admiralty to Commissioners, 20th August 1739; Daniel A. Baugh, British Naval Administration in the Age of Walpole, Princeton 1965, pp. 48–52.

23 NA, ADM 1/3528, Account of the greatest number of sick on shore at one and the same time since July 1739; Cambridge University Library, CH (H), 12/3, Account of the Number of Men put sick ashore at Home, 1st July 1739 to 31st August 1740.

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The first round of complaints levelled at Barclay came from a senior naval officer, Admiral Philip Cavendish.[24] In April 1740, he wrote about the situation at Forton, the name of the naval hospital, and "especially the Quarters for sick and wounded sent ashore". The conditions at the latter were, he claimed, "deplorable": crowded, few, or no nurses, and very dirty. The commissioners responded by writing to Barclay to remind him that his instructions required that he "provide the men with convenient Quarters when the Hospital is full, also a good wholesome Dyett, Lodging, Fire, Candle, Nursing and other Accommodations of all sorts proper and necessary for the sick men". These provisions, as well as cleanliness, contributed to "the Recovery of the Men".[25] Barclay denied that conditions were as bad as the admiral claimed, and refuted the charge that "his neglect [had] cost any lives as reported". Barclay stated that he truly followed his instructions and visited "every House in Town twice a week, and see into every Room continually".[26] He assured the commissioners that he had not spared any "Trouble to get the men as well accommodated as possible", despite facing enormous difficulties.[27]

Barclay's letters evidently convinced the commissioners that he had and would continue to act in the interest of saving men's lives. However, in early October, the circumstances at Gosport became critical, and the commissioners' trust in their surgeon-agent collapsed.

Admiral Cavendish reported on 1st October that 500 to 600 sick men lay on ships near Portsmouth waiting to land "for lack of quarters".[28] Shortly thereafter, the Admiralty presented a complaint against Barclay brought by one of his assistants, Gregory Carlos. Carlos alleged to Admiral Cavendish that the surgeon-agent was responsible for "great abuses committed in regard to the Medicines issued to the sick seamen, and that Sir James very discountenances [Carlos] in his endeavours to have those abuses rectified". The commissioners then ordered Nathaniel Hills, a commissioner who routinely inspected the conditions for sick and wounded seamen, to investigate Carlos's allegations.[29]

24 The illegitimate son of the duke of Devonshire and Member of Parliament for Portsmouth since 1734, Admiral Cavendish was Flag officer on the Princess Caroline from autumn 1739 to autumn 1740.

25 NA, ADM 1/3528, Commissioners to Barclay, 24th April 1740.

26 NA, ADM 1/3528, Barclay to Commissioners, 28th April 1740.

27 NA, ADM 1/3528, Copy of a letter from Barclay to commissioners dated 6th May 1740, Commissioners to Admiralty, 8th May 1740; NA, ADM 1/3528, Commissioners to Admiralty, 3rd May 1740. Toward the end of April 1740, 818 seamen were in care in Gosport and area, of which 461 lodged in town quarters; NA, ADM 1/3528, Abstract of Barclay's Weekly Account for 25th April 1740, Commissioners to Admiralty, 3rd May 1740.

28 NA, ADM 99/12, 1st and 6th October 1740.

29 NA, ADM 99/12, 17th October 1740.

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Commissioner Hills spent roughly two weeks at Gosport. He then presented an abstract of the main complaints to Barclay and asked the surgeon-agent to respond to them.[30] Barclay's answer to the complaints did not satisfy the commissioners, probably because Hills' report suggested that Barclay's "Interest is his sole view".[31] The surgeon-agent was suspended and directed to come to London "to pass his accounts and answer complaints made against his conduct".[32] The formal enquiry at London occurred over eleven weeks, in part because the commissioners paused the process to give Barclay time to collect and present his account books and receipts.[33] The commissioners drafted a report on the case toward the end of February 1741 and presented it to the Admiralty on 6th March.[34] The Admiralty Board considered the commissioners' report and heard Barclay's testimony early the following month.[35] The surgeon-agent could not complain about a lack of opportunity to account for his conduct in light of the complaints levied against him.[36]

The main charge against Barclay was that he had not cared enough for the interests of the navy and seamen while acting as surgeon-agent. Three of Barclay's closest assistants gave sworn testimony that he "had neglected to visit the sick and wounded seamen, and to see the wounds of the latter dressed as often as he ought to have done, and had even refused sometimes to do these offices when requested". Additionally, Barclay "had not taken due Care to have the Medicines properly dispensed; that Weights and Scales were not always to be found in the Dispensary, and that so, Medicines were sometimes made up by Guess". Barclay in reply claimed that the charges brought by his assistants were false and malicious, and "that he had done his Duty in all Respects as well as any man could". The commissioners did not accept this answer because it did not have adequate evidentiary support. Importantly, the navy's physician at Portsmouth, Dr Brady, had not sworn to "the Truth of his Certificate in favour of Sir James". The doctor would have known as well as the assistant surgeons "how and when Sir James Visited the People under his Care, as well as in what manner the Medicines were dispensed and distributed". What Brady said could not "affect the Credit" of the

30 NA, ADM 99/12, 29th October 1740; ADM 99/13, 14th November 1740; NA, ADM 1/3529, Commissioners to Admiralty, Letter on Barclay Case, 6th March 1741.
31 NA, ADM 99/13, 10th November 1740.
32 NA, ADM 99/13, 24th November 1740. A surgeon from Portsmouth, Richard Porter, assumed the responsibility for the care of seamen and medicines during Barclay's absence.
33 NA, ADM 99/13, 16th and 30th December 1740, 7th January 1741.
34 NA, ADM 99/13, 27th February and 6th March 1741; ADM 1/3529, Commissioners to Admiralty, Letter on Barclay Case, 6th March 1741.
35 NA, ADM 3/45, 3rd April 1741.
36 NA, ADM 99/13, 20th and 25th February 1741.

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affidavits testifying against Barclay.[37] There was insufficient evidence, the commissioners' claimed, of Barclay doing his duty as a surgeon and an agent.

The commissioners' report also listed nine objections to Barclay's conduct as agent for the sick seamen. These charges suggested a careless approach to expenses that violated the sick and wounded administration's ethic of saving money. For example, Barclay had not "duly transmitted to [their] Office, Quarterly and Monthly Books of the Sick and Wounded People committed to his Care". The agent had "not taken Care to cause all the Quartering Tickets for them to be duly made out and delivered to the Quarterers, which means it will be exceedingly difficult to make out proper Books for that Time". Such negligence added to the burden of the commissioners' work and damaged their relationship with Gosport townspeople. Barclay had circumvented the proper procedures by charging over 224 pounds for medicines on his own account without obtaining an order for medicine from the commissioners. Similarly, he permitted "one of his assistants to administer his own medicines to the Sick at Fareham instead of supplying them with what was necessary out of the King's stores". He requested reimbursement for the wages of his dispensers totalling 59 pounds "but has produced only a receipt for £6 of the money". Barclay arranged to transport sick seamen from the shoreline to Forton hospital by horse and carriage and charged the commissioners 63 pounds for the cost. He had not yet produced "an account of the Number of times there had been occasion to use them, as he ought to have done".[38]

Barclay's conduct at Gosport demonstrated a lack of proper fiscal probity and proper concern for the sick and wounded. The commissioners' enquiry determined that he had "not visited the Dispensary, nor the sick and wounded people under his care, so often as he ought to have done". This negligence meant that he could not have known "in what manner the medicines were dispensed, and how the People were treated". As agent, Barclay "notoriously failed of his Duty in point of the Books and Accounts which he ought to have kept". Those accounts of expenses he had submitted to the commissioners gave them "very strong reasons to suspect his Integrity".[39] Barclay should not return to work as surgeon-agent, the commissioners concluded.

The core of the commissioners' evidence for Barclay's negligence as a surgeon was the sworn testimony of two assistant surgeons and one medicine dispenser, all formerly his employees. William Fidge, assistant surgeon to Barclay for seven months, and John Ailway, dispenser of medicine for about a month, each sub-

37 NA, ADM 1/3529, Commissioners to Admiralty, Letter on Barclay Case, principal allegations against Sir James in the said affidavits, 6th March 1741.
38 Ibid.
39 Ibid.

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mitted brief statements. Robert Waller, employed as surgeon's mate to Barclay since autumn 1738, provided the longest testimony.[40] Nathaniel Hills subsequently prepared an "Abstract" of the testimonies that Barclay viewed prior to being called to London in November 1740.[41] The view of Barclay's conduct as presented by the testimonies and Hills' abstract was of a surgeon who was unable to ensure that patients received their proper medicines and unwilling to give sick seamen the attention that they needed to recover. For example, the fact that the dispensary, located at Barclay's house, did not have adequate scales and weights made dispensing medicines a matter of guesswork. One of the assistants claimed that he "often complained to Sir James of these abuses, and shewed him some of the medicines so made up". Hills evidently viewed a sample of such work in "four Phials of Oily medicines, which ought to have been the same" but appeared so different "that nobody can believe they were made up at the same place". Barclay's unwillingness to let his assistants bring medicine from the dispensary to seamen in his absence (a rule enforced by Barclay's wife) meant, "the poor people very often went without having their proper Medicines till the next day". Barclay evidently ignored the wounded as well as the sick. He did not visit more than "three Wounded people" staying in town quarters. Additionally, despite having been asked many times "to go through the Wards" of the hospital to inspect the sailors' wound dressings, "and look into their Cases", Barclay went through the whole hospital two times, and once only half of it.[42]

In their letter to the Admiralty Board, the commissioners' submitted anecdotal evidence of Barclay's carelessness with the navy's money. For example, they noted that Barclay charged 39 pounds for 157 trusses "at 5 shillings each furnished to the People under his Care, but neither produced any of their receipts for them, nor so much as a list of the Names of those who had them, nor any receipt of the Person or Persons of whom he might buy them". However, the commissioners reported that Barclay excused some of his negligence with financial records on "the idleness of the clerks he hired to make out the books and tickets". Indeed, the agent had insisted "his time was so fully taken up in Visiting the People under his Care, that it was impossible for Him to look after Them". Barclay believed that he had tried to satisfy the different aspects of the navy's

40 Copies of the affidavits, sworn statements presented as evidence in legal proceedings, numbered 1, 2, and 3, were submitted as part of the commissioners' presentation to the Admiralty dated 6th March 1741 (NA, ADM 1/3529). They were recorded on 11th, 16th, and 12th November 1740, respectively.

41 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741: Nathaniel Hills, Abstract of the Depositions of William Fidge, John Ailway, and Robert Waller given by Mr Hills to Sir James Barclay.

42 Ibid.

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preservative ethic, but found that he could not look after both men and money to the extent demanded by his office.

Barclay's account of his work as surgeon-agent at Gosport presented him acting dutifully in difficult times. If his conduct appeared negligent and careless, it was because circumstances had prevented Barclay from saving lives and managing money at the same time. He submitted three responses to evidence of his negligence, the first composed in late November 1740, the other two probably in December.[43] In the submissions, Barclay laid the blame for his problems in office on his employees, some of whom maliciously attacked him for their own faults. Most notably, Barclay's answers show that he sought to demonstrate how his actions helped the seamen, saved the navy money, and served the public good. Evidently, he believed that rationalising his actions within the navy's preservative ethic could justify restoring him to his office at Gosport.

The surgeon-agent claimed that, given the extraordinary situation of the previous year, he had performed his duties as best he could. For example, he set up at his home the dispensary for medicines prescribed to men staying at town quarters "because I could not meet with any Conveniency till that was fitted up". Prior to then, medicines were dispensed at Forton hospital, at some distance from the town.[44] He refuted the accusation that he neglected to monitor the quality of medicines: "it is impossible for any Person in my Employment", he stated, to inspect medicines "Constantly and particularly". Quality control depended, he averred, "in a great Measure" on the "Fidelity and Diligence of the Dispenser". Those who did not perform their duty Barclay had dismissed and replaced with others.[45] The reason for the surgeon's infrequent visits to the seamen at the hospital was that he had worked to send seriously wounded patients to one of London's hospitals, as required by his instructions. This attempt to rationalise the care for the badly wounded evidently obviated, for him, the need to attend all patients at Forton hospital regularly. He had divided his visits between the patients at the hospital and the men in town quarters, the latter more frequently and "Conscientiously and Indefatigably". Barclay claimed that he never "refused to see and advise upon any particular Case", but neither did he think it reasonable that "I am daily to see every particular Case".[46] If one midshipman, Mr Appsly,

43 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 5 Sir James Barclays Answer to the Affidavits sent the Board, 20th November 1740; No. 6 Sir James Barclays Answer to the Affidavit delivered by himself, n.d.; No. 10, Copys of Sir James Barclays Observations on the Affidavits of Mr Figde, Ailway, and Waller, n.d.

44 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 5 Sir James Barclays Answer to the Affidavits sent the Board, 20th November 1740.

45 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 6 Sir James Barclays Answer to the Affidavit delivered by himself, n.d.

46 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 5 Sir James Barclays Answer to the Affidavits sent the Board, 20th November 1740.

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had complained that Barclay did not visit him at his quarters in town, "it ought not be Attributed as Neglect of one", since Appsly had not called for him. However, if Appsly did call for Barclay, the surgeon-agent "was not told of it, there were at the time above 900 Patients in Town".[47] Nonetheless, as recently as the previous October, he inspected "Compound and other [kinds of] Fractures, Gunshot Wounds, Amputations, and other Cases of Surgery… with such Success to have them all recovered".[48] According to Barclay's account of his work, during a period of extremely high demand for care, he had acted as best he could to save the lives of naval sailors.

If the naval healthcare at Gosport exhibited genuine problems under Barclay's tenure as surgeon-agent, he reasoned that the blame lay with his subordinates. One apothecary hired by Barclay turned out to be an alcoholic and was evidently about to be replaced when Admiral Cavendish gave an order to dismiss the man. Barclay dismissed an assistant surgeon once he found the man "unjust". According to Barclay, the reason why the medicines which commissioners saw at Gosport appeared spoiled and undifferentiated was "the Dispensers forgetting to shake them". He added, "If they stood any time, they will become Ranc'd as the Oil of Linseed, which is the principal ingredient, does by standing."[49] Barclay also impugned the motives of the employees who testified against him. For example, Waller's claim that the dispensary lacked proper weights and measures was in fact Waller's own negligence, "for he owns that he had both, but seldom used them". Indeed, the surgeon had ordered "all medicines to be weighted and measured, and threatened often to turn them out of their employment for such neglects". Mr Fidge, like Waller a surgeon's assistant, had been derelict in his duty. In Barclay's account, Fidge "was Sick the time there was much Surgery in Town", and "had very few material cases under his care". Moreover, although Fidge swore that he worked for Barclay for seven months, in fact he "was absent above three Weeks at one time, and Eight at another, besides other times by bad Weather, and his own private Business". After another employee discovered that Fidge stole medicines, Barclay "had good reasons not to trust [both of] them with any more medicines than the Nature of the Cases would require". "In so doing", he argued, "I think I did my Duty." Barclay concluded his final observation on the accusations brought against him by stressing that "what has been alleged against me, was malicious, and the effects of my care of the public stores, in preserving them from these, I had too great Reason to suspect would not make proper use of

47 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 6 Sir James Barclays Answer to the Affidavit delivered by himself, n.d.

48 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 5 Sir James Barclays Answer to the Affidavits sent the Board, 20th November 1740.

49 Ibid.

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them".[50] By his account, Barclay acted to preserve the navy's resources from dishonest men, only to have them wrongly accuse him of negligence.

Prompted by an investigation into the naval healthcare at Gosport, agent Barclay accounted for his actions within the navy's ethic of preservation. He recounted that he and Dr Brady on occasion forbade some prescribed medicines to the sick "as unnecessary for Hospital practice", thereby saving money for the navy.[51] Similarly, he had stored most medicinal ingredients at his house, and stopped dispensers taking them away in his absence "with no other view, but agreeable to my Instructions, and [the commissioners'] repeated orders, to Husband His Majesties Medicines". In taking care of the medicines intended for sick seamen, Barclay's concern was "not private Practice", because he had "no Interest but the publick good in that affair".[52] He had worked for the recovery of sick and wounded seamen, to save scarce resources, and ultimately for the navy's purposes rather than his own self-interests.

Unfortunately, Barclay could not provide much evidence of his selfless service as the surgeon-agent. Dr Brady, the navy's physician at Portsmouth, certified but did not swear to Barclay's diligence. The surgeon had, Brady acknowledged, "daily visited a great share of the Hospital or Town Quarters, as much as can reasonably be expected of one Man to do".[53] One assistant surgeon likewise certified that Barclay visited the town quarters at nearby Fareham twice a week, and that he supplied the assistant "with medicines, sugars etc for the use of the sick and hurt".[54] Another assistant surgeon, Mathew Mackail, testified that Barclay had "attended [Mackail] almost every other day, and saw the Amputations and Gunshot Wounds dressed" when Mackail temporarily had sole responsibility for "the Surgery business at the Town Quarters at Gosport". Mackail also swore that Barclay assisted him in any difficult surgeries at the hospital when his superior, Gregory Carlos, was ill.[55] However, Carlos stated that while Barclay had "visited the sick at Forton [hospital] as frequently as the Duty required", he had "never regarded the Surgery". Nor could Carlos get Barclay "to see Particular Cases, but with the greatest Difficulty". Concerning the medicines for sick sea-

50 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 10, Copys of Sir James Barclays Observations on the Affidavits of Mr Fidge, Ailway, and Waller.

51 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 5 Sir James Barclays Answer to the Affidavits sent the Board, 20th November 1740.

52 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 6 Sir James Barclays Answer to the Affidavit delivered by himself, n.d.

53 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 7 Certificate of Dr Brady, 10th December 1740.

54 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 9 Certificate of Salter Andrews, 9th December 1740.

55 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 8 Affidavit of Mathew Mackail, 6th January 1741.

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men, Barclay's employees "seldom observed the prescriptions given them, were negligent in compounding, having no regard to weight or measure", and even gave patients the wrong prescriptions entirely. Carlos testified that he took care that this abuse "should not escape Sir James Barclay's knowledge, by taking frequent opportunity to prove it to him".[56]

The official investigation into Barclay's conduct had started when Carlos brought an allegation against him to Admiral Cavendish in mid-October 1740.[57] Carlos's affidavit, recorded the same day (27th February 1741) that the commissioners decided to prepare the report of their findings for the Admiralty, probably settled any doubts about its final determination.[58] Barclay the surgeon had neglected to visit sick sailors, and improperly dispensed medicines; Barclay the agent had neglected to submit his financial records to the commissioners, and those accounts that he had submitted were fraudulent. His oral defence did not convince the Admiralty Board that the commissioners had erred. On the same day as they heard Barclay's case, the Board resolved to dismiss him from the sick and wounded service. Significantly, the Board resolved at the same time "that for the future the Employment of Agent at Gosport be separated from that of the Surgeon and vested in a different Person".[59] Thus, Barclay's case occasioned not only the loss of his office but that office's reformation.

The Admiralty's resolution to split in two the office that Barclay formerly held suggests that they believed that at least part of the reason why he failed to fulfil his duties was that he had been expected to do too much. It might not have been reasonable to expect one man during an unprecedented epidemic of fever in the fleet to oversee the surgical–medical requirements of hundreds of men and find them lodging (and care providers) in two towns six miles apart. Moreover, while doing all this, he was obligated to keep accurate financial records and maintain good relations with dozens and dozens of town quarterers. In other words, the Admiralty, by separating the role of agent for sick and wounded from surgeon at Gosport, recognised tacitly that the office itself had placed unreasonable demands on Barclay. The reason why he failed to act in the navy's interests to the degree that he should was not due to his carelessness or selfishness only. In the end, no one person could do what the navy had expected from its surgeon-agent at Gosport in 1740.

56 NA, ADM 1/3529, Commissioners to Admiralty, 6th March 1741, No. 11 Letter and Affidavit of Mr Gregory Carlos, 27th February 1741.

57 The Admiral was probably very sceptical about Barclay's suitability for his office as early as spring of that year; NA, ADM 1/3528, Commissioners to Barclay, 24th April 1740.

58 NA, ADM 99/13, 27th February 1741.

59 NA, ADM 3/45, 3rd April 1741.

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2. Agent Butler's Irregularities

The office of surgeon-agent nonetheless remained unified from the spring to the late autumn of 1741. On 17th December, John Butler agreed to the commissioners' terms for taking up the office of agent for sick and wounded seamen at Gosport.[60] Butler then worked for the sick and wounded service without incident for over two and a half years. Indeed, in March 1744, the commissioners suggested that the Admiralty double his salary from 50 pounds to 100 pounds per annum. Unfortunately, the Admiralty Board refused the requested increase.[61] Several months later, Butler's employment came under investigation. The enquiry into his wrongdoing developed over several stages, and did not end until March 1746. It resulted in a contested outcome and produced no substantial remediation in the administration of naval healthcare. Despite these differences from Barclay's case, the investigation into Butler's conduct likewise afforded him an opportunity to rationalise his actions within the navy's preservative ethic. It also reveals the problem facing an official required to put the interests of the navy's human resources above his own.

An enquiry into Butler's conduct began just four months after the commissioners recommended him for a pay rise. A complaint that the agent had sent more seamen to town quarters than they could receive "though the Hospital is not full" reached the commissioners in mid-July 1744.[62] Evidently, the allegation stemmed from James Ward, the contractor responsible for Forton naval hospital.[63] The commissioners then instructed Nathaniel Hills, already at Gosport for a routine inspection of the hospital and the town quarters, to enquire into the complaint.[64]

Just why and how the agent would direct men away from the hospital and into town quarters, especially since Butler's instructions required him to put the sick and wounded seamen in the hospital unless it was full, remains in question.[65] It seems probable that Butler hoped to reap extra income by sending men to town quarters instead of the hospital, and by favouring some quarterers over others. Seamen were issued paper tickets, which bore the dates of their arrival on shore

60 NA, ADM 99/13, 6th May 1741; ADM 99/14, 17th and 31st December 1741. Butler could also earn 40 shillings per journey to Portchester castle if he managed the prisoners of war.

61 The National Archives of the UK (NA) London, ADM 3/48 (Admiralty Meeting Minutes) 22nd March 1744.

62 NA, ADM 99/18, 12th July 1744.

63 NA, ADM 99/12, 23rd and 26th July 1744.

64 NA, ADM 99/18, 13th July 1744.

65 NA, ADM 99/18, 26th July 1744; NA, ADM 98/103, Instructions for the commissioners appointed to take care of sick and wounded seamen, 8th February 1742; cf. NMM, ADM/F/7, Commissioners to Admiralty, 10th March 1746, Copy of Nathaniel Hills, Report … Enquires at [Gosport], 26th July 1744.

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and eventually their departure. Quarterers then presented the tickets to the agent for reimbursement at the standard rate of one shilling per man per day. Butler evidently preferentially selected certain town quarters to receive many seamen in exchange for their accepting discounted quarterers' tickets. This practice meant that the agent might only pay a portion of the ticket's "face value", for example, six shillings instead of seven for hosting a seaman for a week. Butler could then turn around and claim the face value of the ticket from a third party, or directly from the Navy Board.[66]

The commissioners were clearly worried that Butler's conduct could upset the relationship between the navy as the major buyer of care on shore and the people willing to sell it. On 20th July, the commissioners instructed Hills to "enquire nicely into… the Complaint, as a Resolution to keep people in Order, will… the people Easy and tend to the honour of the Crown".[67] Experience showed that the women and men who ran sick quarters in Gosport town might refuse to receive and care for seamen, when they were not paid, or when their payment was delayed.[68] Preferential treatment shown by the agent toward some quarterers might also make others reluctant to help when asked; in desperate times, this could make finding accommodation for the sick very difficult. The commissioners' correspondence with Hills did not state another obvious concern related to the complaint: Butler's action threatened the financial viability of the hospital contractor, James Ward. It is no wonder then that Ward brought the matter to the commissioners' attention.

Hills completed a report on his investigation into Butler's conduct by 26th July 1744.[69] The agent learned about the allegations against him at around that time, since by 2nd August, the commissioners had received a letter from Butler stating that "his managing the Affairs between the Tradesmen and Quarterers occasioned a suspension of his discounting Quartering Tickets". They directed him to send them a list of the people with whom he had done business "in order the better to enable the board to judge of that Matter".[70] Butler's claim that he had stopped discounting quartering tickets had an unknown effect on the commissioners' stance toward the investigation. The commissioners did not decide about

66 For a similar process, see Matthew Neufeld, The Biopolitics of Manning the Royal Navy in late Stuart England, in: Journal of British Studies 56 (2017), pp. 506–531.

67 NA, ADM 99/18, 20th July 1744. Several parts of the page are illegible from water damage or mould.

68 Matthew Neufeld, The Framework of Casualty Care during the Anglo-Dutch Wars, in: War in History 19 (2012), pp. 427–444; Matthew Neufeld, Blaine Wickham, The State, the People and the Care of Sick and Injured Sailors in Late Stuart England, in: Social History of Medicine 28 (2015), pp. 45–63.

69 NA, ADM 99/18, 26th July 1744; cf. NMM, ADM/F/7, Commissioners to Admiralty, 10th March 1746, Copy of N. Hills Report 26th July 1744.

70 NA, ADM 99/18, 2nd August 1744.

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the allegations against Butler for another seven months. In the meantime, Butler acted to save himself by undermining his accuser.

During the final six weeks of 1744, Butler, Ward, and the commissioners were embroiled in two additional investigations into the wrongdoing at Gosport. Butler launched at least one of them almost certainly in the hope of helping his cause. The other enquiry served only to confirm the commissioners' suspicions of his actual wrongdoing.

On 17th November, the Admiralty ordered the commissioners to investigate accusations of "very ill attendance [being] given to the sick men" at the hospital. Additionally, seamen at both the hospital and town quarters allegedly were deprived of their clothing and bedding (known to the navy as "slops") only to have their replacement cost charged against their wages.[71] The commissioners responded to the Admiralty's order with a promise to enquire into the allegation, observing to the senior board that "neither Our Agent at Gosport, nor him at Plymouth have any Sort of Advantage by these Slops".[72] In theory at least, Butler had no obvious interest to rob seamen. In fact, by 28th November, the commissioners determined that while seamen at the hospital did not lack adequate care, John Butler indeed had failed to take "due Care of the People's Bedding and Clothes" according to "the Manner prescribed by the 4th. Article of his separate Instructions". They noted their intention "to call him to an Account for the Neglect of it, as well as for some other Misdemeanours of which he stands secured".[73] The same day, however, Butler alleged to the Admiralty that one of Ward's clerks at the hospital, Thomas Ansley, had defrauded several patients.[74] Butler's accusation against one of Ward's employees prompted yet another investigation. At the commissioners' behest, Dr Brady presented Ward with Butler's accusation. Ward then wrote a letter defending Ansley and submitted two affidavits in support of the clerk's good conduct.[75] Acting for the Admiralty, James Stewart evidently made a separate investigation into Butler's allegations. The admiral then found "reason why Ward the Contractor" had charged Butler

71 NA, ADM 3/49, Admiralty Board Minutes, 17th November 1744; NMM, ADM/E/11, Admiralty to commissioners, 17th November 1744. Seamen at both the hospital and town quarters were deprived of their clothing and bedding (known to the navy as "slops") only to be charged for its replacement cost against their wages.

72 NMM, ADM/F/4, Commissioners to Admiralty, 21st November 1744.

73 NMM, ADM/F/4, Commissioners to Admiralty, 28th November 1744.

74 NA, ADM 3/49, Admiralty Board Minutes, 28th November 1744; NMM, ADM/E/11, Admiralty to Commissioners, 28th November 1744.

75 NMM, ADM/F/5, Commissioners to Admiralty, 3rd December 1744; Extract of a letter of 30th November 1744 from Dr Brady, physician at Portsmouth, to the commissioners; Letter of 30th November 1744 from James Ward to the commissioners; Copy of affidavit of John Weatherhead of Alverstoke, 29th November 1744; Copy of affidavit of Thomas Ansley of Alverstoke, 30th November 1744.

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"with ill Practices", which "the Evidences of three Women who take in Sick Men" supported. However, Stewart did not proceed further because the "whole Dispute" between the agent and the hospital contractor was in fact the commissioners' responsibility.[76]

Butler's attempt to draw attention to the misdeeds at Gosport hospital did not take the commissioners' attention away from the accusations against him. The first phase of the formal investigation into his conduct as agent ended in mid-March 1745. The commissioners submitted a report to the Admiralty describing seven "Irregularities and Misdemeanors" for which Butler was responsible; it recommended his removal from office permanently.[77] The Admiralty agreed that Butler had committed "ill Practices" and should be replaced as agent.[78] For an unknown reason, the commissioners did not inform Butler nor send out his replacement until 18th May. In the meantime, the now ex-agent apparently learned about the Admiralty's decision independently. He then submitted his resignation to the commissioners. However, a week after resigning as agent, Butler asked Commissioner William Alix, then at Gosport, for half a day "to inquire into the Matter of the Complaint in order to his Justification". After refusing Butler's request, he resolved to appeal his case to the Admiralty directly.[79] Although the senior Board granted him a hearing on 20th June 1745, Butler's appeal did not receive final consideration until March of the following year.[80]

The central complaints against Agent Butler were his failure to follow his instructions and for putting his own interests ahead of the navy's interests. For example, over a twelve-month period beginning the summer of 1743, Butler put seamen "into Town Quarters without absolute Necessity, [and] contrary to Instructions when there was room in the Hospital". Likewise, contrary to Butler's instructions, seamen lodged in quarters in town were "obliged to lay two in a Bed". Although no seamen had been put "into very bad Quarters, but many into indifferent ones by Direction of the Agent", it seemed reasonable to conclude that Butler acted "with a view to his own Interest". Butler's financial records revealed that he favoured three female quarterers in particular: Scammel, Evans, and Gatenby. Other quarterers who had not accepted discounted tickets claimed that Butler had not sent any seamen to them for up to three years, "except when

76 NMM, ADM/F/7, Commissioners to Admiralty, Sketch of Proceedings in relation to Butler, 10th March 1746.

77 NA, ADM 98/2, Commissioners to Admiralty, 14th March 1745.

78 NMM, ADM/E/11, Admiralty to Commissioners, 16th March 1745.

79 NMM, ADM/F/7, Commissioners to Admiralty, Sketch of Proceedings in relation to Butler, 10th March 1746.

80 NMM, ADM/E/12, Admiralty to Commissioners, 4th March 1746; NA, ADM 99/19, 5th and 6th March 1746.

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the Town was full, though they had often applied to the Agent for that Purpose".[81] Similarly, he refused to send sick men to Elizabeth Gatenby's (subsequently Hilliard) house after she refused "to discount her Tickets with him". He compelled tradesmen to accept quartering tickets as payment for goods and services rendered, "by which means the Crown maybe", the commissioners averred, "rationally concluded to have suffered [in relation to] Quality, Quantity, or Prices". Butler's actions, so the commissioners' concluded, intended to enrich himself at a cost to the people of Gosport, the seamen, and the navy.[82]

The commissioners submitted nine items as evidence in support of the complaints against Butler, including five affidavits from three people, one petition, and one report.[83] The allegation that Butler, contrary to his instructions, discounted quartering tickets was supported by six written proofs. In total, seven people gave evidence in support of the complaints, of whom two, Elizabeth Hilliard and Bannister Hurst, did not work for the navy. Hilliard however provided three items used as proof of Butler's misconduct. For example, Hilliard testified that Butler obliged her "to take of him, or of a Woman who lived with him, common Port wine" at an extortionate price. She also claimed that to be considered as a quarterer of seamen, Butler sometimes required local people to buy wine from him.[84] Her testimony represented the strongest proof that Agent Butler acted out of self-interest instead of the Royal Navy's interests.

Butler's account of his conduct, submitted to the Admiralty in a written statement and several proofs, must be inferred from the commissioners' refutation of them.[85] Essentially, Butler claimed that he did not know that his actions contravened his instructions until just prior to his dismissal. For example, the agent was supposed to put seamen into town quarters only if the hospital was full. Butler had failed to keep track of how many men were at the hospital. This was not, he claimed, due to negligence or preferring town quarters to Ward's hospital.

81 NMM, ADM/F/7, Commissioners to Admiralty, 10th March 1746, Copy of Nathaniel Hills, Report [and] Enquires at [Gosport], 26th July 1744.

82 NA, AMD 98/2, Commissioners to Admiralty, Particulars of the Irregularities and Misdemeanors committed by Mr John Butler Agent at Gosport, in Breach of his Instructions, 14th March 1746.

83 NMM, ADM/F/7, Commissioners to Admiralty, Articles of Complaint against Mr John Butler, late Agent for Sick and Wounded Seamen at Gosport, with Proofs upon which they are founded, 10th March 1746; cf. NA, ADM 98/3, 10th March 1746.

84 NMM, ADM/F/7, 10th March 1746, Copy of the Affidavit of Elizabeth Hilliard sworn to John Mounsher 1st January 1745; Hilliard claimed that Butler obliged her to buy from his common-law wife port wine priced at 50 shillings per dozen bottles "when as good might have been had elsewhere at the Rate of 16 shillings 6 pence per dozen".

85 The Admiralty sent copies of Butler's June 1745 statement and his proofs to the commissioners. They do not survive in either the Sick and Wounded or the Admiralty papers; NMM, AMD/E/12, Admiralty to commissioners, Schedule of Papers in relation to the Conduct of Mr Butler, 4th March 1746.

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In fact, it was because of "Ignorance that he failed of chequing absent people upon his Muster at Forton hospital till February 1744". Similarly, the former agent stated, "he heard nothing of the complaints against him" between the end of 1744 and April the following year. After hearing the allegations, Butler resigned, no doubt hoping to clear his name. Thereafter, he collected testimonies in favour of his conduct, suggesting that he served at least some people well. Finally, on his own initiative, Butler rented a house for the use of sick seamen. Evidently, he regarded this act, the cost of which he was still obligated to bear, as proof of his "Zeal for the King's Service". Butler submitted a substantial body of evidence proving his dedication to the navy's interests. In total, his proofs included ten affidavits, six letters, two attestations, one order, and one petition.[86] The attestations came from "People who keep Sick Quarters" and "several Tradesmen". Three of the affidavits supporting the agent disputed the charge that he had discounted quartering tickets, as Elizabeth Gatonby/Hilliard testified.[87] In sum, the agent portrayed his actions as undertaken according to the best possible information and with the aim of advancing the naval healthcare at Gosport.

The Admiralty reviewed Butler's case on 12th March 1746. The absence of any subsequent correspondence concerning a decision does not itself indicate that one was made or deferred. However, Butler did not regain his post at Gosport during the remainder of the war. Like his predecessor, Butler failed to convince his superiors that his conduct in office aligned with the navy's preservative ethic.[88] They judged that his method of quartering seamen favoured his own interests ahead of saving seamen's lives and the navy's money.

3. Comparing the Cases

The sources surviving from the investigation into Butler's conduct are biased heavily toward the commissioners' attempt to refute the agent's account. From those documents, it appears that Butler tried to argue that his faults were ones of omission and not from a deliberate desire to defraud the navy. However, as was the case with his predecessor, Butler's conduct suggests that the decisions made by his superiors, and the organisation of healthcare on shore, presented him arguably with an insoluble ethical dilemma.

The Admiralty's determination to save money and to save lives created a conundrum for naval officials. Between 1660 and 1750, the navy did not once

86 NMM, AMD/E/12, Admiralty to commissioners, Schedule of Papers in relation to the Conduct of Mr Butler, 4th March 1746.
87 NA, ADM 98/3, Commissioners to Admiralty, 10th March 1746.
88 NA, ADM 99/12, 12th March 1746.

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raise the price for which it paid for care on shore. Although the British economy did not experience as much inflationary pressure as it had during the sixteenth and first half of the seventeenth centuries, the Georgian Royal Navy consistently demanded that officials find people willing to care at the same rate as their late Stuart ancestors.[89] Stated boldly, the navy required the people of towns like Gosport to sell care, and so save the lives of seamen, on its financial terms. Thus, the state's demand for care was inelastic, whatever the supply or willingness of quarterers. Given this reality, the better an agent's relationship with local people, the greater his chances of securing a pool of quarterers who were willing to work with the navy. One way to foster good relations between agent and people would have been for him to develop networks of dependent clients. If such patronage also advanced Butler's financial interests, so much the better for him.

Butler might have regarded discounting tickets necessary to overcome the challenge of finding quarterers at the price that the navy was willing to pay. He might also have thought it a necessary expedient given the Admiralty's unwillingness to compensate him at a just rate. As noted above, the senior Board twice denied an increase to his salary, although Butler's immediate superiors believed that he deserved one. The Admiralty minutes do not say why they denied his March 1744 request, but probably their desire to control costs played a part in their decision. It would not be surprising if, after more than two years of service, Butler felt frustrated by a perceived lack of regard from his employers. There was a longstanding practice of naval officials using their positions to enrich themselves while serving the state, from the treasurer Sir Henry Vane Jr to Secretary Samuel Pepys to the Chatham dockyard dynasty known as the Pett family.[90] Such individuals were accused at one time or another of fraudulent accounting, extortion, bribery, exercising patronage to favour certain business partners over others, and outright theft.[91] By pocketing a portion of the price of care for himself, Butler probably thought that he was doing only what many in his position had done before him.[92]

However, town quarters made up the informal part of onshore naval healthcare at Gosport. Forton naval hospital, run by care entrepreneur, James Ward, made up the formal part. As per Butler's instructions, seamen who needed care at the hospital were supposed to go to Forton so long as it had room; otherwise, they

89 Keith Wrightson, Earthly Necessities: Economic Lives in Early Modern Britain, New Haven 2000, pp. 269–272.

90 Aylmer, State Servants, pp. 156–162; Mark Knights, Samuel Pepys and Corruption, in: Parliamentary History 33 (2014), pp. 19–35.

91 George Everett (Shipwright), The Path-way to Peace and Profit, London 1694; Samuel Baston, Baston's Case Vindicated, Or, A Brief Account of Some Evil Practices of the Present Commissioners for Sick and Wounded, London 1695.

92 Knights, Trust and Distrust (cf. note 13), pp. 243–244.

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went to town quarters. Butler's patronage of certain town quarters might have benefited both parties, but almost certainly disadvantaged Ward, and so threatened to undermine the financial viability of Forton hospital. Without the hospital, the navy would have to rely solely on many informal relationships between the agent and ordinary people for the care of sick and wounded seamen. The navy rejected precisely that situation in 1703 when it opted to rely on private contractors to run hospitals at major centres such as Gosport.[93]

Butler lost his position as agent at Gosport because his actions threatened to disrupt the blended structure of naval healthcare. He probably also enriched himself at a cost to the navy and crowded the sick into pubs and houses where they lay two to a bed. However, he lost his post primarily because his actions favoured himself and the town quarterers over the hospital contractor.[94] The commissioners admitted as much in a note that they sent to James Ward several weeks after the agent lost his post. The contractor had written to enquire about what he considered an issue outstanding between him and Butler. In their reply, the commissioners advised Ward "to consider how he has complied with his Parts of the Contract, and then to judge, whether the Agent's being dismissed, partly for sending People to Town Quarters when there was room for them in the Hospital, be not a sufficient satisfaction for it".[95] Butler acted to protect himself and his favoured quarterers. In response, the commissioners for sick and wounded acted to protect one of their most important private contractors, and so preserve the formal side of naval healthcare at Gosport.[96]

Nonetheless, Butler and Barclay would have reasons for thinking that their conduct as officials of naval healthcare forwarded both their interests and the preservative goals of the navy. The modern British view of corruption emerged, Knights argues, from a conceptual evolution concerning public office, such that officials were supposed to act selflessly in the interests of the public.[97] The cases

93 Neufeld, Wickham, The State, the People (cf. note 68).

94 Further evidence that discounting tickets was not, in fact, as decisive for Butler's dismissal as the commissioners made it appear to the Admiralty is found in the case of his former colleague, Richard Porter. When the Admiralty ordered Porter to be dismissed from his post for discounting tickets, the commissioners endeavoured, successfully in the end, to exonerate the surgeon and restore him to his office; NA, ADM 99/19, 13th March 1746; NMM, ADM/F/7, Commissioners to Admiralty, 13th March 1746; NMM, ADM/E/12, Admiralty to commissioners, 19th March 1746; NMM, ADM/F/2, Commissioners to Admiralty, 21st March 1746. Porter's case might have been helped when the Admiralty learned that his misdeed happened only once, "and then it was done by his Wife (as it is affirmed) without his Knowledge"; NMM, ADM/E/12, Admiralty to commissioners, 28th March 1746.

95 NA, ADM 99/19, 22nd May 1745.

96 Stephen Conway, Richard Harding, Helen Paul, Eighteenth-Century Britain: The Quintessential 'Contractor State?' in: International Journal of Maritime History 25 (2013), pp. 249–253.

97 Knights, Trust and Distrust (cf. note 13), pp. 7, 138.

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examined here show that a concept of selfless action in office could trigger a response from the official that resembles self-defence. The navy's ethic of preservation, saving lives while saving money, justified over-loading one man, Barclay, with duties that proved unrealistic to fulfil. The same ethic rationalised a fixed price for the purchase of care, and a bias toward purchasing care from a contractor rather than local people, despite relying on the latter to save the lives of seamen in a care crisis such as an epidemic. Thus, the organisation aimed to save money and lives via the actions of selfless officials. The human beings occupying the offices, including Barclay and Butler, wanted to serve and to profit from them; at the very least, they did not wish to suffer in the course of performing their duties. The navy's ethic of "care on the cheap", when combined with an unwillingness to reward sufficiently the agent responsible for maintaining good relations with the quarterers, helps to explain, if not to exculpate, Butler's "dynamic equivalent" interpretation of his instructions. Therefore, the way the navy organised care, and the ethic underpinning it, encouraged its officials to take what they probably thought were reasonable steps toward their self-preservation.

One distinction therefore, between eighteenth-century and modern views of corruption might be that while the latter notion demands selflessness from officials, the former was content simply with officials who prioritised the organisation's goals over their own. In other words, so long as officials did not use their posts primarily for self-advancement, they did not have to worry about charges of corruption. Unfortunately, the navy did not provide officials with guidance on how to act when faced with a choice between advancing the navy's interests and damaging their own. However, that dilemma is one which modern moral philosophy has not managed to resolve.[98]

These cases also point to a broadening of our understanding of the ethical and social processes by which modern corruption arose. The concept emerged not only through discursive debates about probity in office nor by the abandonment of moral pluralism in public service but also via social interactions, such as investigations into corruption, that encouraged officials to account for their actions from the perspective of their organisation's ethics.[99] Barclay and Butler attempted, at least, to fit their first-person accounts within the third-person perspective of the Royal Navy. It makes sense to think that the more officials thought about their work from this more objective perspective, and acted it out, the more objectively rational their organisations could become.

98 Alasdair MacIntyre, Three Rival Versions of Moral Enquiry. Encyclopedia, Genealogy, and Tradition, Notre Dame, ID 1990, p. 187.

99 Kerkhoff et al., Corruption (cf. note 13), p. 21.

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Erin Elizabeth Spinney

The Women of Haslar and Plymouth: Washerwomen, Nurses, and the Work of Creating a Healing Medical Environment

The British Royal Navy's large clinical hospitals of Gosport and Plymouth treated thousands of patients during the French Revolutionary Wars and required a workforce equal to the job. Both Plymouth Naval Hospital and Haslar Naval Hospital were state-run and operated by the navy's Sick and Hurt Board.[1] While the work of medical officers onshore and onboard ships has often featured in historical work, these men were but a fraction of the workers within the wider British naval medical system.[2] My own previous work has considered the role of nurses in onshore hospitals and hospital ships, but there were many other women and men who laboured for the state in naval medical spaces not as nurses. This chapter will examine the role of washerwomen at Haslar and Plymouth Naval Hospitals to demonstrate that their work to ensure bedding and clothing were clean (known as hospital dress) both promoted healing and prevented the spread of further contagious diseases throughout the hospitals. Not only was the work of these women essential, nurses and washerwomen were part of a wider network of maritime communities with wives and widows of seamen receiving preferential hiring. As such, women labourers were both recognised by the British state for

1 The Sick and Hurt Board, formally known as Commissioners for Sick and Wounded Seamen and Prisoners of War, was subordinate to the Admiralty and from 1702 was responsible for the appointment of surgeons and surgeons' mates, as well as the supervision of hospitals, contract hospitals, and sick quarters. For details, see P. K. Crimmin, The sick and hurt board and the health of seamen c. 1700–1806, in: Journal for Maritime Research 1, 1 (1999), pp. 48–65. For the establishment of naval hospitals, see Kathleen Harland, The establishment and administration of the first hospitals of the Royal Navy, 1650–1745, Exeter, Diss. 2003.

2 Laurence Brockliss et al., Nelson's Surgeon: William Beatty, Naval Medicine, and the Battle of Trafalgar, Oxford 2005; Christopher Lloyd, Jack Coulter, Medicine and the Navy 1200–1900, 4 vols., vol. III: 1714–1815, London 1961; Catherine Kelly, War and the militarization of British Army Medicine, 1793–1830, London 2011; Margarette Lincoln, The Medical Profession and Representation of the Navy, 1750–1815, in: Geoffrey Hudson (ed.), British Military and Naval Medicine, 1600–1830, New York 2007, pp. 201–226; N. A. M. Rodger, The Wooden World: An Anatomy of the Georgian Navy, London 1986; Brian Vale, Griffith Edwards, Physician to the Fleet: The Life and Times of Thomas Trotter, 1760–1832, Woodbridge 2011.

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their work and, through their naval connections, truly an intrinsic part of that same state.[3]

Within the framework of eighteenth-century medicine, cleanliness was the primary method of controlling the spread of infection. Historians, such as Kathleen Brown, have highlighted the importance of clean body linen and bedding in the early modern period.[4] Although it has also been recognised by Bridget Hill, Deborah Simonton, and Marie-Clair Rouyer-Daney, among others, that women were primarily responsible for cleanliness in homes, similar attention has not been paid to the role of washerwomen in medical settings, whether military or civilian.[5] The lack of attention paid to the role of laundry in medical settings is not solely a phenomenon of the pre-modern period, but persists well into the modern age with laundry services being something that are necessarily performed but do not regularly feature in historical literature.[6] Contributing to this lack of discussion of the importance of laundry, cleanliness, and medical care spaces is the assumption that laundry is unskilled work performed overwhelmingly by women.[7]

Using a prosopographical analysis of Plymouth naval hospital pay lists, Sick and Hurt Board correspondence, and prescriptive regulatory literature, this chapter examines the role of these women "public servants" for the fiscal naval state.[8] Prosopography (the study of a collective group) allows for the study of the characteristics of the nursing and washerwomen workforce at Haslar as well as specific individuals who make up that group. Over the period of study, nurses were given increased responsibility in the hospital spaces, while washerwomen received an increase in pay from three shillings per week in 1769 to four shillings per week in November 1780.[9] Although nurses were always paid more than washerwomen, this pay differential was due to the complexity and distinctly

3 Here I use 'state' to mean the organisation and bureaucracies that allow for the Royal Navy to wage war. This builds upon both the fiscal-naval state and Roger Knight's broader conception of the state as an organisation for war. See Roger Morriss, Foundations of British Maritime Ascendancy: Resources, Logistics and the State, 1755–1815, Cambridge 2011, pp. 8–14 and Roger Knight, Britain Against Napoleon: The Organization of Victory, 1793–1815, London 2013.

4 Kathleen Brown, Foul Bodies: Cleanliness in Early America, Yale 2009.

5 Bridget Hill, Women, Work and Sexual Politics in Eighteenth-Century England, London 1994, p. 118; Deborah Simonton, A History of European Women's Work: 1700 to the Present, London et al. 1998, pp. 93–94; Marie-Clair Rouyer-Daney, The Representation of Housework in the Eighteenth-Century Women's Press, in: Isabelle Baudino et al. (eds.), The Invisible Woman: Aspects of Women's Work in Eighteenth-Century Britain, Aldershot 2005, pp. 28–29.

6 Pat Armstrong, Suzanne Day, Wash, Wear, and Care: Clothing and Laundry in Long-Term Residential Care, Montreal et al. 2017, p. 42.

7 Armstrong, Day, Wash, Wear, and Care (cf. note 7), p. 44.

8 For *Instructions to Royal Naval Hospitals at Haslar and Plymouth* see St George's Field: The Philanthropic Society, 1808, p. 177.

9 Haslar (Pay Lists) 1769–1772, TNA [The National Archives UK], ADM [Admiralty] 102/375; Haslar (Pay Lists) 1780–1781, TNA, ADM 102/379.

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medicalised nature of nursing work as well as their constant interaction with and monitoring of hospital patients. Yet, within the framework of preventative and environmental medicine washerwomen were important as they provided the clean linen instrumental to the maintenance of a healthy environment.[10]

Such a workforce included medical officers, nurses, labourers, and washerwomen. Interestingly, women workers often moved between work as nurses, washerwomen, and washer matrons. Within the framework of eighteenth-century medicine, cleanliness was the primary method of controlling the spread of infection. This paper will examine the fluidity of workers between these important roles and the gendered categorisation of labour within these hospitals by using pay list records from Haslar and Plymouth naval hospitals to track the movements of women workers from nursing roles, to washerwomen, and/or the supervisory role of washer matron. I will focus on two significant shifts in role and status experienced by many women working at the hospital: from washerwoman to nurse, and from nurse to Matron, a position of authority. Migration from one job to another in this fashion also resulted in an increase in pay and permanence. Such analysis is enabled by a prosopographical database of over thirty thousand line entries, covering Plymouth Naval Hospital from July 1777 to December 1799, and Haslar Naval Hospital from May 1769 to January 1779.

1. Role of and Regulation of Washerwomen in British Naval Hospitals

In previous papers, I have illustrated how a household model of hospital management highlights the authority of nurses over the mini households of individual hospital wards.[11] Nurses not only dispensed medicines, and maintained the cleanliness and order within the wards, but were also responsible for locking the door at night.[12] This responsibility reinforced nurses' dual roles as both someone acting as a landlady who controlled access to the ward space and

10 Naval medical officers, such as naval surgeon, Gilbert Blane, credited the "sudden decrease of sickness in the first years of this century" to preventative measures such as "improvement in the method of promoting ventilation and cleanliness". Cf. Gilbert Blane, Statements of the Comparative Health of the British Navy, From the Year 1779 to the Year 1814, With Proposals for its Farther Improvement, in: Medico-Chirurgical Transactions (1815), p. 503.

11 Erin Spinney, Servants to the Hospital and the State: nurses in Plymouth and Haslar Naval Hospitals, 1775–1815, in: Journal for Maritime Research 20, 1/2 (2018), pp. 1–17. For a similar use of the household concept, see Suzanna Wagner, Households Large and Small: Healthcare Civilians and the Prominence of Women's Work in the Edmonton Bulletin's Reporting of the 1918 Influenza Pandemic, in: Journal of the Canadian Historical Association 32, 2 (2022), pp. 1–43.

12 *Instructions* (cf. note 8), pp. 203–205.

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medical provider to sailor-patients. Such a dual role was familiar to civilians and naval personnel within early modern Britain, which promoted a common understanding of the hierarchical relations between nurses and hospital administrators.[13] Nurses were part of the everyday fabric of the naval institutions and provided crucial medical care, ensured the cleanliness of hospital wards, and helped to enable a healthy healing environment through ventilation.[14]

However, nurses were not responsible for all domestic or preventative medical labour in the naval hospitals; rather, this labour was divided among other workers such as labourers and washerwomen.[15] Washerwomen handled the washing of bed linen, but it was the ward nurses' responsibility to see that bedding was changed in a timely matter. It was understood that contagion could be imported into the ward through patient's clothes, bedding, and bodies, so before admission, patients were to be bathed, and bedding and clothing confiscated and relegated to the Bed House.[16] Patients were to be clothed in hospital shirts, and only if there were not enough shirts were they allowed to remain in their own clothes.[17] If a man died in the ward of a disease that was deemed to be contagious, his clothing and bedding were to be burnt.[18]

Though washerwomen were clearly important to both the running of the naval hospitals and the promotion of cleanliness, there were no specific regulations on who should be employed as a washerwoman. Early regulations for washerwomen were often lumped in with those for nurses, such as this directive from 1776 outlined staffing policies during a time of force reduction:

> "They are from time to time to discharge Nurses and Washerwomen upon decrease of Service or such neglect of Duty as they judge may desire that Punishment, but if a reprimand is not sufficient upon any misbehaviour of the other Servants they are to be

13 Leigh Whaley, Women and the Practice of Medical Care in Early Modern Europe, 1400–1800, Hampshire 2011, pp. 150–152; Andrew Wear, Knowledge and Practice in English Medicine, 1550–1680, Cambridge 2000. This would also have been familiar to sick and wounded seamen who had previously been quartered in private homes. "Evan Nepean for Admiralty to Commissioners for Sick and Wounded," three enclosures discussing the state of private sick quarters at Liverpool, Sick and Hurt Board, In–Letters and Orders 1797–1798, NMM [National Maritime Museum], ADM/E/46. See also Matthew Neufeld, Blaine Wickham, The State, the People and the Care of Sick and Injured Sailors in Late Stuart England, in: Social History of Medicine 28, 1 (2015), pp. 45–63.

14 For a similar discussion of gendered labour in army hospitals, see Erin Spinney, Women's Work: Nurses, Orderlies, and the Gendered Division of Care in British Army Hospitals, 1775–1815, in: Nursing History Review 31 (2023), pp. 127–149.

15 Stephen to Sick and Hurt Board, enclosure, 3rd June 1780, NMM, ADM E/42.

16 Haslar Hospital Observations, no date likely 1795, NMM, MID/7/4.

17 Response to Visitation of Haslar Hospital, TNA, ADM 1/3533.

18 Remarks made on an Examination of the Royal Hospital at Haslar from 28th March to 4th April 1794 both days included, 9th June 1794, NMM, ADM/E/45.

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suspended if thought to deserve to be discharged and the matter to be represented to Us."[19]

This lack of specificity concerning washerwomen could suggest a few things: First, that they were not top of the list of regulatory priorities for hospital administrators and the Sick and Hurt Board. Most early regulations for the hospitals focused either on administration (finances, economy, acquisition of supplies) or on the conduct and morality of patients and those in constant contact with them. For instance, the first rules concerning patient conduct issued in 1760 stated that: "No one shall be guilty of blasphemous expressions unlawful swearing Cursing Drunkenness Uncleanness Lying or other Scandalous Actions to the corruption of good manners and in derogation of God."[20] This concern with words and actions was a reflection of eighteenth-century concerns about order and good governance.[21]

Second, the lack of mention of washerwomen in eighteenth-century regulations could be read as a reflection that the work that they were performing was not seen as important. However, given the preoccupation of hospital administrators and the navy with oeconomy and that washerwomen were dealing with hundreds of pounds of linen daily, and that clean linen was seen as of crucial importance to health, this assessment does not hold much sway.[22]

The lack of a definitive discussion of the ideal washerwoman employee makes most sense in light of the prevailing perception that women were innately capacitated to do laundry. This perceived capacity was behind the choice of medical practitioners to employ women as nurses as this choice stemmed from their perceived gendered suitability for nursing work.[23] While it is impossible to know for sure why the duties, required abilities, and ideal characteristics of washerwomen were excluded from the early regulations, it is clear that by the time of the first printed *Instructions for the Royal Naval Hospitals at Haslar and Plymouth* in 1808, the selection process for washerwomen and other labourers was more defined:

19 Instructions, precedents, and historical notes relating to the Sick and Hurt Board, TNA, ADM 98/105, p. 388.

20 Instructions and Precedents (cf. note 19), p. 435.

21 Geoffrey Hudson, Internal Influences in the Making of the English Miliary Hospital: The Early Eighteenth-Century Greenwich, in: Geoffrey Hudson (ed.), British Military and Naval Medicine, Amsterdam et al. 2007, pp. 259–261.

22 For more on oeconomy as a form of financial and management practices in the eighteenth century, see Lissa Roberts, Practicing oeconomy during the second half of the long eighteenth century: an introduction, in: History and Technology 30, 3 (2014), pp. 133–148.

23 See Erin Spinney, Military and Naval Nursing in the British Empire c. 1763–1830, Saskatchewan, Diss. 2018. The gendered division of labour in hospital spaces and the importance of cleaning, ventilation, and care for patients was discussed in Chapter One pp. 28–75, Chapter Two pp. 76–113, and Chapter Three pp. 114–153.

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> "All persons proposed by the respective Officers, to be entered as Labourers, Nurses, Washerwomen, or Servants of any kind, are to be carefully examined by one of the Physicians, or Surgeons, of the Hospital; and you are to be perfectly satisfied that such persons be, in all respects, fit for the employment intended, before you authorize the Agent to enter them on the Hospital muster books. You are to observe that no person, of the above description, is to be received, who may be above thirty-five years of age, if others can be obtained; and, in engaging Nurses, Washerwomen, and Seamstresses, the preference, where merit may be equal, shall be given to the widows of Seamen and Marines, who may have served in His Majesty's Navy; but no foreigners are to be entered for the above services."[24]

The 1808 *Instructions* also delineated the role of the washerwomen, the Overseer of the Wash House, and the Store Matron who was to have ultimate authority over their conduct:

> "You are to regulate, and superintend, the whole business of washing the linen and clothes returned from the several wards, or which may be sent to you by the Steward. You are to keep an account, in the annexed form, of all articles daily sent to be washed, inserting the names of the Washers, and the number or quantity of each article given them respectively to wash, specifying the quantity of soap to be supplied for the same, and, after calculating the whole quantity of soap, &c. required for the day, you are to furnish the Overseer of the wash-house, with a demand for the same, or the Steward, accordingly to the annexed form, specifying the quantities of clothes to be washed, and the number of Washers to be employed thereon; and you are to sign your name thereto, as a voucher to the Steward, to issue the same. The Overseer of the wash-house is to deliver to each Washer the proportion of soap directed in the account of articles sent to be washed, of which you are to give her a copy; and, as you will be answerable for any abuse in the washing department, you are frequently to visit the wash-house, and inspect the conduct of the Overseer and all other persons employed therein, to see that no waste be made of firing, soap, or any other article."[25]

My previous research, which examined how naval nursing regulations changed over the course of the late eighteenth and early nineteenth centuries, suggests that the 1808 regulations were in fact a codification of established practice at naval hospitals. This inference is supported by correspondence between hospital administrators, medical officers, and the Sick and Hurt board. It is probably the case that the same codification process is happening with respect to washerwomen. Although I have yet to find the case of a washerwoman discussed in official correspondence or in the writings of Plymouth Hospital Governor Richard Creyke (governor from 1795–1826),[26] the same pay lists that have proven so

24 *Instructions* (cf. note 8), p. 7.

25 *Instructions* (cf. note 8), pp. 196–197, emphasis mine.

26 P.D. Gordon Pugh, History of the Royal Naval Hospital, Plymouth. Part 1 The Life and Times of Captain Richard Creyke, in: Journal of the Royal Naval Medical Service 58 (1972), pp. 78–94.

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fruitful to my study of nurses can also be used to show both the importance of washerwomen and their contribution to the functioning of the hospital as well as the variety of women's domestic labour within naval hospitals during the Revolutionary and Napoleonic Wars.

While there may have been scant regulation of washerwomen themselves in the naval hospital regulations, clear and detailed instructions were promulgated about how bed and body linen should be handled, the measures to take to avoid contagion or contamination of hospital spaces, along with explicit concern about the theft of items from hospital premises. For example, a directive to Haslar issued on 17th November 1777 stated that the sheets of every patient be changed every fourteen days and "their Body Linen every 4th day and oftener in disorders that require it".[27] The linen itself was, from 1772, to be under the charge of the Hospital Matron who was to determine what quantity of bed and body linen was required for the hospital, while the Overseer of the Washhouse was to keep a "Book of the Soap" recording the quantity of linen and wood ashes delivered to the hospital.[28] The overseer of the washhouse mentioned in the regulations was listed as the 'Washer Matron' in the Haslar pay list records and the 'Overseer of Washers' in the Plymouth pay list records.[29] Although the Steward of the hospital was in charge of dispensing items including linen from the hospital stores, the quantity of linen required and the handling of washing materials was in the hands of the washer matron and washerwomen working in the washhouse. Likewise, from the opening of Haslar in 1756, there were directions for the airing of clothes and linen in the hospital airing grounds, but no specific instructions on how this was to be handled by the washerwomen.[30]

From 1756, each time that a new patient was admitted into the hospital, both the individual and their clothes were to be cleaned so that contagious diseases did not enter the hospital. In the case of the patient, after they were washed with warm water and soap, they were to be outfitted with hospital dress for the duration of their stay. Patients' clothes were to be "taken from them and not to be delivered to their room till they are put into the recovery Wards and his Clothes and Linen to be washed and cleaned before put on and if any apprehension of infection shall be fumigated with Brimstone accorded for that purpose".[31] As with the above fabrication of soap, the quantities of brimstone and the method for fumigation were not detailed in the regulations. Nor did the level of detail surrounding the process of fumigation or airing of clothes and bedding change with

27 Instructions and Precedents (cf. note 19), p. 441.
28 Instructions and Precedents (cf. note 19), pp. 188–189.
29 Haslar (pay lists) 1769–1772, TNA, ADM 102/375; Plymouth: pay lists, 1777–1779, TNA, ADM 102/683.
30 Instructions and Precedents (cf. note 19), p. 377.
31 Instructions and Precedents (cf. note 19), pp. 375–376.

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the subsequent issuing of regulations.[32] This probably indicates that while the standards of cleanliness were set either by medical officers or the Sick and Hurt Board, the delivery of these standards was seen to be the purview of women.

What did change in the regulations, was a concern over the security of linen. The 1808 *Instructions for the Royal Naval Hospitals at Haslar and Plymouth* state that labourers were to be appointed by the Steward to "assist the Nurses of such ward, in taking out, airing, and returning the same"; while the bedding was out of doors, the Hospital governor was to "take the necessary measures for preventing any Patient, or other improper person, from going near it".[33] The measures to prevent the linen from being tampered with on the airing ground can be read in two ways: First, that airing was part of a purifying process which could be sullied by interference by someone not familiar with the process. Such a reading would align with notions of preserving and maintaining cleanliness in the hospital.

The second reading could be as a discouragement against the theft of valuable bed linen. Throughout the eighteenth century, the policing of who could and could not enter the hospital premises became stricter. The hospital porter was authorised to search all who entered and left the institution. In theory, such searches could both prevent the entrance of spirituous liquor and prevent anything (e.g., linen, hospital stores) or anyone (desertion) from leaving.[34] For this purpose the hospital porter was to be constantly available "in order that you may be at all times in readiness to execute the duties of your station".[35] In order to assist the porter with searching workers, including washerwomen, who arrived for work in the morning and left in the evening, all workers were to arrive before the morning General Muster. Any "Workman, Labourer, Washerwoman, or other person employed by the day" who entered after this point were to have the time of their entry noted by the Porter, so that "such stoppage may be made from his or her wages, as the case may require".[36] The mention of washerwomen by name in this regulation singles them out from the other large group of women workers—nurses—who lived in the hospitals and did not commute from local communities daily. Additionally, the check performed by the porter on washerwomen who arrived late for work acted like a punch clock, affecting their earnings for the days on which they were not punctual.

Although washerwomen were day labourers who lived outside the hospital household, they were entitled to employment-related provisions paid for by the

32 *Instructions* (cf. note 8).
33 *Instructions* (cf. note 8), p. 17.
34 *Instructions* (cf. note 8), pp. 211–213.
35 *Instructions* (cf. note 8), p. 211.
36 *Instructions* (cf. note 8), p. 214.

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navy.[37] The inclusion of washerwomen in sick pay regulations stems from the instructions to hospital governors in 1795,[38] though such sick care was stipulated for nurses in hospital instructions from as early as 3rd May 1763.[39] However, while the official regulations may have stipulated sick pay for washerwomen only from 1795, the practice of offering sick pay to washerwomen can be seen from the earliest available pay lists for Haslar and Plymouth naval hospitals.[40] By 1808, sick pay regulations categorised washerwomen under the heading "Labourers, Nurses, Washerwomen, or other Servants of the Hospital".[41] This heading covered the most common job categories for both men (labourers) and women (nurses then washerwomen).

For both Haslar and Plymouth naval hospitals, sick pay and care in the sick ward involved a significant investment from the state on behalf of women workers. From the period of May 1769 to December 1779, just 40 sick days were paid out for washerwomen at Haslar.[42] In the case of Plymouth over the much longer period from July 1777 to December 1799, there were 2,886 sick days paid for washerwomen compared to a total number 75,525 days worked by washerwomen. In other words, approximately 3.6 per cent of the wages that were paid to washerwomen were paid as sick pay.[43] However, as washerwomen were day labourers, they seem to be much more likely than was the case with nurses to be discharged from the hospital if they fell ill for longer than a month.[44]

37 Instructions to George Mottley Agent to the Royal Hospital at Haslar, ADM 1/3533, Letters from Haslar and Stonehouse Naval Hospitals 1793–1800.

38 Sick and Hurt Board to William Yeo, 14th August 1795, National Maritime Museum, ADM E/45, Sick and Hurt Board, In Letters and Orders 1794–1796.

39 Instructions and Precedents (cf. note 19), p. 385.

40 Haslar (Pay Lists), 1769–1772, TNA, ADM 102/375 and Plymouth (Pay Lists), 1777–1779, TNA, ADM 102/683.

41 *Instructions* (cf. note 8), p. 12.

42 Haslar (Pay Lists), 1769–1772, TNA, ADM 102/375; Haslar (Pay Lists), 1773–1776, TNA, ADM 102/376; Haslar (Pay Lists), 1777–1778, TNA, ADM 102/377; Haslar (Pay Lists), 1779–1780, TNA, ADM 102/378.

43 Plymouth: Pay Lists, 1777–1779, TNA, ADM 102/683; Plymouth: Pay Lists, 1780–1781, TNA, AMD 102/684; Plymouth: Pay Lists, 1782–1784, TNA, AMD 102/685; Plymouth: Pay Lists, 1784–1788, TNA, ADM 102/686; Plymouth: Pay Lists, 1789–1794, TNA, ADM 102/687; Plymouth: Pay Lists, 1794–1797, TNA, ADM 102/688; Plymouth: Pay Lists, 1798–1799, TNA, ADM 102/689.

44 See, for example, Sarah Black, discharged from after Haslar on 30th November 1778 after being sick for 54 days (28 with half pay and 26 days with no pay). Haslar (Pay Lists), 1779–1780, TNA, ADM 102/378.

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2. Numbers and Careers of Washerwomen at Haslar and Plymouth

As with the number of nurses, the number of washerwomen fluctuated with the number of patients that were in the hospital as shown in Table 1. In total, eighty-seven washerwomen worked at Plymouth from July 1777 to December 1799.

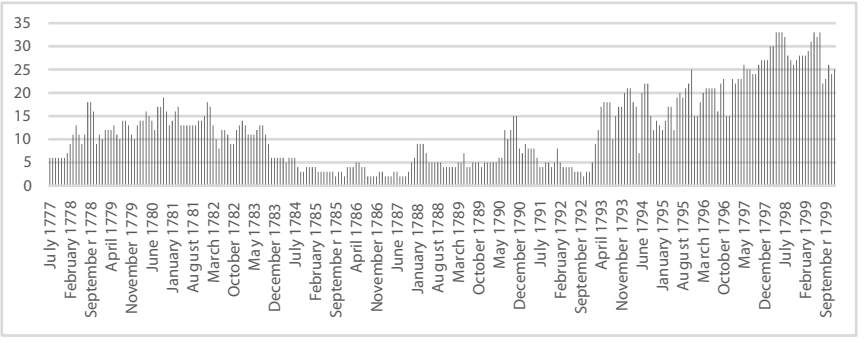

Fig. 1: Numbers of Washerwomen at Plymouth Naval Hospital 1777–1800[45]

Between May 1769 and January 1779 (the current limits of my Haslar database), the number of washerwomen per month at Haslar was much higher. This is unsurprising given the much higher number of patients at Haslar, with more than 3,000 on average in the first years of the American Revolutionary War.[46]

The workforce of washerwomen was also very constant at times of stable patient numbers. Only when the number of patients spiked or fell drastically was there either a large influx of new washerwomen or a corresponding reduction in numbers. Usually, those people most recently employed were the first to be discharged. Thus, the patterns of hiring and firing both nurses and washerwomen were very similar.

However, there were two significant differences between the two groups of women workers at the navy's permanent onshore hospitals in Britain. First, nurses were paid more at £1/month than washerwomen's three shillings and six pence per week. Second, nurses lived within the hospital either in the hospital wards (where they slept in what was known as nurses' cabins), or in garret rooms on the upper levels. By contrast, washerwomen commuted to work every day

45 Plymouth: Pay Lists, 1777–1779, TNA, ADM 102/683; Plymouth: Pay Lists, 1780–1781, TNA, AMD 102/684; Plymouth: Pay Lists, 1782–1784, TNA, AMD 102/685; Plymouth: Pay Lists, 1784–1788, TNA, ADM 102/686; Plymouth: Pay Lists, 1789–1794, TNA, ADM 102/687; Plymouth: Pay Lists, 1794–1797, TNA, ADM 102/688; Plymouth: Pay Lists, 1798–1799, TNA, ADM 102/689.

46 Charles Creighton, A History of Epidemics in Britain, 2nd edn., London 1965.

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from their homes in the Plymouth and Gosport area. They were also given both Christmas and Easter off.[47] Although many nurses who worked at Plymouth and Haslar had families (even families with small children) in the local community, they were required to request leave from the hospital administrator to attend to any sick or dying family members. While the same was true for washerwomen who may have needed to stay home during the day, they would at least have had the flexibility to attend to family affairs in the evenings and overnight. This flexibility could account for why some nurses may have chosen to take a pay cut from that of a nurse to that of a washerwoman.

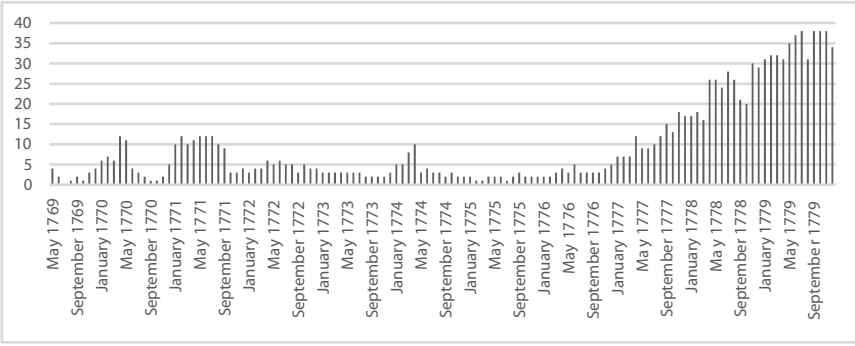

Fig. 2: Numbers of Washerwomen at Haslar Naval Hospital May 1769–December 1779[48]

There were quite a few cases of women crossing over between the nursing and laundry workforces. A close analysis of crossover cases highlights how domestic skills and experience were privileged in both. In the roughly ten-year span of pay list records that I have examined from Haslar, I found ten instances where washerwomen became nurses: Ann Barrett, Ann Green, Ann Pain, Elizabeth Bunten, Elizabeth Morgan, Elizabeth Patterson, Hannah Stride, Jane Dinch, Jane Wilson, and Judith Bowden. I tried to ascertain why these women made this switch in the hospital work environment through studying their careers as expressed in the pay lists. Unfortunately, the pay lists only have a limited 'notes' section, and this section is not used to explain why these washerwomen moved into the better paying and more complex labour of daily patient care.

Nonetheless, the pay list records provide rational grounds to speculate on why some women made the change from washer to nurse. For example, Ann Barrett was originally hired to work as nurse on 9th January 1770. She worked as a nurse

47 For example, see Plymouth pay lists for December 1792 with the notation "not pd Xmas Day". Plymouth: Pay Lists, 1789–1794, TNA, ADM 102/687.

48 Haslar (Pay Lists), 1769–1772, TNA, ADM 102/375; Haslar (Pay Lists), 1773–1776, TNA, ADM 102/376; Haslar (Pay Lists), 1777–1778, TNA, ADM 102/377; Haslar (Pay Lists), 1779–1780, TNA, ADM 102/378.

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until 12th April before being discharged from the hospital. By 24th April she was rehired as a washerwoman, a job she held until 28th May 1770. Over the summer of 1770, she was not working at the hospital but returned to work as a nurse in November 1770 and stayed in this position until 21st December 1771. From then on, her work was more casual, working as a nurse from April to June 1772, and again from December 1773 to March 1774 in both the British wards and as a contract hire for the Russian sailors in sick quarters at Haslar. In March 1774, she switched to being a washerwoman contracted for by the Russian Service, before being discharged on 23rd April 1774. She ended her career at Haslar with two stints of working as a nurse in July and August 1775, and February and March 1776.[49] Barrett was clearly thought to have the capacity to nurse, as this was what she was originally hired to do, but she often worked as a washerwoman. Her career highlights both the flexibility of women's labour roles in Haslar Hospital, and the reliance on casual labour from the local community.

Ann Green, another woman originally hired to work as a nurse at Haslar in December 1769, worked as a washerwoman for a brief period. Green had stopped working as a nurse on 13th April 1770, being entered as a washerwoman the very next day in the pay list records. She would continue this work until 28th May 1770, before like Barrett not working the summer of 1770 and returning to work as a nurse in November 1770 a position she would continually hold until 21st June 1771.[50] Barrett and Green's experiences were atypical, both having been hired originally to work as nurses, and then jumping between work as a washerwomen and nurses for the remainder of their careers.

The other eight women who went from being washerwomen to working as nurses all started their employment at Haslar as washers. Based on the years I have analysed thus far, there is no evidence that someone went from nursing to being a washerwoman and back to nursing. The example of Elizabeth Bunten illustrates this more general trend. Bunten entered the hospital as a washerwoman on 13th August 1777, a position she worked in until 21st November 1777. After this point she was briefly discharged from Haslar hospital, before re-entering the hospital as a nurse on 5th December. There are no notations in Bunten's pay list records to explain this development. Indeed, the only notations were her three days of sick time and half pay in December 1778, after which time she was discharged dead from the institution on 21st December. Her daughter, Mary Bunten, signed the pay list records to indicate that she had received the pay owed her mother for October, November, and December.

When looking at nurses who became and stayed as washerwomen, I discovered six examples: Betty Butler, Elizabeth Churchman, Elizabeth Vincent,

49 Haslar (Pay Lists), 1769–1772, TNA, ADM 102/375.
50 Haslar (Pay Lists), 1769–1772, TNA, ADM 102/375.

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Elizabeth Webber, Jane Dickerson, and Margaret Stinson. When examining the careers of these women, I was particularly interested in seeing if they were demoted from the higher-paying position of responsibility due to misconduct in their nursing work. One way to infer misconduct from pay list records is to see whether these women were 'chequed' or 'docked' pay. Although this system could also be used to grant unpaid leave, the minute and memoranda book of Governor Creyke at Plymouth shows that docking pay was used as a punishment. Yet, none of these women ever had been chequed pay, or had anything unusual in their careers. The case of Elizabeth Vincent exemplifies the typical move from nurse to washerwoman. Vincent began her career as a nurse on 13th February 1778. On 27th April she was discharged as a nurse and the next day re-entered the hospital as a washerwoman. She continued in this position until 1st June, when she was discharged and never worked at the hospital again. There is no notation in the pay list to explain this change in position, nor could I find any mention in official correspondence between hospital administrators and the Sick and Hurt Board of Vincent or the other five nurses who made this shift.

The cases of two women who were both promoted to the position of Washer Matron, or as it was known in the prescriptive regulatory discussed earlier, the 'overseer of Washers', deserve mention. Mary Butler, known as Mary Butler 2 in the pay list records to distinguish her from another Mary Butler already employed at Haslar, entered the hospital as a washerwoman on 16th February 1771.[51] She worked in this position constantly until she was discharged on 31st December 1776. After a month away from the hospital, she became the Washer Matron on 1st February 1777 and would remain in this position until 31st December 1777, at which point she was demoted back to washerwoman on 14th January 1778 after a short period of discharge. Likewise, Ann Burk's career at Haslar covered the entirety of my analysis period. Burk began working as a nurse at the hospital on 7th September 1769. She was one of a small minority of nurses at Haslar who had the ability to sign her name. She worked almost continually as a nurse until 5th April 1777, after which point, she had an eight-month discharge from the hospital before returning to work as the Washer Matron on 1st January 1778, replacing Mary Butler in the position. Although her literacy abilities undoubtedly were an asset to the Washer Matron position, she had a prolonged period of sickness for the last three days of April and all of the month of May. After her recovery, she returned to working as a nurse, a position in which she would remain until the end of my analysis period.[52]

The hierarchy of family relationships versus the importance of the ability of a Washer Matron to sign their own name, can be seen with the career of Washer

51 Halsar (Pay Lists), 1769–1772, TNA, ADM 102/375.
52 Haslar (Pay Lists) 1779–1780, TNA, ADM 102/378.

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Matron Elizabeth Matthewson, who succeeded Burk in the position on 1st June 1778. Matthewson had entered Haslar hospital to work as a washerwoman on 27th August 1768.[53] Matthewson had never been sick or checked pay during her time working as a washerwoman. On 1st June 1771, she took over the position of Washer Matron from her niece, Mary Whittle. Whittle had entered Haslar on 24th August 1755 and was listed with the pay if not the title of Washer Matron on the first available play list records from May 1769.[54] The family connections between Whittle and Matthewson can be seen on pay list records from March to May 1771 with the notation "Eliz Matthewson the Niece" in the place of Whittle's signature for her pay. For four days in May 1771, Whittle was listed as sick on the pay list records, after which she died in the hospital on 25th May with the notation "discharged dead", recorded.[55] Matthewson stayed as the Washer Matron until 1st February 1772 when she was discharged from the hospital,[56] only to re-enter the hospital as a washerwoman on 7th February 1778, a position she continued to hold until she succeeded Burk in June.[57] Unfortunately, there is no notation on the decision to promote Matthewson or mention of her previous work as the Washer Matron, so it is impossible to know why this replacement was made. However, Matthewson, who could not sign her own name, would remain in this supervisory position until the end of my current analysis period.

These careers show that in certain instances, women working at Haslar moved fairly seamlessly between the roles of nurse, washerwoman, and Washer Matron. As my research into this topic continues, I hope that a larger sample size of women who contributed their labour to naval medicine will better illustrate the boundaries between the various forms of women's domestic labour.

Highlighting the role of washerwomen in eighteenth-century naval hospitals demonstrates how their role aligned with the medicalised understanding of cleanliness present in the eighteenth century. Furthermore, it illustrates another example of the mobilisation of civilian women for the British war effort.[58] Meanwhile, the ease with which these women moved into other gendered work

53 The pay lists in ADM 102/375 also list the initial day that a worker entered the hospital even if this date was before the time covered by the pay list. Haslar (Pay Lists), 1769–1772, TNA, ADM 102/375.

54 Haslar (Pay Lists), 1769–1772, TNA, ADM 102/375. June 1769 shows her listed as Washer Matron—the first of any woman at Haslar to be granted that title.

55 Haslar (Pay Lists), 1769–1772, TNA, ADM 102/375.

56 Haslar (Pay Lists), 1769–1772, TNA, ADM 102/375.

57 Haslar (Pay Lists), 1777–1778, TNA, ADM 102/377.

58 Women's mobilisation is traditionally seen as the purview of the First and Second World Wars; however, it was also part of eighteenth-century warfare. See John A. Lynn, Women, Armies, and Warfare in Early Modern Europe, Cambridge 2008; Kit Candlin, Cassandra Pybus, Enterprising Women and War Profiteers: Race, Gender and Power in the Revolutionary Caribbean, in: Alan Forrest et al. (eds.), War, Demobilization and Memory: The Legacy of War in the Era of Atlantic Revolutions, London 2016, pp. 254–268.

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within the same institution suggests that gender and the experience of working at the hospital was more important in selecting labourers than previous experience in a specific role. Integrating the work of washerwomen into the history of British naval hospitals broadens our understanding of the workforce of the hospitals and thus a more inclusive history of eighteenth-century healthcare.

3. Conclusion

This chapter rests at the nexus of "the significance of medical spaces" and "war and welfare". The growth of the nursing and washerwomen workforce at Haslar mirrors the growth in the naval medical establishment and the complexity of onshore naval medical care. While nurses and washerwomen were expected to work for their wages, the naval state took care of its own by preferentially hiring sailors' wives and widows. Through the provision of medical care, both nurses and washerwomen were physically cared for when ill while they received half pay. In their cases, war and medicine provided them with a measure of employment security and perhaps even an employment identity.

Furthermore, an understanding of naval hospitals as medical spaces demonstrates women's agency as persons with authority over ward spaces, and the preventative medical act of washing bedding, body linen, and clothing. Additionally, in return for their labour in state-financed medical spaces, women could gain a sort of financial independence through regular pay, the ability to continue to care for their families and children outside the walls of the institution, and contribute to their kinship and familial networks. Pay list records demonstrate how mothers and daughters, and aunts and nieces, worked together within and in relation to the hospital. The lists suggest that women already employed at naval hospitals arranged or recommended that those in their familial networks work as nurses and washerwomen. In future, when pay list prosopography is compared to other fragmentary record sources such as parish records and minutes of physicians and council at Haslar Naval Hospital, it is probable that these records will demonstrate a complex set of relations around women's labour that has been previously absent from the historiographical discussion of labour history in the early modern period.

As naval medicine became more professionalised in the second half of the eighteenth century, the delineation of roles in medical settings increased through the increased scrutiny of selection and credentials for medical officers and the construction of clinical naval hospitals. As shown above, this included the categorisation of tasks under job titles, with differing pay scales, labour benefits (sick pay, seniority, etc.), and a gendered division of medical care. Without the demarcation of these roles, including those for washerwomen and nurses, the

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successful operation of a complex medical infrastructure would be doubtful. Washerwomen and nurses at Haslar and Plymouth naval hospitals did their jobs in a manner that contributed to the wider professionalisation of medical spaces and the success of the British Royal Navy in times of peace and war. The care work performed by these women, and the professionalisation afforded them, exemplifies that rather than distancing itself from a care economy, care work was central to the proper functioning of the early modern naval medical system and therefore the British Royal Navy.

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Sabine Jesner

Healthiness and Morality: Venereal Diseases and the Habsburg Army in the Late Eighteenth Century

Sharpening the senses for the presence and effects of war on civil societies away from the front line contributes to the understanding of a far-reaching cultural dimension of warfare. The early modern world received impulses from the soldierly lifeworld that touched the civil sphere in various facets and vice versa, the handling of disease representing just such an example of this reciprocal exchange.

The containment and treatment of war epidemics was and is of crucial importance for the health and well-being of societies. In contrast to other so-called classical diseases of war like pneumonia, typhoid, dysentery, malaria, bubonic plague, and trench fever, the medical and social consequences of sexually transmitted diseases persisted long after the end of a conflict. This chapter focuses on venereal diseases among the Habsburg army in the late eighteenth century. Sexually transmitted infections had an enormous impact on familial and social ties as well as sexual relationship structures and provoked gender bias. The linkage of the army as a catalyst for the spread of venereal diseases was recognised as a constant companion of war, but the consequences for social structures have been neglected by the early modern historical research for a long time.

In the 1920s, the physician and medicine historian Owsei Temkin contextualised "morality" and "syphilis" as parameters for perceiving venereal diseases in the light of divine punishment for a sinful life and behaviour on the one hand, and as peccadillo among privileged social clusters on the other.[1] This influenced the emergence of hegemonic ideas of morality and gender stereotypes, which have a lasting effect to the present day. According to Michel Foucault, eighteenth-century governmental health management that aimed to improve medical (infra)-structures was based on the emergence of a multi-faceted health policy, which was linked with the recognition of disease as an economic and social issue. He famously described the role of the early modern state as

1 Owsei Temkin, Zur Geschichte von "Moral und Syphilis", in: Archiv für Geschichte der Medizin 19, 4 (1927), pp. 331–348.

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initiator, organiser and controller of health politics, and emphasised the shift from charity to social medicine during the eighteenth century: preserving the health of the population became a general objective of early modern states.[2] An early example of what nowadays is known as "public health" includes the early modern Habsburg state's attempt to shift the attention from rather permeable care for the poor to more drastic medical prevention strategies.[3]

Efforts to combat venereal diseases were part of this development. The idea of degenerated males reducing the potential of the empire's fighting forces, stemming from sexually transmitted diseases, was taken seriously. Joan Sherwood pointed out in her study on wetnurses in a Parisian hospital in the eighteenth century that the church saw venereal disease as undermining the soul, while the government saw it as undermining the health of the family and the state. Under these considerations, the state sought to control these maladies with their potential to corrupt the social structure.[4] Similarly, the control of male and female sexuality became part of governmental health policy. The tangible culprits for the rampant spread of venereal diseases were often easily found in clandestine prostitution, and were primarily women.[5] Furthermore, the state was worried about the effectiveness of the armed forces, because the loss of manpower weakened its fighting forces, and medical cure was costly in terms of time and money.

Research on venereal disease and warfare concentrates on the modern era. Especially, research on the Great War has enhanced the state of research and contributed to a better understanding of how medical innovations improved the medical treatment, and how gender-based connotations were manifest in the ways of fighting venereal diseases, which in turn impeded sexual equality.[6] The

2 Michel Foucault, Die Politik der Gesundheit im 18. Jahrhundert, in: Österreichische Zeitschrift für Geschichtswissenschaften 7, 3 (1996), pp. 311–326, here pp. 311–313.

3 Recently Branka Gabrić, Darija Damjanović Barišić, The Church's Promotion of Public Health in the Southern Part of the Nineteenth-Century Austro-Hungarian Empire, in: Studies in Church History 58 (2022), pp. 284–305; Sandra Hirsch, Medicine on the Edge of the Habsburg Territories: Medical Practices and Medical Care at the Banat Military Border (Late 18th Century–Early 19th Century), in: Acta medico-historica Adriatica 19, 1 (2021), pp. 33–60; Tatjana Buklijas, Emese Lafferton, Science, medicine and nationalism in the Habsburg Empire from the 1840s to 1918, in: Studies in history and philosophy of biological and biomedical sciences 38, 4 (2007), pp. 679–686, here pp. 679–680 or for an overview Dorothy Porter, The History of Public Health and the Modern State, Amsterdam et al. 1994.

4 Joan Sherwood, Treating Syphilis: The Wetnurse as Technology in an Eighteenth-Century Parisian Hospital, in: Journal of the History of Medicine and Allied Sciences 50, 3 (1995), pp. 315–339, here p. 316.

5 Josef Schrank, Die Prostitution in Wien in historischer, administrativer und hygienischer Beziehung, Vienna 1886.

6 Lutz Sauerteig, Militär, Medizin und Moral. Sexualität im Ersten Weltkrieg, in: Wolfgang U. Eckart, Christoph Gradmann (eds.), Die Medizin und der Erste Weltkrieg, Herbolzheim 2003, pp. 197–226; Mark Harrison, The British army and the problem of venereal disease in France

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older German speaking historiography subsumed the topic under the term *Sittengeschichte* (history of morality).[7] The historian Nancy M. Wingfield brings together in her studies on the late Habsburg Monarchy the entanglement of prostitution, morality, and the soldier's world, while offering a cultural and gendered dimension.[8] Most studies on the early modern Habsburg Monarchy take different approaches to the topic. Often the surviving source material is not substantial enough to obtain satisfying answers. Much remains unknown about how venereal diseases influenced and shaped relationships at the junction of civil and military environments. The issue is interwoven with the word pair "shame" and "blame"—emotions—that have to be embedded in their contemporaneous perception or assessment, and simultaneously were part of the moralistic canon of behaving correctly or not at the time.

The role of soldiers for transmitting sexual diseases was recognised early. After the outbreak of syphilis on European soil during the fifteenth century, French troops in Naples were identified as the trigger for the spread of the disease. The term 'French disease' originated from that time and became a synonym for the malady in the German- and English-speaking world, while it was called the "Italian disease" in the French-speaking world. This illustrated the potential of a negative connoted usage by linking a disease with a hostile army.[9] By using the term 'venereal diseases', we mainly refer to syphilis and gonorrhoea. Until 1831, these maladies were not recognised as different diseases and often mixed sexual infections afflicted sufferers.[10]

This chapter examines the governmental strategies for controlling venereal diseases among the Habsburg army in the late eighteenth century. The study

and Egypt during the First World War, in: Medical History 39 (1995), pp. 133–158; Oswald Überegger, Krieg als sexuelle Zäsur? Sexualmoral und Geschlechterstereotypen im kriegsgesellschaftlichen Diskurs über die Geschlechtskrankheiten. Kulturgeschichtliche Annäherung, in: Hermann J. W. Kuprian, Oswald Überegger (eds.), Der Erste Weltkrieg im Alpenraum. Erfahrung, Deutung, Erinnerung, Innsbruck 2006, pp. 351–366.

7 Magnus Hirschfeld, Sittengeschichte des Ersten Weltkrieges, Hanau/Main 1929.

8 Recently Nancy M. Wingfield, Gendered Moral Panics in the Late Habsburg Monarchy: Prostitution, sex trafficking, and venereal disease, in: Katalin Fábián et al. (eds.), Routledge International Handbook to Gender in Central-Eastern Europe and Eurasia, London 2021, pp. 292–300 or Nancy M. Wingfield, 'The Sad Secrets of the Big City': Prostitution and Other Moral Panics in Early Post-Imperial Vienna, in: Austrian History Yearbook (2019), pp. 99–123.

9 Concerning the phenomenon of connotation, see, among others, Brigitte Fuchs, Škerljevo, Frenjak, Syphilis: Constructing the Ottoman Origin of Not Sexually Transmitted Venereal Disease in Austria and Hungary, 1815–1921, in: Jörg Vögele et al. (eds.), Epidemien und Pandemien in historischer Perspektive, Wiesbaden 2016, pp. 59–73.

10 The difference was recognised by Philippe Ricard in 1831. We have to keep in mind that the medical thinking and symptoms have changed over time, and this paper is not focused on the Nonvenereal endemic syphilis which appeared in the region of interest at the beginning of the nineteenth century. For details on this disease, see Carl Ludwig Sigmund, Untersuchungen über die Skerljevo Seuche und einige damit verglichene Krankheitsformen, Vienna 1855.

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focuses on the attempts to contain the spread of sexually transmitted diseases via regulatory interventions, by shaping medical spaces, and by the attempt to overcome moral taboos. 'Medical policing' became the pivotal point in these endeavours. The chapter also offers insights into the management of venereal diseases within rural landscapes, where the emergence of venereal diseases provoked an ethical dilemma and led to social stigma of demographic groups. The Habsburg regions of Banat and Transylvania as well as the Habsburg Military Border will function as case studies.[11]

The chapter seeks to contribute to a better understanding of early modern military healthcare and restoring men's health as a neglected field of gender research, and will shed light on the impact of sexually transmitted diseases meandering between civil and military spheres. The insights are part of the new cultural history that tries to centre human behaviour at a time from a pluralistic perspective.

1. Medical Policing and the Army

Based on a request of the Court Chancellery (*Hofkanzlei*), the Aulic War Council (*Hofkriegsrat*) addressed a note to all general commands in the Monarchy on 5th February 1791: "The Court Chancellery requested the behest that the military should not release soldiers for leave without a medical examination, and if soldiers suffering from a venereal disease are ascertained, they have to be cured in hospitals in order to prevent the spread of the malady over the rural population."[12]

The motive behind this letter can be found in an alarming increase in venereal diseases among the Habsburg troops at the time. Against the background of the still ongoing Austro-Turkish War (1788–1791), the Viennese authorities expressed their worries about the transmission of sexual diseases from armed

11 The principality of Transylvania became part of the Habsburg Empire with the Treaty of Karlowitz (1699) and the Banat with the Treaty of Passarowitz (1718). Both regions were beforehand incorporated into the Ottoman Empire. The Military Border was established in the sixteenth century, but expanded over time, and was split up in a Transylvanian, a Banatean, and a Croatian-Slawonian part in the eighteenth century as own administrative territories.

12 "*Die Vereinigte Hofkanzleiy hat um die Veranlassung das Ansuchen gemacht, womit vom Militar kein Beurlaubter ohne vorhergegangener chirurgischen Visitierung entlassen – und bei den Befund einer Venerischen Krankheit vürhin in den Spitälern geheilet werden mögen, damit dieses Übel unter dem Landvolk nicht verbreitet werde.*" See the letter from the Aulic War Council to all General Commands from 5th February 1791: OeSTA [Österreichische Staatsarchiv] KA [Kriegsarchiv] ZSt [Zentralstellen] HKR [Hofkriegsrat] HR [Hauptreihe] Akten 1937, 30/196–31/380, 1791–31–58.

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forces to the civil population. Here, their concern encompassed a transmission on the population near the theatre of war as well as on the population in the soldier's homelands. The military surgeons were urged to release soldiers for leave only after a strict medical investigation of their status of health. The preventive strategy was linked with a medical control over soldiers, apart from on the battlefield. This way of monitoring was part of a larger process known to historians under the term "medical policing". In 2010, Karl Härter prescribed how 'security' and 'welfare' became a leading category within governmental activities in the early modern era.[13] The *Gute Policey* were state ordinances that included among others the maintenance of public safety and order expressed via Christian sexual morality. During the eighteenth century, the *Gute Policey* developed into its own university discipline. We will use Härter's definition of *Gute Polizey* for the understanding of the praxeological implementation behind governmental ideas concerning the protection of the population from the spread of venereal diseases: "The Early Modern concept of gute Policey points to more or less modern concepts of state-based internal public security [*innere Sicherheit*], dealing for instance with terrorism and similar violent threats, on the one hand, and social or human security, which focuses on the security needs of the individual human or social groups on the other hand."[14]

The *Medicinal Polizey* (medical police) received its functional empowerment from that political programme (*Gute Polizey*) and was part of this ideological frame. The discourse on healthiness and illness was influenced and borne by medical experts and primarily encompassed questions dealing with the prevention of illness and defences against epidemics. Since historian George Rosen put the Habsburg medical police into context with governmental health strategies, the issue has received more attention.[15] Rosen's work paved the way for a better understanding of the development of public health and the emergence of social medicine.[16] On the other hand, Rosen's approach was criticised because of his emphasis on the despotically acting governments in the German territories.[17]

13 Karl Härter, Security and "Gute Policy" in Early Modern Europe: Concepts, Laws, and Instruments, in: Historical Social Research 35, 4 (2010), pp. 41–65.

14 Härter, Security (cf. note 13), p. 45.

15 Christian Barthel, Medizinische Polizey und medizinische Aufklärung. Aspekte des öffentlichen Gesundheitsdiskurses im 18. Jahrhundert, Frankfurt/Main 1989; Ute Frevert, Krankheit als politisches Problem 1770–1880. Soziale Unterschichten in Preußen zwischen medizinischer Polizei und staatlicher Sozialversicherung, Göttingen 1984; Lukas Lang, Medicinische Policey in den habsburgischen Ländern der Sattelzeit. Ein Beitrag zu einer Kulturgeschichte der Verwaltung von Gesundheit und Krankheit, Vienna 2021.

16 George Rosen, A History of Public Health, New York 1958; George Rosen, From Medical Police to Social Medicine: Essays on the History of Health Care, New York 1974; George Rosen, Die Entwicklung der sozialen Medizin, in: Deppe Hans-Ulrich, Regus Michael (eds.), Seminar Medizin, Gesellschaft, Geschichte, Frankfurt/Main 1975, pp. 74–131.

17 Lang, Medicinische Policey (cf. note 15), pp. 15–17.

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The scientific discourse on power and 'medicalisation', a term coined by Michel Foucault,[18] derived from that and affects the ongoing discussion whether and how the government is allowed to intervene on health questions.[19] Indeed, since the outbreak of Covid-19, the issue of medical policy has become topical again. It includes the biopolitical theme that is based on discipline and security and seems still able to burst social structures, while the question, how far under the premise of "healthiness" public interference into the private sphere is legitimate, remains unanswered.

During the second half of the eighteenth century, the Aulic War Council assumed increased responsibility for several sanitary matters. At this time, sanitary, hygiene, and medical care were already considered to be important factors concerning the care for soldiers in war and postwar phases. Therefore, the use of the military (infra-)structures for sanitary purposes was not a novelty when in January 1776, the highest military institution of the Monarchy was entrusted with a new task: The sole maintenance of the sanitary and health affairs at the Habsburg–Ottoman border including the management of the quarantine stations (Ger. *Contumazstationen*) in the border zone. The Habsburg quarantine stations had been erected at the end of the Habsburg–Ottoman War in 1739 as permanent medical spaces at the Monarchy's external border. Following the medical technique of quarantine, all border crossers (including livestock and goods), who arrived from the Ottoman Empire were put into seclusion in order to protect the public from the spread of contagious diseases. Locally recruited soldiers, paid with land grants and serving as border soldiers (*Grenzer, Grenzsoldaten*), provided the structural and personnel frame for this medical prevention strategy and guaranteed a continuously monitored border.[20]

The Habsburg Military Border initially was established in the sixteenth century by rewarding refugee settlers from the Ottoman Empire with land for military duties. The border zone was geographically enlarged until the eighteenth century from the Adriatic Sea to the Carpathian Arch in Transylvania. The militarily administered strip of land was characterised by the so-called *zadruga*, a family household structure marked by patrilineality. Building on this traditional structure, the Habsburg Monarchy obligated all males who lived in this zone to

18 Michel Foucault, The Birth of the Clinic: An Archaeology of Medical Perception, London 1976. The term 'medicalisation' is still not fully defined.

19 See Francisca Loetz, Why Change Habits? Early Modern Medical Innovation Between Medicalisation and Medical Culture, in: History and Philosophy of the Life Sciences 32, 4 (2010), pp. 453–473; Claudia Stein, The Birth of Biopower in 18th-Century Germany, in: Medical history 55, 3 (2011), pp. 331–337.

20 For the development from a Habsburg military cordon toward a sanitary cordon, see Sabine Jesner, Habsburg border quarantines until 1837: an epidemiological 'iron curtain'?, in: Sevasti Trubeta et al. (eds.), Medicalising borders: Selection, containment and quarantine since 1800, Manchester 2021, pp. 31–55.

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enter military service.[21] During the long eighteenth century, the preventive characteristic became advanced by sanitary politics. The mechanism of precaution at the external border by forming a militarily controlled sanitary cordon followed the nascent idea of medical policing by stimulating the security needs of the public. The entanglement of surveillance as prophylaxis formed a pillar of the following stages of medical policing. The fight against venereal diseases based on that ideological understanding and the exposed measures originated in large part from that approach.[22]

Within the militarised society of the Habsburg Military Border, venereal diseases often occurred in the late eighteenth century. At that time, the predominant economic policy in the Monarchy was still mercantilism, which defined "health" as a means to a progressive and economically strong state. The *Protomedicus,* leading physician of the Habsburg lands, Anton von Störck, stated in his textbook for military and civil surgeons (*Feld- und Landwundärzte*) in 1776 concerning the threat that was outgoing from what was contemporarily known as syphilis (Ger. *Liebesseuche* or *Lustseuche*): "No disease is known, that is such harmful for the state, as the *Liebesseuche*, because it is a perpetual and slinking plague: Uncountable suitable people will be decimated by the disease or at least mutilated and in a miserable shape, that they are in their best age completely exhausted, where they should be most effective, unfit for services and a burden for the state."[23]

Reduced manpower and working ability was identified as detrimental to the effectiveness of the army. A court decree, dated 11th December 1792, referred to a new regulation by the Aulic War Council: "The Aulic War Council has announced, that it should made sure that during the assentation, whether the *Lustseuche*, who has such an impact on the population number, is prevalent among the young people and what is necessary to put the malady in the place."[24]

21 Women were included in the household of their husband, and the head of the household (*pater familias*) was exempted from the military service. The frontiersmen were not allowed to divide households, because this would have resulted in more *pater familias* and less soldiers. For details, see Karl Kaser, Freier Bauer und Soldat. Die Militarisierung der agrarischen Gesellschaft an der kroatisch-slawonischen Militärgrenze (1535–1881), Vienna 1997.

22 Jesner (cf. Note 20), pp. 31–55.

23 "*Es ist keine Krankheit bekannt, die dem Staate so schädlich wäre, als die Liebesseuche, denn sie ist eine immerwährend und schleichende Pest: Es werden durch selbe unzählbare und oft die tauglichsten Leute hingeraffet oder wenigstens dergestalt verstümmelt und elend gemacht, daß sie in ihrem besten Alter, wo sie am wirksamsten seyn sollten, gänzlich entkräftet, zu den meisten Geschäften untauglich und dem Staate Zur Last sind.*" See Anton Freyherrn von Störck, Medicinisch= praktischer Unterricht für die Feld= und Landwundärzte der österreichischen Staaten. Erster Theil, Vienna 1776, p. 96.

24 "*Es hat der k.k. Hofkriegsrath die Anzeige gemacht, daß bei den Assentirungen sich überzeuget werde, wie sehr das auf den Populationsstand so wichtigen Einfluß habende Übel der Lustseuche eingerissen, wie viele junge Leute hiedurch und wie es nöthig sei, diesem Uibel so viel*

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The idea behind was the attempt of a timely recognition of the potential risk already during the recruiting process and not on the battlefield, when it was frequently too late for precautionary measures.

The presence of sexually transmitted diseases in the Habsburg Empire is documented also by considering medical institutions and spaces. The *Bürgerspital* (Civic Hospital) was one of the most important institutions for poor relief and healthcare in the city of Vienna. Established in the thirteenth century, the hospital incorporated the *Siechenhaus St. zum Hiob Klagbaum* and the hospital *St. Marx* at the beginning of the eighteenth century. The hospital *St. Marx* was also founded in the thirteenth century and specialised in the care of syphilitic patients. Along with the reforms of Joseph II, co-regent of his mother, the Habsburg ruler, Maria Theresa, the patients (mainly syphilitic people, so-called "fools"[25] and expectant mothers) of the hospital *St. Marx* were transferred in 1784 to the re-opened Vienna General Hospital (*Allgemeine Krankenhaus,* AKH).[26] Based on a recorded room division (*Stubeneinteilung*) from 1735, historian, Melanie Linöcker, determined that among the 239 patients, there were 43 male and 36 female patients with venereal diseases; based on a table of the distribution of dishes (*Tag- und Speiß-Zettul*), dated 21st August 1754, in August 1754 there were, among 349 patients, 43 male and 38 female sufferers of sexually transmitted diseases at the AKH.[27] For this hospital, it is documented that the sick persons were not safe from prying eyes, since visitors were allowed on some days to enter the sickrooms. The mostly syphilitic patients and pregnant or puerperant women in this hospital were subject to visitors' moral disapproval.[28]

Starting from the middle of the eighteenth century, Empress and devout Roman Catholic, Maria Theresa, began to act against the spread of venereal diseases in her realms. In 1752, she established a special commission for chastity (*Keuschheitskommission*) with its own courts to fight against diverse moral offences, such as extramarital sexual intercourse or homosexuality.[29] The commission provoked contemporary criticism, because of the widespread practice of

nur möglich mit Ernste Schranken zu sezen." Cited after Erna Lesky, Österreichisches Gesundheitswesen in Zeitalter des aufgeklärten Absolutismus, Vienna 1959, p. 157.

25 The term was used as a synonym for mental illness.

26 Sarah Pichlkastner, Vom Physikus über die Hebamme bis zur Kindsdirne. Medizinisch-pflegerisches Personal im Wiener Bürgerspital und seinen Filialen in der Frühen Neuzeit, in: Virus. Beiträge zur Sozialgeschichte der Medizin 16 (2017), pp. 43–64.

27 Melanie Linöcker, der unzucht und lastern derbey entspringende krankheit. Syphilis und deren Bekämpfung in der Frühen Neuzeit am Beispiel des Wiener Bürgerspitals St. Marx, Saarbrücken 2008, pp. 158–159.

28 Schrank, Prostitution (cf. note 5), p. 228.

29 Unfortunately, the files of the *Keuschheitskommission* burnt during the July Revolt of 1927 (Ger. *Wiener Justizpalastbrand*).

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spying and disproportionately severe punishment.[30] Until 1769, the main function of the commission was to prevent the much maligned practice of prostitution. Woman, prostitutes, or by contemporaneous word usage, "wanton females" (Ger. *liederliche Frauenspersonen*) received the main share of the blame for their immoral vocation. As Joseph II visited the military hospital in Gumpendorf in March 1774,[31] his main worry was the high percentage of infected soldiers. His proposed remedy included capturing all known wanton females during their usual evening strolls together with the soldiers and to put the women in seclusion in *St. Marx* or in prisons, where they would be cured by midwives and surgeons.[32]

Maria Theresa's 1769 criminal law *Constitutio Criminalis Theresiana* required that prostitutes who infected their clients with a venereal disease should have their heads shaved, coated with tar or soot, and whipped in front of a church.[33] For these stigmatised women, who became criminals because of indecency offences, the Viennese Court installed a special form of punishment that was strongly linked to the regional focus of this chapter, the southeastern regions of the Habsburg Monarchy: The *Temeswarer Wasserschub.* This form of punishment was a deportation, a forced migration, to Temeswar (Rom. Timişoara), the provincial centre of the Habsburg Banat, by boat over the river Danube. The region was underpopulated, and the deportees were seen as a cheap but important workforce. The idea behind was to reintegrate individuals who behaved morally reprehensible with their work activity into society. The first transport took place in 1744 and included only 49 'dissolute' arrested women. Later, also men were included in the expulsions, but women always formed the greater part of these deportations. Over 2,500 persons were punished in this way. Until the last deportation of this kind in 1768, many women and men died in the Banat because of the bad living conditions, in particular a lack of hygiene or insufficient provision of nutrition, clothes, and medical care. Joseph II initiated the end of the deportations after his journey in the region between April and May 1768. He expressed his concerns in terms of the lack of hospitals for sufficient care for the often still sick or infected deportees at the time of arrival and the fact that they had to pay for the medical care themselves.[34]

30 Andreas Trupp, Die Wiener Keuschheitskommission. Welche Auswirkungen hatte die Politik des konfessionellen Katholizismus unter Maria Theresia (1740 bis 1780) auf Personen, die nicht katholisch glaubten und nicht katholisch handelten?, Vienna, Diss. 2017.

31 Part of Vienna.

32 See the letter of Joseph II to Feldmarschall Neipperg on 31st March 1774. Printed by Schrank, Prostitution (cf. note 5), pp. 227–228.

33 For the *Constitutio Criminalis Theresiana,* see Schrank, Prostitution (cf. note 5), p. 163.

34 For the letter of Joseph II, see Stephan Steiner, Rückkehr Unerwünscht. Deportationen in der Habsburgermonarchie der Frühen Neuzeit und ihr europäischer Kontext, Vienna et al. 2014, pp. 551–552.

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2. Fragmentation of Moral Taboos and the Emergence of New Ideals of Caring

The older historiography blamed an epidemic of venereal diseases between the 1780s and 1800 in the Banat and the neighbouring Habsburg region on the governmental deportations. However, the deportations, known as *Temeswarer Wasserschub*, had stopped more than ten years before.[35] Nevertheless, there was an enormous number of patients suffering from sexually transmitted diseases in those regions at that time that set off alarm bells among the provincial and central authorities. In October 1785, the regiment surgeon, Joseph Zimmerman, informed the *Protochirurg* (chief/first surgeon of the Empire), Alessandro Brambilla, about the status of venereal diseases in the military hospital, Weißkirchen (Serb. Bela Crkva/Бела Црква; Hun. Fehértemplom; Rom.: Biserica Albă), today situated in Serbia. Weißkirchen was located in the Banatean Military Border section and served as the administrative centre of the Wallachian–Illyrian Border regiment. Zimmermann reported that he had treated and released 159 patients who suffered from a sexually transmitted disease. This sum comprised 100 men, 56 women, and three children. Ten sick persons died due to a complex course of the infection. In his report, the surgeon tried to trace the origin of the illness to the behaviour of the local people. Based on contemporaneous stereotypes and ethnic ascriptions, Zimmermann denounced the immoral behaviour of the so-called "vlachs", as the Romanian population was named. He also criticised masturbation, unbridled adolescent sexuality, and a lack of parental oversight. As reason for that he filtered out, on the one hand, "deficits" in the religious teaching about correct moral behaviour according to religious standards by the Orthodox Catholic Church at the time, and on the other hand, the excessive consumption of spirits. The military surgeon noted that alcohol had a harmful impact on the army's manpower, and he found another component for the high number of infections in the hygienic shortcomings of family households. In addition, Zimmermann offers a glimpse into the medical culture of the time as he blamed the local population for seeking cures for sexually transmitted infections from mostly female herbalist healers. The cures offered by those healers were based on, he claimed, superstition, benedictions, and fumigations of ulcers which were/are a symptom of venereal diseases. Zimmermann's report was forwarded from Brambilla to the Aulic War Council and Joseph II. In response to the report, the regent started a causal analysis, and Joseph II found hints for the recent increasing number of infected in the administrative incorporation of 14 civil villages of the district, Karansebesch (Rom. Caransebeş; Hun. Karánsebes), today

35 Concerning the deportations, see Steiner, Rückkehr (cf. note 34), pp. 299–384.

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in Romania, into the Military Border zone, which was inhabited by border soldiers and their families. During the incorporation process were discovered 123 cases of venereal diseases among the new border soldiers. Joseph II draw the conclusion that not only in the military border zone, but also among the civil population of the Banat, the rate of sexually transmitted diseases must be high.[36]

The incidents had a prehistory. Based on a note of the Aulic War Council in September 1784, we learn that for nearly a year, the problematic circumstances in the Military Border were known in Vienna. The Aulic War Council referred to different reports of regimental surgeons, which revealed that entire villages were infected at high rates. The note implied the suggestion of Brambilla to establish regular medical screenings by military surgeons, the separation of healthy and infected soldiers, and the free medical cure for poor patients. The latter aspect awoke disapproval within the highest military institution because they demurred to spend money for wilful misconduct, especially for sexual dissipation that often went hand in hand with venereal diseases in their opinion. Despite the concerns, the proposal of Brambilla was approved, but the Council added some instructive points of improvement for the general command in the Banat: they criticised the role of the clergy as too passive, and demanded from the general command to initiate more proactive measures to improve the social and moral behaviour of frontiersmen. The general command had to instruct the military medical staff to travel into the infected villages to examine patients and to provide them with the needed drugs at the expense of the fiscus (royal treasury).[37]

Seven months later in April 1785, Joseph II received another letter on the problematic health circumstances related to venereal diseases in the civil areas of the Banat. Particularly affected were three regions, the regions of Lugosch (Hun.: Lugos, Rom.: Lugoj, Serb.: Лугош), the region of Kapolnasch (Rom. Căpălnaş), and the region of Karansebesch. The competent civil authorities in the Banat proposed the erection of special hospitals in those districts. The authorities in the Banat were worried that sexually transmitted diseases could not be contained as long as the patients were not effectively separated from their housemates, nor could it be guaranteed that they would properly follow the provisions of the surgeons and would take their medication correctly and regularly. The proposal of the regional authorities has not been heard.[38]

36 See the report of Zimmermann printed in Johann Peter Frank, Supplement=Bände zur medicinischen Polizei oder Sammlung verschiedener, in diese Wissenschaft einschlagender, eigener Aufsätze. Zweiter Band, Leipzig 1825, pp. 207–212.

37 For the note of the Aulic War Council from 23rd September 1784, see Frank, Supplement (cf. note 36), pp. 213–216.

38 Note of the Ungarischen Statthalterei in Ofen to Joseph II, dated 5th April 1785. See Frank, Supplement (cf. note 36), pp. 216–218.

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Fifteen years later, in the early 1790s, the circumstances of medical caring and nursing had changed little. Once again, an initiative by local authorities to erect special hospitals to cure venereal diseases in the Banat more effectively was not fully supported. In 1800, the University in Pest opposed the necessity of such medical institutions, because in their understanding, the number of infected individuals was not high enough, and the readiness among infected persons to stay in a hospital was not given. The university recommended domestic cures and a hospital stay only for complicated cases.[39] This review was forwarded to the Medical Faculty of the University in Vienna, which endorsed the assessment. The faculty members were worried about the geographical shift from the urban to the rural regions as centres of infections and blamed the army for this. The mobility of regiments and garrison towns was recognised as triggers for that process.[40] The faculty also criticised—again—the immorality among "children", their lack of moral education, the habit of a shared bedroom per household, poor personal hygiene, a lack of knowledge on the transmission of venereal diseases, the trust in superstition and quacks, the low number of proper educated physicians or surgeons, and the lack of efficient policing in the Banat. The persistent idea to erect special hospitals was estimated by the Viennese faculty as a very expensive endeavour. In particular, the medical treatment and the nursing in hospitals was seen as extraordinarily cost-intensive. In their minds, the nursing work could also be performed by family members, and a long hospital stay would have negative effects on agricultural productivity. In contrast, in-house care was acknowledged to be completely inadequate. The faculty members grasped that the proper change of dressings or the separation of healthy and infected individuals could not be overseen by the understaffed medical civil and military personnel in the region. Therefore, the medical faculty proposed a compromise: The larger part of the sick should be treated at home, and regularly investigated by qualified medical staff in 14-day intervals. Only difficult cases or the infected without their own homes or a family caregiver available should be treated in hospitals.[41]

Decision makers did not like spending money for persons who suffered from venereal diseases. The question of who had to pay for the treatment became a much-debated issue at the end of the eighteenth century. For the Transylvanian Military Border, the following decision was made in 1787: Based on the idea of the

39 For the review of the University in Pest, see Frank, Supplement (cf. note 36), pp. 221–225.

40 "*Volkreiche, dem Sittenverderbnisse mehr unterworfene Städte schienen lange allein bestimmt, den traurigen Beweis dieser Wahrheit zu liefern; allein, seitdem die Lustseuche unter den ungeheuren Heeren, die jetzt systemmäßig für beständig unterhalten werden müssen, zur alltäglichen Krankheit geworden ist, hat sich dieses Uebel auch selbst auf dem Lande, wenigstens nahe um die Hauptstädte und da, wo starke Garnisonen stehen, auf eine schreckbare Weise verbreitet.*" Frank, Supplement (cf. note 36), p. 226.

41 Frank, Supplement (cf. note 36), pp. 228–233.

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Aulic War Council, the cured border soldiers had to pay treatment and medicines for themselves, even if some of them were not able to raise enough money. The principle was mitigated by the fact that at first, the local authorities should balance the debts via the *Dorfskassen*, a sort of local village coffer. But this step would have overloaded the entire village society. Finally, the Aulic War Council made the decision to return the balance of funds to the local *Proventenfond*, a coffer that was under the supervision of the Aulic War Council.[42] During this process, "destitution" among the population became recognised as an imperial field of responsibility. The fact that a great number of those border soldiers were not in a position to settle their debts, made deviations from the traditional values and norms on morality necessary. The consequences of the 'new' approach was tangible in 1792 in the military border section of the Banat. In the year before, 59 border soldiers (from the Wallachian–Illyrian Regiment) had been separated and medicated in a shed (originally used for drills) in Jasenova (Serb. Jasenovo/Јасеново). Based on a report from December 1791, the curing costs comprised 490 florins and 50 kreuzer, whereof only three florins and 27 kreuzer were balanced by the cured border soldiers themselves.[43]

After the moral taboos of spending money on the treatment of STDs were broken and the problem of compensation costs was solved, an organisational problem became evident: New difficulties arose with the issue of provisioning drugs, which were based on the division of competences between the civil and military authorities in medical issues in the Habsburg Empire. The civil pharmaceutical market was insufficiently developed in the rural provinces of Transylvania and the Banat, which boosted the role of the army as supplier. From the 1780s, Franz Wilhelm Edler von Natorp fulfilled the role as external pharmacy supplier of the army (*Armeeapothekenlieferant*) and together with his staff, he was responsible for the overall pharmaceutical supply of the Habsburg army in war and peace. Until 1782, the supply was organised by the Viennese Pharmacy Board. This board was disbanded in 1782 by Joseph II. The disbandment of the board emerged from abuses concerning the delivery of falsified and inferior medicines for the army. With Franz Wilhelm Natorp, the financially weak Habsburg state gained a strong partner, who over the decades was able to organise the whole field of pharmacy on his own. This was very burdensome for Natorp because he had to recruit trained staff (so-called *Apothekenprovisoren*, i. e., pharmacist and lab workers), and he had to maintain the chains of supply for the products including the transport and the price risk. On the other hand,

42 For the note of the Aulic War Council to the General Command in Transylvania from 30th June 1787, see OeStA KA ZSt HKR HR Akten 1555, 30/101–31/220, 1787–31–216.

43 Concerning the note of the Aulic War Council to the General Command in the Banat from 1st January 1792 and the report from the general command in Timişoara on 17th December 1791, see OeStA KA ZSt HKR HR Akten 2026, 30/71–31/30, 1792–31–7.

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Natorp held a sort of monopoly on delivering drugs to the army, and he was exempt from customs costs within the "Composite Monarchy" with so-called "*Freipässen*" (free passports for economic reasons). In August 1793, after the Habsburg–Ottoman War (1788–1792) and before the Coalition Wars, Natorp cancelled his contract. The risks associated with doing business with the state, such as insufficient or delayed payments, and some hostilities from civil pharmacists, which feared for their business, could have been motives for Natorp's decision to terminate his dealings with the Habsburg state.[44] A problem arose because Natorp was not allowed to sell medications, which belonged to the field pharmacy, to the civil population. The alarmingly high rates of venereal disease infections blurred such a duality of shared responsibilities. In June 1793, the Aulic War Council gave the green light to instruct Natorp to provide medications against the *Lustseuche* for the civil population in Transylvania too with the same —reduced—price as it was already practised for the army.[45] Natorp agreed, but insisted on issuing a formal instruction, because the new order collided with his contract concerning the distribution restrictions, and he demanded, in order to make the deal more lucrative for him, a respectable sum of purchases which had to be paid monthly.[46]

The source material neither allows us to indicate the chain of infection of the venereal disease nor is it possible to trace "patient 0" on the edge of the Empire. What we know is that the spread of the disease reached almost epidemic proportions in the southeastern parts of the Habsburg Monarchy and had an adverse impact on the strength of the military border regiments and their duty to monitor the Habsburg external border for sanitary reasons as well as, more generally, the health of the local population in these distant provinces.

44 After Natorp's termination, the Viennese Court found no proper successor for Natorp, and Emperor Franz II decided to organise the drug supply by the state again. It was more difficult than expected. Finally, the Viennese Court handed the agenda over to pharmacist, Martin Lessner, who suggested installing a new governmental institution, the *Militär-Medicamentenregie*, which was finally headed by Lessner as director until his death in 1811. Natorp was rewarded for his work for and with the state with the *Reichsherrnstand*, a noble promotion, in 1801. For a short curriculum vitae of Franz Wilhelm Natorp along his promotion on 27th February 1801, see OeStA AVA [Allgemeine Verwaltungsarchiv] Adel [Adelsarchiv] RAA [Reichsadelsakten] 290.6.

45 For the note of the Aulic War Council to the Transylvanian Court Chamber, Brambilla, and the Transylvanian general command on 27th June 1793, see OeStA KA ZSt HKR HR Akten 2104, 1793–31–261.

46 For the letter of the Aulic War Council to the Transylvanian Court Chamber, the Transylvanian General Command, and Brambilla on 14th July 1793, see OeStA KA ZSt HKR HR Akten 2104, 1793–31–295.

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3. Conclusion and Outlook

We can assume that governmental actions facilitated the anti-venereal treatment of sick people and alleviated their suffering. However, we have to consider that effective control of venereal diseases depends on different variables. The ways of transmission have to be known, logistics and infrastructure should be established, and even today, morally inflected and specific medical ideas could have a negative impact on the containment of venereal diseases. Often, governmental initiatives are perceived as coercive measures that hamper effective actions to curb epidemic threats.

During the eighteenth century, the Habsburg authorities recognised that venereal diseases had dramatic demographic consequences, which alarmed them enough to take up the fight against them. During the last two decades of the eighteenth century, the Habsburg early modern state started to reconsider its longstanding principles on morality and responsibility for its population. This process is reflected within the new tailored modes of treatment of STDs. In this phase, the handling of venereal diseases turned from a criminal and moral question into a demographic and medical problem, along with considerations of their impact on the economic prosperity and the military strength of the Habsburg Monarchy. These two factors were of crucial importance for the consolidation of the Empire during the long eighteenth century. Prevention, containment, and cure of STDs became an issue for governmental military healthcare and demanded new policies to tackle the threat.

The Habsburg state broke with traditional ways of thinking which had functioned for a long time as its moral compass and had their origin mostly in the moral understanding of the Roman Catholic Church, where the sexual behaviour of male and female humans was strictly codified and restricted. During the period under examination here, the obstacles that emerged from those rules became circumvented in the form of a reassessment based on the nexus of merging philanthropy, economic benefits, and military success. The chosen regional focus illustrated the transfer of actions directed against venereal diseases from more urban centres toward rural regions. The populations in our case studies—Transylvania, the Banat, and the Military Border—were mostly Orthodox and were considered by the Viennese court and its bureaucrats as backward and uneducated with differing moral ethics.

The human factor gained more influence in the Monarchy, since Joseph von Sonnenfels (1732/33–1817)—jurist, professor, novelist, and central for transmitting enlightening ideas in the Habsburg Monarchy—demanded a free, anonymous, and "humane treatment" in our contemporaneous understanding

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for infected persons.[47] Nevertheless, the medical policing strategy focused on moral disciplining dominated until the death of Maria Theresa at the beginning of the 1780s. Medical policing in order to contain the spread of venereal diseases was not effective enough in the rural case studies. In particular, this was because there was a lack of proper surveillance in the southeast of the Monarchy, where the administrative structures were less pervasive as in the Habsburg core lands and the urban milieu.

In 1788, during the Habsburg–Ottoman War (1788–1791), the Aulic War Council decided that all soldiers suffering from venereal diseases or chronic diseases had to be sent to the hospital in Pest.[48] Only soldiers with those diseases were to be admitted to this hospital, because from these sick soldiers "was not expected any further military service during this campaign, which is the reason that the hospital [in Pest] could not be seen as a field hospital," wrote the Aulic War Council. The typological delimitation from a field hospital was emphasised because it had an impact on the salary scale and the status of the hospital staff, which differed in war and peace time. Such a functional allocation of medical spaces for specific diseases demanded new logistical considerations and a complex system of ambulance services. Additionally, under the rationality of respecting the effectiveness of manpower, the allocation indicates that the medical techniques of quarantine—at least a sort of seclusion—have become methods to disturb the chain of infections.[49] The new developments are mirrored by more compassionate care within medical spaces. The *Allgemeine Krankenhaus* in Vienna, re-opened in 1784, was equipped then with a separate space for people suffering from venereal diseases, who were isolated from the public and visitors. Likewise, the newly established hospitals in Prague, Linz, and Graz in the 1790s had a separate space for the sick afflicted with venereal diseases.[50]

The establishment of separated hospital wards, the incremental introduction of free treatments for infected people, or the volition to overcome traditionally

47 "*Auch hier muss die Aufnahme leicht, die Verschwiegenheit der darübergesetzten Aerzte eine Pflicht und die Wartung menschenliebvoll seyn, damit die Unglücklichen unverrathen ihres Uebels los werden können; damit die Härte der Aerzte und Wärter nicht einen solchen Zufluchtsort empfindlicher als das Uebel selbst machen.*" Cf. Joseph von Sonnenfels, Grundsätze der Polizey, Handlung und Finanzwirtschaft. Erster Theil. Dritte Auflage, Vienna 1770, pp. 238–239.

48 Today part of Budapest, the capital of Hungary.

49 "*In das Pester Spital sind nur solche chronische, und venerische Kranke bestimmt, von denen keine Dienstleistung mehr in dieser Campagne zu hoffen ist, dahero dieses Spital nicht wie ein Feldspital angesehen werden kann, und die allda zeilich angestellt werdenen Individuen nur den ihre Charge anklebenden Gehalt nach dem Friedens:Fuß auf die Zeit dieser ihrer Dienstleistung erhalten können, […].*" For the note from the Aulic War Council to the Hungarian general command and Brambilla from 9th September 1788, see OeStA KA ZSt HKR HR Akten 1655, 1788–31–546.

50 Lesky, Gesundheitswesen (cf. note 24), pp. 166–167.

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separated civil or soldierly spheres and structures, formed important stages toward proper nursing care, more respectful interactions, and greater awareness of patients' dignity. Although the shift toward more humane treatment was driven in particular by economic and demographic motives, the development fit with the idea of enlightenment and the growing awareness of a need for improved care for the population, whatever the causes of their sicknesses. The category "healthiness" became more visible in the Habsburg political programme and the handling of venereal diseases was recognised as an important part to restore health as a functional aspect of welfare. Recently, a case study focused on sexually transmitted infections among German paratroopers and navy soldiers revealed a high percentage of infections.[51] Venereal diseases remain a risk factor to the proper functioning of both an army and civil society.

51 For the result of the study: "Proportions of suspected sexually transmitted infections were 17.5% and 20%, and proportions of diagnosed sexually transmitted infections were 13.9% and 11.3% for paratroopers and navy soldiers, respectively. Chlamydia trachomatis, human papillomavirus, and genital scabies were observed in paratroopers and navy soldiers, while Gardnerella vaginalis, herpes simplex virus, Molluscum contagiosum virus, Neisseria gonorrhoeae, and Trichomonas vaginalis were additionally identified in navy soldiers." Cf. Carina Gottwald et al., Sexually transmitted infections in soldiers – a cross-sectional assessment in German paratroopers and navy soldiers and a literature review, in: European Journal of Microbiology and Immunology 9, 4 (2019), pp. 138–143.

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Christian Promitzer / Marcel Chahrour

Blind Comrades: Medical Treatment of Trachoma Among the Habsburg Army in the Early Post-Napoleonic Years

At the beginning of July 1823, the Vienna ophthalmologist, Anton Rosas (1791–1855), received an urgent message from the emperor. Rosas was called to the duchy of Carinthia in the south of today's Austria. An epidemic of diseases of the eye was causing severe losses among the men of the Wimpffen Regiment, an infantry unit that had been moved to the area only recently. Alarmingly high numbers of the regiment had lost their eyesight after suffering from a disease that some suspected to be contagious. However, according to existing medical knowledge, the issue, whether ophthalmias were contagious or not, was a bone of contention.

Rosas was an authority in the field of ophthalmology. Holding the chair of ophthalmology at Vienna University, he was one of the foremost experts in the field in Europe. Educated at Vienna in the early 1800s, the ideas of eighteenth-century medicine were very present in his thoughts. Yet Rosas was a "mundane doctor", not a military physician. Emperor Franz I had called for his expertise for overcoming the pressing issue of the epidemic eye disease against which the local military physicians seemed helpless. Rosa's intervention therefore put military medicine and its privileged role to test.

The case study presented in this chapter focuses on the controversial ideas and concepts of physicians when deploying medical methods to cure a hitherto unknown infectious disease. It traces the engagement of a headstrong military physician, who was just about to overcome traditional principles of humoral pathology. He was sufficiently spirited to advocate his scientific observations against the predominant medical scientific perceptions and institutions at the time. The issue of disease transmission remained part of a controversial debate during the first decades of the nineteenth century. In this phase, the Habsburg Empire had already installed preventive mechanisms to control the spread of diseases mostly by way of quarantines and purification methods. However, an unknown disease evoked new questions and triggered fear among the state leadership. The chapter illustrates how the Viennese court constituted mixed commissions, which put civilian and military experts together—as well as

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medical and non-medical ones of each—in order to get to grips with a novel ailment. This disease, having first emerged among the Habsburg's army rank and file, very quickly threatened the civilian population of the Empire. The authorities eventually used their expertise to issue recommendations and findings to overcome the medical crisis.

The role afforded to military medicine in the early nineteenth-century Habsburg Monarchy was not only an outcome of the demands thrown up during the Napoleonic Wars, but also of key concerns dating back to the reign of Emperor Joseph II (personal rule 1780–1790). Following the defeats and stalemates of three Silesian wars,[1] the Austrian army's medical service needed reform. The army of a European Great Power required efficacious military medicine that did not focus on healing wounded soldiers only, but increasingly gave preponderance to preventive measures against war epidemics that could severely affect the military structures. Concern about epidemics related to the research of diseases and ailments of army personnel both in the barracks and on campaigns. Joseph II sought to address these concerns in part through the foundation of the Military Medical School in Vienna (Josephinian Military Academy of Surgery) in 1784/85. The medical education offered at the *Josephinum*, as it was known, became a competitor vis-à-vis the well-established medical faculty of the University of Vienna. The Emperor's providence was proved right during Austria's participation in the Russo-Turkish War (1787–1792) and the French Revolutionary and Napoleonic Wars. Austrian military medicine and its empirically oriented research exemplified the medical progress in general.[2] However, following the Peace of 1815, the prestigious role of military medicine was cast into doubt, partly by developments related to the Second Viennese School of Medicine. It was into this context that civilian doctor, Anton Rosas, was invited to intervene in a difficult problem facing Austrian military medicine: the widespread cases of trachoma and ophthalmia among Austrian soldiers.

Reports of all kinds of unspecified ophthalmias date back to antiquity. Egypt had been a hotspot for diseases of the eye for millennia.[3] The high incidence of ophthalmic diseases was reported by European observers as early as the sixteenth century.[4] European travellers were stunned by the number of blind people in

1 Eighteenth-century wars between Austria and Prussia, 1740–42, 1744–45, and 1756–62. The first and second were part of the War of the Austrian Succession; the third formed part of the Seven Years War.

2 Brigitte Lohff, Die Josephs-Akademie im Wiener Josephinum. Die medizinisch-chirurgische Militärakademie im Spannungsfeld von Wissenschaft und Politik, Vienna et al. 2019.

3 For the period of the Crusades cf. Friedrich Prinzing, Epidemics resulting from wars, London et al. 1916, p. 15.

4 Prosper Alpini, Medicina Aegyptiorum, Venice 1719. The book was first printed in 1591 and has been reprinted as a standard reference until 1829.

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Egypt. For example, the French physician, Nicolas Tourtechot-Granger, called Egypt "the land of the blind" in 1745.[5] After Napoleon's expedition to Egypt, the predominant explanation among physicians was that the French soldiers there came into contact with the disease and transmitted it to the opposing armies, who would be afflicted with it throughout the nineteenth century.[6] In 1889, Nathaniel Feuer (1844–1902), a provincial health inspector in Budapest, questioned this explanation. Although he did not provide any further reference, Feuer contended that the disease was present in Europe earlier, since eye epidemics occurred in English and Italian garrisons shortly before Napoleon's campaign to Egypt.[7] Feuer further noted that trachoma was not a typical wartime disease, but also occurred among soldiers in peacetime, called "barracks events" ("*Kasernenereignisse*") alluding to the epidemiological role of barracks as building facilities in which soldiers were housed together.[8] In fact, barracks were rare in Austria before the last quarter of the eighteenth century.[9]

In Austria, the first cases of epidemic "blennhorrhoea" were observed among the Viennese garrison in 1817. Just over 170 more severe cases were registered within the next ten years, including 15 completely blind and 45 half-blind.[10] The next serious outbreak would materialise in 1822 among the Wimpffen Regiment, i. e., the Line Infantry Regiment No. 13, at the time stationed mostly in the Klagenfurt district of Carinthia and occasionally in Styria. This outbreak attracted the attention of the military authorities such as the *Innerösterreichische Generalkommando* (Inner Austrian General Command) in the city of Graz and the *Hofkriegsrat* (Aulic War Council) in Vienna. As fears rose that the epidemic would spread to the civilian population, civilian authorities like the district offices of Klagenfurt, Judenburg, and Bruck and the *Gubernium* (regional government) of Styria and even the *Hofkanzlei* (Austrian Court Chancellery) in Vienna started to pay attention.

5 Max Meyerhof, A short history of ophthalmia during the Egyptian campaigns of 1798–1807, in: The British Journal of Ophthalmology 16, 3 (1932), pp. 129–151, here 131. Egyptian society had adapted to the prevailing threat of the disease. Cairo's famous Al Azhar University had established classes for the blind as early as 1737, religious endowments were founded to exclusively support those who had lost their ability to work due to the illness.

6 Sabine Herrmann, Landestypische Krankheiten in der Description de l'Égypte, in: Studien zur Altägyptischen Kultur 39 (2010), pp. 141–152, here 144–145; M. R. Smallman-Raynor, A. D. Cliff, War Epidemics: An Historical Geography of Infectious Diseases in Military Conflict and Civil Strife, 1850–2000, Oxford et al. 2004, p. 103.

7 Nathaniel Feuer, Das Trachom in der österreichisch-ungarischen Armee, in: Joh. Schnitzler (ed.), Klinische Zeit- und Streitfragen, vol. 3, Vienna 1889, pp. 281–310, here p. 281.

8 Feuer, Das Trachom (cf. note 7), p. 283.

9 Markus Swittalek, Kasernen in Österreich. Baudenkmale und Zeugnisse unserer Vergangenheit, Vienna 2016.

10 Burkhard Eble, Die sogenannte contagiöse oder ägyptische Augenerkrankung, Stuttgart 1839, p. 35; Feuer, Das Trachom (cf. Note 7), p. 283.

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The Imperial and Royal Infantry Regiment Baron Wimpffen had been created in 1814 from the remnants of Italian troops previously under Napoleon's command (wherefrom they could have brought the disease).[11] In 1815, the regiment was relocated to Brno (Brünn) in Bohemia because it was assumed that these units would be more reliable if they were moved away from their home regions. At Brno, military physicians had noticed the first cases of eye infections, moving 13 patients to a hospital near the city. In 1816, the unit was transferred to Klagenfurt, where twenty sick people were recorded upon arrival.[12] The medical staff in charge initially blamed the outbreak on the strain of the march from Brno to Klagenfurt. However, even the two sub-medics in charge were stricken with the disease after a short time. In an expert opinion requested by the commander of the particularly affected ninth company, the Italian regimental physician stated that the disease originated in Egypt and had been present in Europe for several years. He supposed that if it could be treated immediately, it would pose no danger.[13]

Nevertheless, the disease was not harmless; five soldiers were discharged in 1816 because of blindness, in 1817 another ten were released for the same reason, and in 1818 ten more were. However, this flare-up was not severe enough to attract outside attention.[14] In 1819 and 1820, the illnesses seemed to subside; only three soldiers were discharged because of blindness from the regiment in each of these years. In 1821, the disease struck the inmates of the *k. k. Erziehungshaus für Knaben*—a boarding school attached to the barracks; almost all the boys fell ill. Again, in the fall of that year, the disease seemed to recede. Between 1815 and 1822, the regiment had lost no fewer than 47 soldiers to total or partial blindness.[15]

The year 1822 saw a disastrous outbreak of the inflammations. Military surgeons and physicians called these inflammations "ophthalmia", a very general term that could be used to describe all kinds of diseases of the eye as we know them today. Making use of the anti-inflammatory arsenal of the dominating

11 The owner and thus eponym of the regiment was Maximilian Freiherr von Wimpffen (1770–1854), one of the most influential military leaders of his time. Wimpffen had participated in the last war of the monarchy against the Ottoman Empire (1787–1792) and fought in the Napoleonic Wars, reaching the highest military ranks. For Wimpffen, see Constantin von Wurzbach, Biographisches Lexikon des Kaiserthums Oesterreich, vol. 56, Vienna 1888, p. 252. On the history of the Wimpffen Regiment from the Napoleonic Wars to the early 1820s, see Friedrich Mandel, Geschichte des k. u. k. Infanterie-Regiments Guidobald Graf von Starhemberg Nr. 13, vol. 2, Krakow 1893, pp. 193–194, 200–203.

12 Anton Rosas, Actenmässige Darstellung der in den Jahren 1822 und 1823 im k.k. Infanterie-Regimente Baron Wimpffen, Nro 13, zu Klagenfurt herrschend gewesenen Augenkrankheit, in: Medicinische Jahrbücher des kaiserl. königl. österreichischen Staates, vol. 2 (1824), pp. 390–460, 531–630, here 399.

13 Rosas, Actenmässige Darstellung (cf. note 12), p. 399.

14 Rosas, Actenmässige Darstellung (cf. note 12), pp. 399–400.

15 Rosas, Actenmässige Darstellung (cf. note 12), pp. 401–404.

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medical concepts, medical practitioners of the time were confident of their ability to treat these ophthalmias successfully. However, the specific character of these inflammations was alarming: while starting as an ordinary inflammation, it eventually made a large number of patients lose their eyesight. Several hundred soldiers had fallen ill in 1822, several dozens of whom ended up blind.

1. The Events in Carinthia and Styria during the First Phase of the Epidemic

During the first six months of 1822, the incidence of eye disease among the soldiers of the Wimpffen Regiment became worrying. There was a marked increase in cases in May 1822 and again at the end of August, which was caused by crowded quartering.[16] In late summer, an informal temporary medical commission was initiated in Klagenfurt. It consisted of the regiment's Supreme Staff Army Doctor (*dirigierender Stabsfeldarzt*), Karl Riedl (1768–1842), the local district physician, Dr. Thomas Jacob Kißlinger (1761–1829), and Alois Hussa (1786–1861), professor for surgery at the Lyceum (a minor medical school) in Klagenfurt. Their prediction was somewhat conservative: they assumed that the epidemic would take a favourable development due to the already initiated treatment method and the complete isolation of eye patients.[17] Riedl considered the prevailing sanitary conditions, the climate, and the soldiers' marching and drill stresses to be the most prominent disease-producing factors. Acting according to the prevailing doctrine, he ordered bloodletting and the administration of a particularly lean diet. In addition, efforts were made to separate the sick from each other as much as possible, since a "contagium" could not be excluded.[18] In any case, in mid-September 1822, the Inner Austrian General Command claimed that the condition of the sick soldiers, all of whom belonged to the Wimpffen Regiment, had improved.[19] At the beginning of October, the *Gubernium* received further reassuring news from the Klagenfurt district office, as the aforementioned Dr. Kißlinger (1761–1829) confirmed that the epidemic had not spread to the civilian population.[20]

16 Austrian National Archives AT-OeStA [Österreichische Staatsarchiv] /AVA Inneres HK Allgemein A 1271, Vienna, 6th August 1823.
17 Styrian Provincial Archives, Graz, StLA [Steiermärkische Landesarchiv], Gubernium, file 67–312–1823, Innerösterreichisches Generalkommando Graz, 7th January 1823.
18 Rosas, Actenmässige Darstellung (cf. note 12), pp. 411–418.
19 StLA, Gubernium, Einreichungsprotokoll No. 118 (1822), 14406–22572, #21117.
20 StLA, Gubernium Einreichungsprotokoll No. 119 (1822), 22573–30506, #22697; Carinthian Provincial Archives (Kärntner Landesarchiv, hereafter referred to as KLA), AT-KLA 182–211 Su, "1917 vom Militär-Hilfsamt ausgehobene und nicht retournierte Akten".

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Hopes that the epidemic had ended proved unfounded. As units were moved to less crowded conditions by early fall, cases decreased again with the illness returning to insignificant numbers in the final three months of 1822.[21] According to another source, however, the number of soldiers with ophthalmia in the Klagenfurt hospital in the same period rose to 287 patients, a number that did not include those treated in the barracks.[22] During late fall, the Judenburg district office in neighbouring Styria took precautions against the eye disease prevalent among the regiment's soldiers garrisoned in the town of Judenburg.[23] These measures included the prohibition of close contacts between members of the Wimpffen Regiment with those of the tenth Jäger Battalion, who were stationed in the same barracks.[24]

At the end of the year, the Aulic War Council sent Dr. Wilhelm Werneck (1787–1842), a graduate of the Military Medical School in Vienna, to Klagenfurt, to bring the epidemic under control. Werneck considered himself to be in the tradition of Johann Adam Schmidt (1759–1809), one of the first scientific ophthalmologists, who had taught at the *Josephinum.* The university-based professor of ophthalmology, Georg Joseph Beer (1793–1821), was to become the second teacher of Werneck in the field of ophthalmology.[25] According to his own statement, Werneck had been confronted with the "contagious ophthalmia" for the first time in 1808, namely in Vicenza, and later on in the Kingdom of Naples.[26] After he had reached the rank of a Regiment's Doctor (*Regimentsarzt*), he was involved in the treatment of the eye epidemic among the Viennese garrison hospital in the years after 1817.[27] Werneck was already a staunch contagionist, which he demonstrated in an 1819 paper on inflammations, in particular hospital gangrene, which he argued was a contagious disease.[28]

21 AT-OeStA/AVA Inneres HK Allgemein A 1271, Vienna, 6th August 1823.

22 Cf. Wilhelm Werneck, Ueber die Gaumennath und das contagiöse Augenüben. Ein Sendschreiben, in: Journal der Chirurgie und Augen-Heilkunde 6, 1 (1824), pp. 102–117, here p. 110.

23 StLA, Index Kreisamt Judenburg, vol. 15/1 1822–1825 A-L, #10626/1822.

24 Wilhelm Werneck, Über Vorbeugung gegen ansteckende Augenblennorrhöen, in: Journal der Chirurgie und Augen-Heilkunde, 8 (1825), pp. 425–468, here 431–432.

25 This information may well be correct in principle, but it must be considered that Beer only became an associate professor at the University of Vienna in 1812, while Werneck had already received his doctorate in 1811. On the biography of Wilhelm Werneck, see Hans Remky, Pierre Amalric, Zur Geschichte der Photochirurgie des Auges, in: Gesnerus 47 (1990), pp. 67–82, here p. 68; for further biographical information, see also the obituary in: Salzburger Zeitung, No. 134, 9.7.1842, pp. 534–536.

26 Werneck, Sendschreiben (cf. Note 22), p. 114.

27 Cf. Burkard Eble, Ueber den Bau und die Krankheiten der Bindehaut des Auges, Vienna 1828, p. 210.

28 Werneck studied at the *Josephinum* and had already published his insights on *Hospitalbrand*, a "contagious disease", in 1819. The study was reprinted in 1847. See Werneck, Kurzgefasste

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On his way to Klagenfurt in early January of 1823, Werneck met the governor of the Styrian district of Bruck. Thereafter, the latter informed the *Gubernium* in Graz of Werneck's assessment that around 500 soldiers of the regiment, both in Klagenfurt district and in Styria, had the disease. Fifty of them had lost their eyesight and had been committed to the house of the disabled in the town of Pettau (today Ptuj in Slovenia). The district's governor further pointed out that the disease was "contagious in the highest degree". Therefore, he appealed to the *Gubernium* to ask the Inner Austrian General Command, to instruct its subordinate bodies to watch out for signs of disease among the soldiers, to prevent its spread to civilians. According to the district's governor, some of the soldiers who had already contracted the disease were used for tax collection among the rural population and subsequently had to be called up for medical treatment.[29] The *Gubernium* informed the Inner Austrian General Command which then responded positively: it pointed out that diseased soldiers from a transferred unit of the Wimpffen Regiment, formerly garrisoned in the Styrian town of Judenburg, had been temporarily committed to the military hospital of the town of Leoben (located in the prelacy of the district office of Bruck). This location was not, however, suitable for the separation of the eye patients from those suffering from other diseases.[30]

Werneck also visited the Leoben military hospital, examining the diseased soldiers who had been moved in from Judenburg. He first confirmed the "truly contagious" nature of the disease to the local military physician in charge. In this, Werneck could rely upon an already rich body of literature that held the same view: British physicians had described the disease as contagious as early as 1803. Contemporaries spoke of "contagiousness", which suggested the direct transmissibility from person to person and is not to be equated with our contemporary understanding of contagion. This "contagium" could be concealed in secretions or transmitted over short distances by air.[31] In the case of "Egyptian ophthalmia", this concept was linked to the clear derivation of the transmission route from Egypt. Nonetheless, both the origin of the illness in Egypt and its contagiousness were strongly debated in light of standard aetiological concepts.

Werneck clearly took the side of the contagionist explanations. He insisted on a principle of isolation; he had the patients—at the time twelve or thirteen—separated not only from healthy soldiers, but also from each other. Consequently, those patients who displayed the disease at a higher degree were put in a different room from other patients who were less affected. Convalescent patients, in turn,

Beitraege zur Kenntniss der Natur, Entstehungsweise, der Verhütung und Heilung des Hospital-Brandes, 2nd edn., Salzburg 1847.

29 StLA, Gubernium, file 67–312/1823, Kreisamt Bruck, 4. 1. 1823.

30 Ibidem, Innerösterreichisches Generalkommando Graz, 7. 1. 1823.

31 Burkhard Eble, The so-called contagious or Egyptian inflammation of the eye, 1839, p. 21.

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were separated from the ones who were still sick; they remained under the strictest supervision of the doctor for six weeks, before they were released. In general, beds were kept five feet apart. Playing cards with each other was forbidden; the sick had rather to deal with themselves in isolation from each other. Each patient was to have his own wash basin and his own clean towel. The latter had to be replaced daily with fresh ones, and the unclean ones washed daily with soap and lye. For wiping the eyes, each patient was given his own fine linen spot. The sickroom should have a stable temperature of 16 degrees Réaumur (20 degrees Celsius). Apart from regular airing, Werneck suggested undertaking acetic fumigations in the morning and evening hours to purify the air. A healthy attendant, obliged to observe strict cleanliness, was always present to accompany the patients to the privy. They were otherwise not allowed to walk around with bare feet and had therefore to be provided with slippers.

Every sick person had to be "lovingly admonished" and made aware of the danger threatening him, so that he no longer wiped his eyes with the upper part of the bed sheet, which was immediately at hand; for this purpose, small, fine, frequently changed canvas patches were provided. The doctor who cleaned the eyes of the patients had to be careful not to contaminate himself with the purulent matter oozing from the eyes, to rub his eyes with his fingers, and cause immediate infection through carelessness. Several times a day, he was to clean his hands with ice-cold water and soap. As a means of prevention, Werneck recommended the use of an ointment consisting of one part of grey mercury ointment and three parts of wax ointment, with which the tarsi of the eyelids would be slathered twice a day.[32] Tracing the international medical literature on the subject, Werneck observed the recommendations of Annibale Omodei (1779–1840) in his *Treatise on the Egyptian Contagious Eye Infection* and stipulated the washing out of the eyes, both as a means of protection for the healthy soldier and in order to dilute the contagious substance in the case of inflammation.[33]

Werneck tried to teach his peers how to diagnose the disease. He pointed out that the disease had its seat at the conjunctiva of the eyelid and spread only secondarily onto the eyeball, referring to the shaggy, often wart-like excrescences, mostly under the upper eyelid, whose granular texture could be felt with the fingers. Thus, even when the eyeball was already freed from all redness, the disease could nevertheless hide under the upper eyelid and break out again with intensity. Therefore, the sick could not be declared non-contagious and

32 StLA, Gubernium, file 67–312/1823, Regulativ, Leoben, 3.1.1823, transcript; these instructions are also reproduced in Rosas, Actenmässige Darstellung (cf. note 12), p. 423 and in Werneck, Vorbeugung (cf. note 24), p. 455. The necessity of hygiene had already been pointed out by the Briotn Vech in 1807. Cf. John Vetch, History of Ophthalmia, 1817, p. 12.

33 Annibale Omodei, Abhandlung über die ägyptische ansteckende Augenentzüdung und ihre Verbreitung in Italien, Frankfurt/Main 1820, p. 12.

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healthy until the conjunctiva took on a healthy shape and colour: it had to be reddish yellow, perfectly smooth, it should no longer secrete dirty yellowish mucus, and the eyelids should no longer stick together at night. The treatment itself was focused on the elimination of the excrescences under the eyelids, which for this purpose had to be everted, before they could be treated. In the instruction, Werneck did not specify the pharmaceuticals by which this should be realised. He only mentioned that the eyes should be cleaned frequently with cold river water, mixed with good vinegar at a six to one ratio.[34] From other sources, we know that he recommended the application of mercuric amidochloride in mild cases and caustic agents like ethanoic acid, lead sugar, also known as Goulard's powder, bluestone (cuprum sulfuricum), silver nitrate or caustic potash, whereby he warned against their abundant application that could cause secondary excrescences.[35] In the case of severe pain, Werneck recommended phlebotomy and the administration of china-bark. He also recommended anti-inflammatory treatment with the administration of *antimonium tartaricum*, neutral salts, and a frugal diet as well as phlebotomy, in case the inflammation spread onto the eyeball.[36] Phlebotomy, however, was to be applied locally (close to the eyes) and with leeches only.[37]

When Werneck finally arrived in Klagenfurt, he still found 27 patients with ophthalmia in the hospital. He discovered 50 convalescent soldiers in the back wing of the building as well as 38 partly and 34 fully disabled.[38] By mid-February, Werneck induced the transfer of all completely healed individuals, 164 in number, to the barracks at Völkermarkt (near Klagenfurt) from where they were supposed to be released to their companies after a three- to four-week observational quarantine.[39]

As early as 7th February 1823, Werneck had reported to the General Command in Graz that it was necessary to send the regimental physician, Dr. Alberto Muzzarelli (1770–1852), to the regiment's supplementary districts in Italy to inform the local physicians about the disease, since many of the troops sick with the ophthalmia had been sent home on leave the previous year and could have spread the contagium of the Egyptian eye disease at home.[40] In another report, he underscored that it was certain that the contagion was attached to the regiment at

34 StLA, Gubernium, file 67–312/1823, Regulativ, Leoben, 3. 1. 1823, transcript.
35 Werneck, Sendschreiben (cf. note 22), pp. 115–116; Rosas, Actenmässige Darstellung (cf. note 12), pp. 457–458.
36 StLA, Gubernium, file 67–312/1823, Regulativ, Leoben, 3. 1. 1823, transcript.
37 Werneck, Sendschreiben (cf. note 22), p. 116.
38 Werneck, Sendschreiben (cf. note 22), p. 111.
39 Rosas, Actenmässige Darstellung (cf. note 12), p. 431.
40 Rosas, Actenmässige Darstellung (cf. note 12), pp. 428–430.

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the time of its establishment.[41] By the end of February, Werneck finished his meticulous examination of each soldier of the regiment by focusing on the conjunctiva of the eyelids and the eyelids themselves. In this way, he discovered several hidden cases and arrived at a total number of 623 afflicted patients, whom he started to separate from the community of healthy people together with the suspects.[42] In order to separate patients with different degrees of affection from each other, he established several wards. The first ward was for ophthalmic patients who were at the same time afflicted with other diseases. The second ward was for bleary-eyed patients with fever. The third ward was filled with bleary-eyed patients without fever, while in the fourth ward, one could find those whom the ophthalmia had rendered disabled or suffered from other long-term effects of the disease. The fifth and final ward was reserved for convalescent soldiers.[43] By the end of March, Werneck sent 117 soldiers, whom he declared convalescent, to quarantine in Wolfsberg (also in Carinthia).[44]

Turning to the situation in Styria, we have already mentioned the precarious situation in the military hospital in Leoben, which housed eye patients temporarily, but could not separate them from the other patients. By the end of February, the number of soldiers afflicted with ophthalmia who had been moved in from Judenburg amounted to 42.[45] Thus, the responsible district office in Bruck an der Mur was instructed to find an isolated building in Leoben for the sick soldiers. The building chosen was the so-called *Josephshof*, but the preparation work took several months. Six convalescent soldiers were admitted on 23rd June.[46]

The protracted affair with the isolation hospital in Leoben showed that the separation of several hundred infected soldiers was not easily achieved. In this vein, Werneck asked the Aulic War Council to send the already barracked convalescent soldiers out into the countryside. Thereby he hoped to prevent recidivism caused by the common military way of life, since in April the number of recently diseased soldiers further increased and would reach 120 by the end of the month. The Aulic War Council initially approved this measure, but the civil authorities were not enthused about it. It was probably the Austrian Court Chancellery in Vienna, the highest authority for civil matters, which established a new medical commission that consisted of a military and a civilian part. The

41 Rosas, Actenmässige Darstellung (cf. note 12), p. 429.
42 Cf. Werneck, Sendschreiben (cf. note 22), p. 111; AT-OeStA/AVA Inneres HK Allgemein A 1271, Vienna, 06.08.1823. This increase in cases was also noted by Burkard Eble: Eble, Die sogenannte contagiöse (cf. note 10), p. 37.
43 Werneck, Vorbeugung (cf. note 24), pp. 456–457; Rosas, Actenmässige Darstellung (cf. note 12), pp. 429–430.
44 Rosas, Actenmässige Darstellung (cf. note 12), pp. 435.
45 Rosas, Actenmässige Darstellung (cf. note 12), pp. 434–435.
46 StLA, Gubernium, file 1–48–5257/1823.

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reason for having a civilian part included in a commission on a disease within a military body was the fear that the epidemic could spread to the civilian population. The commission was more formal than its predecessor, set up the previous summer. Its military head consisted of lieutenant field marshal Franz Matthias Baron Gorup of Besánez (1749–1835), as commander of Klagenfurt, Leonhard Count Rothkirch and Panthen (1773–1842) as brigadier in Illyria, and colonel Peter Mazzetti (?–1824). Members from the ranks of the army doctors were the aforementioned Karl Riedl and Alberto Muzzarelli as well as Werneck. The civilian part of the commission was headed by the governor of the district of Klagenfurt, Johann Friedrich Baron Löhr (1771–1838). The latter was accompanied by four medical professionals. These included: district physician, Dr. Kißlinger, and the surgeon, Dr. Alois Hussa, who were both members of the first commission in summer 1822; Dr. Johann Evangelist Sti(e)ger (1776–1846) from Graz, whom the Styrian estates had appointed to a position as ophthalmologist by their grace (*ständischer Augenarzt*); and Dr. Johann Gottfried Kumpf (1781–1861), one of three municipal physicians funded by the estates of Carinthia.[47]

The mixed commission and the ongoing suffering of the soldiers garnered the attention of the public. On 28th April, a society of local theatre lovers under the direction of Mrs. Josepha Baroness Gailberg, née Gräfin von Aicholt (?–1828) organised a charity event in Klagenfurt for the benefit of those soldiers who had gone blind. After deduction of the expenses, the money raised was about 1,170 florins.[48]

At approximately the same time, the commission decided that the soldiers of the regiment ought to leave the barracks, so that the buildings could be cleaned of the contagium. Werneck's suggestion to disperse soldiers who had recovered among peasant households in the countryside was not approved, however, since undiscovered cases of the disease could spread among the rural population, which in turn could contaminate the billeting soldiers with syphilis and scabies.[49] By mid-May, the Austrian Court Chancellery had also adopted this view and informed the Aulic War Council. In order to clean the barracks, particular buildings had to be found in which the healthy soldiers could be accommodated in one section that was separated from the other for the sick. The Chancellery and the Aulic War Council also discussed moving some of the soldiers to the spacious

47 Rosas, Actenmässige Darstellung (cf. note 12), pp. 549–550; Nekrolog. Johann Evangelist Stiger, in: Grätzer Zeitung, 60 (1846), 24.11.1846, pp. 6–7; Karl Frick, Dr. med. Johann Gottfried Kumpf (1771–1862) und die ägyptische Augenkrankheit, in: Carinthia I, 156 (1966), pp. 679–712.

48 Der Sammler. Ein Unterhaltungsblatt, No. 59, 17th May 1823, p. 236.

49 Rosas, Actenmässige Darstellung (cf. note 12), pp. 550–553.

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Tanzenberg Castle that could accommodate a considerable part of the soldiers while being only some twelve kilometres away from Klagenfurt.[50]

From 1st March to 6th June, another 265 more men were afflicted by ophthalmia. On the latter date, the troops were finally transferred within Carinthia. Quarters for a total of 458 men were created in the Dominican monastery in Friesach, the Augustinian monastery in Völkermarkt, Loretto Castle, Freyenthurm, Hallegg, and Ehrenhaus castles; the convalescents, among whom a relapse could not be excluded, were housed also in Tanzenberg Castle, Griffen, and Thalenstein.[51] In Styria, the relocation of the division stationed in the "Former Jesuit barracks" of Judenburg, numbering 138 people, was also prepared. In mid-June, the *Gubernium* instructed the district office to move them out, so that the building could be cleaned according to medical principles, which included the application of mineral fumigations. The castle of Weyer, south of the town, was designated as the alternative housing for the soldiers. After the castle's adaptation was completed, they were able to move to the new quarters in mid-August, taking great care not to come into contact with the civilian population.[52]

2. Debating Contagiousness

Meanwhile, the epidemic had caused some concern in Vienna. On 1st July, Emperor Franz I decreed that both the highest-ranking military physician and the most renowned civil ophthalmologist of the Empire were to examine the epidemic eye disease in Klagenfurt. They were to form another medical commission whose representatives should be military and civilian physicians who would present their findings to both the civil and military authorities.[53] We can only speculate about the immediate reason for this decree. Two reasons might be considered: by mid-June, the Inner Austrian commanding general, Friedrich Franz Xaver Prince Hohenzollern-Hechingen (1757–1844) informed the Styrian *Gubernium* that negligence had emerged during the evacuation of the Klagenfurt barracks. In particular, cleaning measures and other precautionary measures were missed.[54] In another letter, dated 24th June, Hohenzollern informed the

50 AT-OeSta/AVA Inneres HK Allgemein B 243: 12892/1297, 73, May, p. 308; …41/1454, 98, May, p. 314 and …/…, 136, May, p. 323; 13649/1365, 144, May, p. 324, and …/…, 152, May, p. 327. (the missing digits are due to the fact that the source is partly burnt).

51 Apart from the already mentioned quarantine locations (*Contumazhäuser*) in Völkermarkt and Wolfsberg, see Rosas, Actenmässige Darstellung (cf. note 12), p. 554; Werneck, Sendschreiben (cf. note 22), pp. 111–112; Werneck, Vorbeugung (cf. note 24), pp. 465–466.

52 StLA, Gubernium, file 1–48–5257/1823.

53 AT-OeSta/AVA Inneres HK Allgemein B 243: 21177/1920, 51, July, p 435; AT-KLA 182–211 Su, Commissions-Protocoll, 23rd July 1823, p. 1b.

54 StLA, Gubernium Präsidium, Index u. Einreichprotokoll 1823, #1154, 16th June 1823.

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Gubernium that he had asked the Aulic War Council for a professor (of the Josephinian Military Academy of Surgery) to assess the curative treatment applied by Werneck in Klagenfurt.[55]

Another possible incentive for the imperial decree was the discovery in May 1823 of a local epidemic of trachoma among the rural population in the district of Villach, more than hundred kilometres west of Klagenfurt.[56] A soldier of the Wimpffen Regiment had contracted the eye disease in the summer of 1822 and again in October, but both times quickly recovered. This soldier then worked as a tax collector among the rural population in the territory of the dominion of Greifenburg, in the district of Villach. There he fell ill a third time and was nursed by a farmer's wife. Soon thereafter, her eldest son fell ill and eventually lost his sight, while his siblings went partially blind. The authorities thereupon discovered about fifty cases of trachoma among the local population.[57]

After this outbreak among the civilian population, the disease no longer concerned the Habsburg Army only, but civil authorities—therefore, it seemed appropriate to send the most prominent civilian expert to Klagenfurt. The two experts whom the emperor nominated were Johann Nepomuk Isfordink (1776–1841), director of the Josephinian Military Academy of Surgery and head of the Supreme Sanitary Department of the Army (*Oberstfeldärztliche Direktion*), but no ophthalmological expert,[58] and the Viennese eye specialist, Anton Rosas (1791–1855), who in 1821 became full professor of ophthalmology at the University of Vienna.

By mid-July, both of them arrived in Graz, where they negotiated with the Styrian *Gubernium* and with Prince Hohenzollern-Hechingen.[59] The latter asked Rosas to report on all actions taken by Generals Gorup and Rothkirch, and the regimental physicians, Muzarelli and Werneck, with regard to the eye malady.[60] After that, Isfordink and Rosas travelled on to Klagenfurt, where the commission —the third in this affair—was constituted. Besides Werneck, the army's sanitary sector was represented by Riedl, Muzzarelli, Dr. Kumpf, and Burkard Eble (1799–

55 Ibidem, #1175, 20th June 1823.

56 AT-OeSta/AVA Inneres HK Allgemein B 243: 14881/1446, 146, May, p. 325 and ../.2, 107, June, p. 380.

57 Johann Gottfried Kumpf, Einige Notizen über die Entstehung und den Gang der contagiösen Ophthalmie unter der k. k. Garnison zu Klagenfurt, wie auch über ihre Verbreitung auf das Landvolk in Kärnten, in: Medicinisch-chirurgische Zeitung, No. 687/6, 19th January 1824, pp. 203–208; Frick, Kumpf (cf. note 47), pp. 709, 712.

58 Johann Nepomuk Isfordink joined the Austrian army after having completed his studies in Freiburg. Isfordink advocated the equality of the Joseph Academy with the universities, and from 1822 he was the army's chief field physician as well as director of the academy. Cf. Leo Santifaller et al. (eds.), Österreichisches biographisches Lexikon 1815–1950, Graz 1957, p. 43.

59 AT-OeSta/AVA Inneres HK Allgemein B 243: 22535/2073, 159 July, p. 460.

60 AT-OeStA/KA ZSt HKR HR Akten 4024, L 1/1/141–1/7/125: 1823 L 1/1/171: Rosas to Hohenzollern-Hechingen, Klagenfurt, 13th September 1823, p. 20a.

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1839) who was a surgeon in the artillery district of the Viennese garrison, and would become one of the most prominent experts on the disease in the 1830s. Civilian authorities were represented by the *Protomedicus* of Styria Joseph von Schöller (1757–1836), the district physician, Kißlinger, the aforementioned Dr. Hussa, Dr. Joseph Scheitz, and Joseph Buchmüller (1785–1857), who had been employed as a surgeon in Klagenfurt since May.[61] Between 16th and 21st July, the medical commission held nine sessions. During these sessions, a significant controversy between Werneck and Rosas, both of whom had different opinions on several aspects, dominated the discussions.

Already in the first meeting, Werneck tried to argue that the disease had been in the regiment for many years; however, his evidence based on the testimonies of officers was rejected.[62] Rosas, himself, started to read the old reports, among them one from 1814. The reports contained detailed information about some of those already ill along with their military careers and medical records. Two of the regiment's captains had already been to Egypt with the Napoleonic expedition and had survived eye diseases there.[63] Rosas further consulted the files of the military administration, and meticulously reconstructed the events and the outbreaks of the disease. The documents provided to him by the doctors made it possible to trace the course of the disease. Some evidence indicated that it was mostly simple conjunctivitis. He consequently adopted Riedl's 1822 reports on the origin of the disease. Despite the mention of a "contagium" that could contribute to the spread of the disease locally, both Riedl and Rosas saw the causes in climatic conditions and the circumstances of soldier training. Rosas concluded that a "transformation of the disease" had occurred in the summer of 1822, because of a hurricane that had raged in Klagenfurt in mid-July.[64] Since it was not conceivable for him to assume that the soldiers had brought a contagium with them from Italy, he concluded that the predominantly young incoming soldiers fell sick because they were not yet accustomed to the local climate, the food, or the clothing.[65]

Werneck also partly followed the same aetiology insofar as he recognised that the specific climatic local conditions had rendered the disease more contagious. He also conceded the negative influence of military training, extensive marches as well as soldiers wearing inappropriate uniform clothing and headgear, but he insisted on a dormant contagium that was implanted by the soldiers themselves. Werneck therefore refused the presumption of a nonspecific and purely catarrhal inflammation of the eyes that by the influence of "the social and cosmic-telluric

61 Rosas, Actenmässige Darstellung (cf. note 12), p. 558.
62 Rosas, Actenmässige Darstellung (cf. note 12), pp. 561–562.
63 Rosas, Actenmässige Darstellung (cf. note 12), p. 397.
64 Rosas, Actenmässige Darstellung (cf. note 12), pp. 566–580.
65 Rosas, Actenmässige Darstellung (cf. note 12), pp. 412–414.

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conditions" in Klagenfurt had become malignant.[66] He would later declare that the contagium was native to the Orient, namely Egypt, from where it had been transferred to Europe, where it never could have arisen by itself. He stated that "their continued existence for so many years can only be attributed to reproduction through infection, and in this respect is similar to the plague of the Orient and yellow fever, the threats of which can be averted by wise measures of medical police."[67]

From a present-day point of view, Werneck's methods of diagnosis and treatment were truly innovative, but one has also to observe that his argumentation followed the lines of "medical orientalism" dominating the way, while physicians were talking about the Ottoman Empire and the Eastern Mediterranean at large. Like the doctors of the Napoleonic expedition, who had already established correlations between the incidence of disease and social conditions, Werneck contributed to the establishment of a certain image of the Orient in medicine: as unclean and unhygienic.[68] He furthermore entangled orientalism with prejudice toward Jews, alluding to their Oriental origin, when he pointed to their predisposition—at least to those of the unclean lower classes, who were living jammed together in insalubrious dwellings and were nurturing themselves with non-digestible food like onions, to contract the Egyptian eye disease.[69]

The issue of the origin of the disease became a major point of discussion in the newly formed third commission. In that commission, the civilian physicians around Rosas apparently were more in favour of a local origin of the disease in Klagenfurt, while by contrast, the military physicians emphasised the contagious factors. Only one civilian doctor—Johann Gottfried Kumpf—adhered to Werneck's views. He was, as Rosas would note in his description of the events, one of the army doctors requested by the Supreme Sanitary Department of the Army.[70] Both sides agreed, however, that the climate of Carinthia, the proximity of the mountains, which darkened the valley, and the variable daily temperatures, and even fog formed by the nearby marshes and lakes, played a role in the increase in eye diseases.[71]

66 Rosas, Actenmässige Darstellung (cf. note 12), pp. 435–439; Werneck, Sendschreiben (cf. Note 22), pp. 109–111, 114; see in detail Werneck, Vorbeugung (cf. note 24), pp. 433–440, 443–445.
67 Werneck, Vorbeugung (cf. note 24), p. 429.
68 Cf. Marcel Chahrour, Der Medizinische Orient. Wien und die Begegnung der europäischen Medizin mit dem Osmanischen Reich (1800–1860), Stuttgart 2022.
69 Werneck, Vorbeugung (cf. note 24), p. 434. Kumpf would subsequently publish his own report of the events which showed that his medical view was identical to the one of Werneck; see Kumpf, Einige Notizen (cf. note 57), pp. 81–111 and vol. 27, No. 693, 9th February 1824, pp. 203–208.
70 Rosas, Actenmässige Darstellung (cf. note 12), p. 558.
71 Rosas, Actenmässige Darstellung (cf. note 12), p. 566.

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The debate about the origin of the disease gave rise to a closely related second question: Was "Egyptian ophthalmitis" truly a disease in its own right? In 1822, the Berlin ophthalmologist, Georg Helling (1763–1840), could clearly distinguish different forms of ocular inflammation of which "contagious ocular inflammation" (trachoma proper) was one.[72] Werneck argued in the same vein, but Rosas did not want to give the peculiarities of the "Egyptian ophthalmia" the status of a disease in its own right. He treated it as a common "eye catarrh".[73] With this assessment, Rosas followed his teacher, Beer, who had published a textbook on ophthalmology in 1817, in which the "Egyptian eye inflammation" was absent, however.[74]

Rosas recognised the transmissibility of the disease only in its advanced stages.[75] The commission finally agreed, "That the ex- and intensely stronger degree of contagiousness of this catarrhal eye inflammation may have received a contagious force through the contagious tinder that had perhaps already adhered to the regiment since its establishment." The structure of this argument was a compromise: the infection could happen not only by direct contact, but also miasmatically, if the contagium dissolves in warm air and the patient stays for an indefinite, longer time in this atmosphere.[76] With respect to the aforementioned transmission of the disease to the country people of Villach district, Rosas would once even speak of a "catarrhal contagium".[77]

Concerning the treatment that Werneck had applied, the medical commission did not raise any objections at all. For his part, Rosas lodged a dissenting opinion and declared that this treatment could be useful in the later contagious stage of the disease, whereas in the earlier catarrhal phase, anti-catarrhal treatment should be used.[78] Werneck was still able to demonstrate significant success by focusing the treatment entirely on the local manifestations, since "[…] my striving was directed to seek out the place of the original infection, to limit and eradicate the contagious process in the seized organ, before it could spread to other nearby entities most susceptible to it."[79] Even Rosas had to admit that the measures proposed by Werneck had served to prevent the spread of the disease,

72 Cf. Georg Helling, Praktisches Handbuch der Augenkrankheiten, nach alphabetischer Ordnung, Berlin 1822, pp. 124–128, 130.
73 Rosas, Actenmässige Darstellung (cf. note 12), pp. 407, 412, 579, 590.
74 Cf. G. Joseph Beer, Lehre von den Augenkrankheiten, als Leitfaden zu seinen öffentlichen Vorlesungen entworfen. Zweyter Band. Vienna 1817.
75 Beer, Augenkrankheiten (cf. note 74), p. 412.
76 Beer, Augenkrankheiten (cf. note 74), p. 591.
77 AT-OeStA/KA ZSt HKR HR Akten 4024, L 1/1/141–1/7/125: 1823 L 1/1/162, Beylage zum Sitzungs-Protokolle, Villach, 8th August 1823.
78 AT-OeStA/AVA Inneres HK Allgemein A 1271, Vienna, 6th August 1823, transcript; Rosas, Actenmässige Darstellung (cf. note 12), pp. 594–604.
79 Rosas, Actenmässige Darstellung (cf. note 12), p. 596.

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although he could not refrain from stating that Werneck had only profited from the steps taken by Riedl.[80]

The commission put Werneck's treatment methods to the test and tried to harmonise his opinion that the disease was contagious with Rosa's assessment of its catarrhal–rheumatic character, by claiming that the disease was not contagious at the beginning, but could become so during the progress of the epidemic.[81] According to the prevailing doctrine, treatments had to respond closely to the particular form of an illness; vitalist ideas foregrounded strengthening the vigour and the self-healing powers of the body. Such considerations appeared to have motivated the commission to ask whether Werneck's treatments had been "not enough individualizing", too "stormy" and "too radically intervening"; but even Rosas was forced to reject these accusations.[82]

3. Recommendations and Further Debates

From 23rd to 27th July, the findings of the various subcommissions were presented and debated by the plenum assembly that included local and regional representatives of the civilian and military authorities. Among the former was recently nominated Governor of Styria, Franz Count Hartig (1789–1865), who served as chairman of the assembly; Löhr, as the governor of the district, and one of his commissioners, Franz Georg Alber (1775–1859). Generals Gorup and Rothkirch, as well as Major Joseph (Guiseppe) Boccolari, represented the military.[83] The assembly's task was to work out concrete suggestions for the emperor who would thereafter decide what was to be done. Thus, it was decided to move the remaining 155 sick soldiers from Klagenfurt to the Tanzenberg Castle, so that cleaning and health-related construction measures (like the new construction of the privies) could take place. Troops would be transferred from unhealthy areas to the Venetian region. Before decampment, all parts of the soldier's uniform must be cleaned again and the service duties must be carried out as gently as possible.[84] The Styrian governor then reminded the commission that there was a danger that the transfer of the regiment could increase the risk of infection. To this notice, the medical commission responded that this danger would not exist if precautionary measures were observed during the march, and that contact with

80 Rosas, Actenmässige Darstellung (cf. note 12), p. 599.
81 Rosas, Actenmässige Darstellung (cf. note 12), p. 602.
82 Rosas, Actenmässige Darstellung (cf. note 12), pp. 604–606.
83 AT-KLA 182–211 Su, Commissions-Protocoll, 23rd–27th July 1823, p. 1a.
84 Ibid., pp. 1c–2d, 5a–7c.

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the rural population along the route via Villach, Tarvisio, and Pontebba could be avoided.[85]

On the initiative of the governor, it was decided that most of the quarantine sites in the Klagenfurt district and in Styria (Judenburg and Leoben) would be visited by him and selected members of the medical commission. It was also decided that individual members of the medical commission should go to Villach at the beginning of August to inspect the sites there.[86] With regard to this tour to Judenburg and Leoben, the relevant district physicians and surgeons were instructed in the treatment of persons suffering from ophthalmia.[87]

During the ensuing meetings of the medical commission in the town of Villach, they also addressed the outbreak of the epidemic among the rural population of Greifenburg, about seventy kilometres northwest. The instruction of surgeons from the district of Villach, which was originally entrusted to Werneck, subsequently was handed over to Rosas according to orders from higher authority.[88] As for the instruction of the physicians and surgeons of the Klagenfurt district, which so far had also been the task of Werneck, Rosas received an imperial decree with the same content in early September.[89]

Another issue, which had been discussed in Villach, was the yet unsolved issue of the convalescent and recovered soldiers of the regiment. Should they form a separate military body, which with the retirement of individual soldiers would be gradually dissolved, or should they be discharged as soon as possible? Isfordink favoured the latter option. Both the Aulic War Council and the Austrian Aulic Chancellery shared his view as they had already done on 6th August, when they had informed the emperor about the results of the medical commission and the assembly in Klagenfurt.[90] The governor of Styria preferred the first opinion, however, and eventually convinced the Aulic Chancellery.[91] The final quartering of the soldiers in the Venetian region also became a matter of discussion. The headquarters of the Wimpffen Regiment warned of the negative atmospheric influences of the province of Venetia and argued for the transfer of the troops to

85 Ibid., pp. 3a–4a.

86 Ibid., pp. 7c–8b.

87 StLA, Gubernium Präsidium, Index u. Einreichprotokoll 1823, #1500, 26th July 1823.

88 AT-OeStA/KA ZSt HKR HR Akten 4024, L 1/1/141–1/7/125: 1823 L 1/1/162, Commmissionsprotocoll, Villach, 6th August 1823.

89 StLA, Gubernium Präsidium, Index u. Einreichprotokoll 1823, #1734, 9th September 1823—the decree is dated 5th September 1823.

90 Ibid., #1584, 13th August 1823; AT-OeStA/KA ZSt HKR HR Akten 4024, L 1/1/141–1/7/125, here 1823 L 1/1/162: Commissionsverhandlung, Villach, 8th August 1823; AT-OeSta/AVA Inneres HK Allgemein B 243, [26389/24]92, [142 August, p. 533]; AT-OeStA/AVA Inneres HK Allgemein A 1271, Vienna, 6th August 1823, transcript.

91 AT-OeStA/KA ZSt HKR HR Akten 4024, L 1/1/141–1/7/125, here 1823 L 1/1/162: Graz, 10th August 1823; Vienna, 17th August 1823.

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a colder region of the Monarchy, but should the transfer of the weakened troops have to happen as directed, they should at least not be quartered in the unhealthy lagoon or lido of Venezia.[92]

On 30th August, the Emperor Franz I decided that the Wimpffen Regiment, accompanied by a staff doctor, should be transferred before the arrival of bad weather. All locations used by the soldiers had to be cleaned. Improper adjustments of the uniform should be prohibited. The destination of the regiment was the Venetian mainland, where the troops would be housed in acceptable barracks, separated from other troops, for which the Venetian General Command was responsible. The emperor further decreed the division of the regiment into two battalions, to be housed separately from each other. One consisted of those soldiers who had never suffered from the eye disease, while the other held convalescent and recovered troops, whose transfer would take place only after their full recovery. Their discharge would be discussed later in alignment with their stipulated period of service. No new recruits were to be assigned to the regiment for the time being. The disabled were to be admitted to special institutions. The emperor further asked the medical commission in Klagenfurt to discuss the necessity of the daily examination of the healthy troops by eversion of the eyelids, which had been introduced by Werneck. Should Rosas ever conclude that this procedure was not necessary, it was to stop. Finally, the emperor asked that the Aulic War Council examine whether the commanding officers in Klagenfurt had fulfilled their responsibilities in regard to the eye disease.[93]

The decampment of the Wimpffen Regiment followed. On 9th September, the medical commission met one last time to discuss several issues raised by the imperial decree, among them the issue of the eversion of the eyelids. The majority of members declared that the daily examination of the conjunctiva by eversion of the eyelids of soldiers considered to be healthy, was not necessary. Werneck and Muzzarelli declared, however, that the eyelids of healthy troops should be examined weekly for at least another three months. Rosas agreed merely because it would certainly be useful to detect any catarrhal eye disease as soon as possible. Rosas drew attention to the fact that every time the examining physician touched the eyelids of a soldier or turned them inside out, he must reckon that the examined could be afflicted with other diseases of a contagious nature, especially on the genitals, or that he could secrete pungent substances. Therefore, the physician had to take care that his fingers, stained with impure matter, did not touch his own eyes or those of any other individual until they had been cleaned

92 Ibid., Padova, 9th August 1823.

93 AT-OeStA/AVA Inneres HK Allgemein A 1271, Vienna, 6th August 1823, Rescript from 30th August 1823, transcript.

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carefully. Rosas thought that this procedure should be performed with an instrument specifically designed for this purpose.[94]

Despite his rejection of the contagious nature of the Klagenfurt ophthalmia, Rosas in this case appeared to follow different principles concerning hygiene matters than he would in the future. A quarter of a century later, in the 1840s, he would rise to the highest administrative positions in the sanitary administration as well as at Vienna's General Hospital. During that time, Rosas would become one of the main adversaries of Ignaz Semmelweis (1818–1865) who caused considerable controversy in Vienna's medical community by suggesting that when his colleagues left the autopsy room, they should wash their hands before they went to the first obstetrical clinic of the Viennese General Hospital.[95]

Two days after the meeting of the medical commission, an assembly chaired by General Rothkirch prepared the details of the regiment's decampment from all of its present locations in the districts of Klagenfurt, Judenburg, and Bruck. This body consisted of officers of the Wimpffen Regiment, and the military physicians Isfordink, Werneck, Muzzarelli, Eble, and Rosas as the only civil physician. In a written statement, Rosas solemnly protested against any further employment of Werneck within the Wimpffen Regiment. The head military physician, Isfordink, replied that the engagement of any field physicians was under his exclusive command.[96]

On 13th September, Rosas sent a letter to Prince Hohenzollern-Hechingen, in which he justified his demand. Rosas conceded that Werneck's diagnostic method was able to detect the disease at an early stage. However, Werneck had wrong views about the nature and treatment of the disease by assuming that only a contagium was the reason. By the too frequent application of strong drugs, Werneck had caused considerable damage, for example, the disfigurement of the inner surface of the eyelids, which in many cases resulted in the dismissal of the affected soldiers. Werneck had thereby often created an eye disease where none had been, or prolonged the existing one. Werneck's healing method was often excessive and far too experimental. Werneck had furthermore only been able to reach 600 patients by admitting all individuals who appeared even the least bit suspicious to the hospital.[97]

Rosas did not restrict himself to medical arguments only, but questioned his rival's character. Rosas accused Werneck of arrogance of Olympian proportions against colleagues, along with the physical and mental abuse of the patients

94 Rosas, Actenmässige Darstellung (cf. note 12), pp. 619–622.
95 Cf. Erna Lesky, Ignaz Philipp Semmelweis und die Wiener medizinische Schule, Vienna 1964, p. 3.
96 AT-KLA 182–211 Su, Sessions-Protocoll, Klagenfurt, 11th September 1823.
97 AT-OeStA/KA ZSt HKR HR Akten 4024, L 1/1/141–1/7/125: 1823 L 1/1/171: Rosas to Hohenzollern-Hechingen, Klagenfurt, 13th September 1823, p. 20a–25b.

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whom he did not otherwise neglect. For example, upon his arrival at Klagenfurt, he had bragged about eradicating the epidemic within eight weeks, flattering himself to be protected by the Aulic War Council and his military superiors. Finally, Werneck had used stocks from the pharmacy of the military hospital for his private practice. In addition, he had deceived the authorities for a long time about the true state of the disease by means of false reports. Finally, Werneck did not want to return to his original place of duty because of reluctance towards his previous regimental commander and therefore by "wilful neglect of the welfare of the sick", he wanted to stay in Klagenfurt for as long as possible.[98] "It is for certain, however," wrote Rosas, "that Dr. Werneck, through several offenses as a human being and a physician, has incurred the disgust of his superiors, his colleagues, as well as of the officer corps, the local civilian physicians, and the population of Klagenfurt."[99]

According to a letter from the Styrian *Gubernium*, Rosas asked not only for the removal of Werneck from the Wimpffen Regiment, but from the whole territory of the Inner Austrian General Command.[100] Isfordink and Werneck's colleagues were able to defend the latter by personal testimonies with respect to his alleged offences, but there were also testimonies by officers of the regiment about Werneck's "hot temperament" and his use of "unseemly and pithy words".[101]

Rosas eventually won the struggle with the military physician, whose methods and ideas were far more innovative than his. Nonetheless, Rosas' ad hominium attacks on Werneck serve as a foreshadowing of his misguided and likewise excessive criticisms of Semmelweis decades later.

4. Concomitants and Aftermath

On 25th September, all healthy detachments of the regiment gathered in Klagenfurt. The following day, Rosas examined each soldier. These troops formed the healthy battalion, which left on 28th September. The second battalion, comprising five detachments of recovered soldiers, left their locations between 30th September and 7th October. The staff of the regiment left Klagenfurt four days later. Each battalion was accompanied by their respective army doctors and the civil physicians Hussa and Carl Toepler (1798–1850), a doctor from Hungary who was just in Klagenfurt. Werneck was the only one not to be considered. The second battalion was accommodated in Bassano di Grappa near Vicenza and in

98 Ibid.
99 Ibid.
100 AT-OeSta/AVA Inneres HK Allgemein B 243: 29739/2837, 127, September, p. 601.
101 AT-OeStA/KA ZSt HKR HR Akten 4024, L 1/1/141–1/7/125: 1823 L 1/1/171 enlists all accusations and counterstatements.

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Feltre not far from Belluno. During the whole march, eighteen cases of eye disease emerged which had been brought to be admitted to local hospitals (Klagenfurt, Udine, Treviso, Ceneda). Rosas arrived on 5th November in Padova, where he informed the Venetian General Command that he considered the catarrhal eye disease among the second Battalion extinct, so that isolation measures were not necessary any longer. All those, who were still suffering from the ophthalmia were held in separate locations in Völkermarkt, Ceneda, and Cividale in November.[102]

The Carinthian epidemic could not be contained within the ranks of the military; neither was it the only epidemic of trachoma to seize the Klagenfurt garrison. Consequent on the outbreak in Greifenburg, a hospital in a former monastery in the village of Weißenach was established. Although the success of this institution was evident immediately, it remained in operation until 1829.[103] In 1833, the Klagenfurt barracks, which were this time populated by the 2nd battalion of the Peterwardein Border Infantry Regiment No. 9, was visited by a second epidemic of trachoma, but on this occasion, the scourge remained a regional affair.[104]

What happened to Wilhelm Werneck, after he had been ousted by Anton Rosas? In the archives of the *Polizeihofstelle,* we find a partly burnt anonymous letter, probably from August 1823 and probably authored by Isfordink. It mentions the "interjections and interferences against Doctor Werneck, who treats this evil plague very expediently" and was therefore in need of spiritual support by brigadier Rothkirch and the author of the letter. The letter notes that in the case of the Greifenburg epidemic, the Illyrian *Protomedicus* Johann Evangelist Schneditz (1765–1843) had insisted on having Dr. Werneck explain to him both the mode of transmission and the therapy of the disease: "Were it not for this extremely skilled Dr. Werneck, the epidemic there would have certainly become devastating."[105] As for the banishment of Werneck by Rosas, the Aulic War Council rejected it unanimously. It also informed the Inner Austrian Command in this respect and expressed its intention to forward the information to the emperor.[106]

Werneck was not rehabilitated. Already in June, he had prepared a treatise on the healing method in the Klagenfurt epidemic that he wanted to see printed after

102 Anton Rosas, Actenmässige Darstellung der in den Jahren 1822 und 1823 in dem k.k. Infanterie-Regimente Baron Wimpffen herrschend gewesenen Augenkrankheit, (Fortsetzung.), in: Medicinische Jahrbücher des kaiserl. königl. österreichischen Staates, vol. 3 (1826), pp. 56–77.

103 Kumpf, Einige Notizen, pp. 203–208; Frick, Kumpf (cf. note 47), pp. 709, 712.

104 Cf. AT-KLA 182–211 Su, files Klagenfurt, 26th August 1833 to Klagenfurt, 1st September 1834.

105 AT-OeStA/AVA Inneres PHSt H52.1823: Illyrien Augenkrankheit.

106 AT-OeStA/KA ZSt HKR HR Akten 4024, L 1/1/141–1/7/125, here 1823 L 1/1/147, Vienna, 11th October 1823.

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having already obtained the promise of financial support from the Illyrian government. When the Illyrian governor in August asked for the opinion of Rosas on this treatise, the latter conceded that it had some "literary value", but he deferred to recommend it for use in the instruction of surgeons.[107] In November, the Court Chancellery inquired after the publication of an edition of the treatise at public expense, and pointed to the related pending decision of the emperor.[108] We can see in consequence, however, that while Rosas was able to publish his documentary presentation of the Klagenfurt epidemic in 1824 and 1826 in the highly renowned public *Medical Yearbook of the I. R. Austrian States*, Werneck's papers on the topic had to be published in a German professional journal on surgery and ophthalmology outside the Habsburg Monarchy.

In the following years, Werneck attempted to stain secretions of the conjunctiva with brazilwood in order to examine them microscopically. In 1827, while working as operating surgeon, he suffered an infection caused by a "poisonous gangrenous exudate", which led to blindness in his left eye. He began managing private eye hospitals in the cities of Braunau and Salzburg. As this was no longer compatible with his duties as a regimental doctor, he left the army in 1832. Werneck also worked on plastic surgery and the anatomy of the eye lens. His microscopic research also focused on infusoria, which would probably have made him one of the trailblazers of bacteriology, had his research in this field not been lost.[109]

Throughout his life, Rosas remained committed to his view on the Klagenfurt eye epidemic as a catarrhal disease. He took a cantankerous tone in his *Lehre von den Augenkrankheiten*, which he published in 1834 as a basis for his ophthalmological teaching. In the book, he claimed that it would not have been necessary to speak of a separate "Egyptian ophthalmia", if it was not for the "everlasting physicians, who, probably misled by [the Italian physician Annibale] Omodei, assume it to be an undoubted fact that Egyptian ophthalmia is of a very peculiar nature, different from all previously known eye diseases, and that it has spread to Europe by infection since the year 1801".[110] The relevant literature had, nonetheless, long since declared ocular inflammation to be an "Egyptian" one. Rosas, too, had to accept this. Nevertheless, he referred precisely to those works that had recently appeared in Prussia: "Read up on the various monographs

107 AT-OeStA/KA ZSt HKR HR Akten 4024, L 1/1/141–1/7/125, here 1823 L 1/1/162: Commissionsprotocoll, Villach, 9th August 1823; Beylage zum Commissions-Beschlusse, Villach, 9th August 1823.

108 AT-OeSta/AVA Inneres HK Allgemein B 243: …/…, [6th November], p. 713; 35630/3387, 106, November, p. 741.

109 Remky, Amalric, Zur Geschichte der Photochirurgie (cf. note 25), pp. 68–70.

110 Anton Rosas, Lehre von den Augenkrankheiten. Zum Gebrauche für practische Aerzte und Wundärzte. Vienna 1834, p. 212.

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dealing with contagious ocular inflammation in the European armies, and you will convince yourself that this disease has almost everywhere arisen and progressed under the influence of similar pests, such as were those which affected the Wimpffen regiment, and which have been cited by me in the aetiology."[111]

The enormous changes that the military had taken in the years surrounding the Napoleonic Wars had narrowed Rosas' view. When he wrote about his experience with the Klagenfurt epidemic, the Congress of Vienna was only ten years in the past; the long wars in Europe had brought about the formation of large popular armies with conscription, barracking, new clothing, and increased service in arms even in peacetime. Not without reason, Rosas argued that these circumstances were unlikely to have affected earlier soldiers.[112]

The military physician, Isfordink, had followed the commission's findings closely. Shortly after the events at Klagenfurt, he published a fundamental work on "Military Health Police", in which precise instructions were given for dealing with recruits, barracking, and marches. He advised that marches should not be overdone with the young recruits, in line with Rosas' ideas. During marches, the recruits should be "spared as much as possible, so that they do not fall ill before they gradually get used to marching in an orderly fashion". Therefore, an infantry-recruit transport should never be accompanied by cavalry, because this would make the trains too fast, and in general the sparing of young recruits during marches was recommended, "because the danger of illness is greater with them".[113] Isfordink also took up the idea of proper accommodation for soldiers during transfers, who should not be housed in mass quarters. Instead, they should be divided among as many wards as possible; they were entitled to a bed of straw and a sheet of linen so that they could undress and not have to cover themselves with their clothing. Isfordink also attached great importance to laundering clothing.[114] He himself spoke of the "contagious inflammation of the eyes", but abstained from a more detailed description of the disease itself.[115]

The "Egyptian ophthalmitis" was a remnant of the Napoleonic Wars that were inextricably linked to the Orient. The scientific controversy over the disease involving Wilhelm Werneck and Anton Rosas, one an accomplished and innovative army physician, the other a professor and influential ophthalmologist at

111 Rosas, Actenmässige Darstellung – Fortsetzung (cf. note 102), p. 402.
112 Rosas, Actenmässige Darstellung – Fortsetzung (cf. note 102), p. 403.
113 Cf. Johann Nepomuk Isfordink, Militärische Gesundheits-Polizei, mit bes. Bezug. auf die k. k. österreichische Armee, Vienna 1825, p. 72.
114 Isfordink, Militärische Gesundheits-Polizei (cf. note 113), p. 77.
115 He did, however, go into more detail on the subject of cleanliness and criticised the fact that the previous regulations, which did provide for the washing of the eyes and hands, were not far-reaching enough. Only recently had it been pointed out that it was important to wash behind the ears and on the neck as well, and that the skin as a whole had been neglected too much in general. See Isfordink, Militärische Gesundheits-Polizei (cf. note 113), pp. 222–230.

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the prestigious Medical Faculty of Vienna, was a dispute between two different medical approaches, whereby the military side favoured a contagionist perspective. Rosas, however, favoured the more fashionable point of view that the origin of the disease was local and miasmatical. This dispute would go on for the next two decades: In Vienna, Burkhard Eble and Friedrich Jäger—both teaching at the *Josephinum*—conducted further research in the 1830s, and in 1841, Josef Piringer (1800–1879),[116] a student of Jäger in Graz, published a book on Blennorrhoea, in which he settled the question of contagiousness in Werneck's sense.[117]

Apart from these observations, we can generally recognise that after the Napoleonic Wars, the health of the military could not be treated as a self-contained issue any longer since the garrisons in the towns led to multiple contacts with civilians. For example, soldiers were deployed to support tax collecting among the rural population. From there, it was not a far-fetched idea to protect the civilian population from potential epidemics, rampant among the army. Such an idea led state authorities to the concept of temporary advisory bodies which consisted of a military and a civilian part. Even the logistical transfer of troops for the need of containment was a consequence of intense debates between civilian representatives and those of the military. This advisory work became part and parcel of a rigid performance within state-run medicine. Consequently, individual physicians received detailed instructions about prevention and treatment, whereby the chain of command and the strict hierarchical control within the military made direct access to the single soldier and his health condition far easier than among the civilian population. In towns and the countryside, physicians were still dependent on the collaboration of the parish priests and the local authorities.

116 Dr. Joseph Friedrich Piringer (1800–1879) studied in Vienna and assisted Friedrich Jaeger and Anton Rosas. Piringer was awarded a doctorate in 1826 and a master's degree in ophthalmology in 1828. In May 1828, he applied for extraordinary lectures on ophthalmology in Graz; a first eye clinic, supervised by Piringer, was established on 1st May 1829. On the Graz eye clinic and Piringer, see Norbert Weiss, Ophthalmology in Graz, in: Spectrum of Ophthalmology 27, 6 (2013), pp. 258–268.

117 Joseph Piringer, Die Blennorrhoe am Menschenauge, Graz 1841, p. 57.

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Nebiha Guiga

Soldiers, Surgeons, Civilians, and the State: Formal and Informal Medical Care during the Napoleonic Wars

A cursory look at the regulations of the French and Austrian military health services applicable during the Napoleonic Wars give the image of medical care given in state-run military hospitals primarily, with precisely planned evacuation lines.[1] Yet, a closer study already reveals the importance of non-state actors for military medicine during these conflicts—through the use of contractors of civilian authorities to organise housing and food during evacuations or through the requisition of carriages and carts to transport the wounded.

Memoirs give an even more central place to non-state actors in the care of wounded men, up to cases where a whole parallel system of care can be identified. This is, for example, the case of Pierre-Martin Pirquet's treatment. This Austrian officer from Liège in modern-day Belgium, whose diary was published in the 1970s,[2] was wounded at the battle of Ebelsberg (3rd May 1809) when a bullet went through his lung. He survived, and in his diary, related the whole course of his treatment, which took four years in total before he was able to go back to active service. After being left for dead on the battlefield, and brutalised by Napoleonic soldiers looking to plunder what they thought was his corpse, he was finally rescued the next day by another soldier from the same army, who brought him to the ambulance. The first dressing of his wound he received there, however, was the only treatment he received from state-run military health services. After a few days spent in a hospital, seeing some of his friends die from lack of treatment, his

1 For the French case, the most important text is the 1794 regulation of the military health services, later modified several times, notably in 1813. All the relevant regulatory text can be found in Service Historique de la Défense, Vincennes [SHD], GR Xr12. In the Austrian case, the 1788 regulation is the main relevant document; see Johann Alexander von Brambilla, Reglement für die Kaiserliche Königliche Feldchirurgen in Kriegszeiten. Auf Befehl Seiner kaiserlische königlische Apostlische Majestät Joseph des Zweyten, vol. 2, Vienna 1788; various reforms over the years (notably in 1808 and 1809) are visible in the 1815 regulation of Austrian military hospitals; see Revidirter und verbesserter Auszug aus dem Militär-Sanitäts-Reglement, Vienna 1815.

2 Pierre-Martin Pirquet, Journal de Campagne de Pierre-Martin Pirquet (1781–1861): Officier au Service de l'Autriche. vol. 1, 1799–1813, Liège 1970.

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social status as a nobleman and family connections allowed him to be housed by a local baroness and then in a privately run civilian hospital. Even after being released from a very theoretical captivity, his long-term care was only partly taken charge of by regiment surgeons, and more often than not, he went to the local civilian surgeon for the many operations that his wound necessitated.

In both these cases, though in different proportions, formal and informal modes of care were put to use in the treatment of wounded soldiers. The aim of this paper is to map the interactions of formal and informal modes of care and of various actors taking part in the treatment of wounded soldiers during the Napoleonic Wars. The central argument concerns the significance of the constant interaction of formal and informal modes of care, as well as the role of both civilians and military officials. Formal modes of care will be provisionally defined as corresponding to official military regulations, or directly ordered by state authorities, but it should be noted that the distinction is partly artificial.[3]

This essay contributes to the field of the history of medicine which examines the relationships between the medical profession and the state in a military context. Most historians of military health services have looked at it through the lens of the medicalisation of war and militarisation of medicine.[4] This approach encompasses the complex movement of the integration of medical and military logics and, positioning itself at the level of the relationship between physicians and the army, aims to understand mutual influences and to reconstitute the importance of these interactions for medicine in society in a more global way. This approach thus reintegrates military medicine and the effect of war into a cultural and social history of medicine. While it was developed for the study of modern wars, this framework has been used successfully to write a history of the British military medicine of the Napoleonic Wars.[5] Research on an earlier period, notably Erica Charter's work on the Seven Years War, has also looked at the role of military medicine in the building of the modern state.[6] The question of medical professionalisation and the place in this trend of military physicians and surgeons has also received scholarly attention.[7]

Similarly, placing military medicine in the larger framework of early-modern and modern state building has looked primarily at the care provided by military health services, and examined the quality of care in the formal, state managed

3 This artificiality can be seen in the presence of informal elements in even the most strictly state-run of modes of care.

4 Roger Cooter et al. (eds.), Medicine and Modern Warfare, Amsterdam 1999.

5 Catherine Kelly, War and the militarization of British Army medicine, 1793–1830, London 2011.

6 Erica Charters, Disease, War, and the Imperial State, Chicago et al. 2014.

7 Marcus Ackroyd, Advancing with the army: medicine, the professions, and social mobility in the British Isles, 1790–1850, Oxford et al. 2006.

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services. While this framework provides a powerful tool to understand global dynamics, it also tends to underestimate the place and importance of informal modes of care, in particular in the case of massive armies such as the ones which were engaged in the European theatre of operations during the Napoleonic Wars.

Thus, while the main point of this essay is to underscore the constant interaction of formal and informal modes of care for wounded and sick soldiers, a particular focus will be put on the informal side of the equation, which, concerning the Napoleonic Wars in particular, has received less sustained scholarly attention. Knowledge transfer between military physicians and surgeons and local civilians in an imperial context has been researched.[8] Yet, a centring of informal approaches in an attempt to conceptualise their place in the treatment of sick and wounded soldiers in this period has yet to be undertaken. This essay marks just such an attempt to address this question.[9]

What follows will mainly focus on soldiers wounded in major battles, as the sudden influx of patients, leading to the overwhelming of health services, reveals modes of care which otherwise are difficult to follow in the available sources. Additionally, informal modes of care also tend to be particularly visible in testimonial sources such as letters, diaries, and memoirs, which tend to give a larger space for major battles. While it will not be the focus of this essay, a study of informal modes of care in the case of epidemics would be an important research question, all the more so that the involvement of civilians in the treatment of potentially contagious sick soldiers has implications in terms of the extension of the sanitary consequences of war for non-combatants.[10]

A comparison based on the campaigns of 1805, 1809, and 1813 allows for an analysis of the interactions within a relatively similar geographical space: the region of central Europe between Dresden, Prague, and Vienna. The battles of Austerlitz (2nd December 1805), Aspern-Essling (21st–22nd May 1809), Wagram (5th–6th July 1809), and Leipzig (16th–19th October 1813) will be in particular focus. The sources derive mostly from the French and Austrian armies. They include testimonies from soldiers, civilians, and surgeons, notably letters, diaries, and memoirs, medical sources such as hospital inspection reports or case studies, hospital supply contracts, regulatory sources, administrative correspondence

8 Marie-Cécile Thoral, Colonial Medical Encounters in the Nineteenth Century: The French Campaigns in Egypt, Saint Domingue and Algeria, in : Social History of Medicine 25, 3 (2012), pp. 608–624; Pierre Nobi, Officiers de santé et soignantes créoles face à la fièvre jaune, in: Histoire, médecine et santé 10 (2016), pp. 45–61.

9 For a fuller discussion, see Nebiha Guiga, 'Le champ couvert de morts sur qui tombait la nuit': Être blessé au combat et soigné dans l'Europe napoléonienne (1805–1813), Paris et al., Diss. 2021.

10 Nebiha Guiga, Épidémies, routes d'évacuations et implications des sociétés civiles dans les guerres napoléoniennes (1805–1813), in : Revue Historique des Armées 303 (2021), pp. 28–37.

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between military health services and military authorities, and listings of soldiers being cared for in civilian homes. Using these materials takes into account the vast scale of the Napoleonic Wars, while still retaining the necessary understanding of the workings of military health services, which are specific to each belligerent. This essay does not consider the cases of insurrectionary wars, which would necessitate different research, as the interaction between soldiers and civilians, which is at the heart of informal modes of care, is markedly different in this context.[11]

A summary of formal and informal modes of care, and their respective roles at each step of a wounded man's journey, follows. Thereafter, the essay examines the forms of interactions that can be identified, trying to understand the role that such interaction played in the quality of medical care during the Napoleonic Wars. The final section is a case study of wounded soldiers cared for in civilian homes in Dresden in 1813, a well-documented instance which will illustrate the various forms of interaction previously discussed.

1. Formal and Informal Modes of Care at Every Step of Wounded Men's Journey

Formal and informal modes of care were in constant interaction at every step of wounded men's journey, from the very moment they were injured on the battlefield itself, to their return to the regiment, their discharge, or their death. Even before the battlefield, the preparations for the battle, when it could be prepared for, involved civilians and informal modes of care. Particularly at the end of the campaign, civilians or poorly qualified personnel were frequently used to replenish the ranks of care workers.[12] The sick and less seriously wounded were evacuated to the rear, and vehicles and linen were requisitioned from civilians.[13]

After 1809, on the battlefield, specialised corps were charged with picking up the wounded after the fighting, called *Sanitätscompagnie*[14] in Austria and

11 On this question, see Thomas Ramonda, Les évacuations sanitaires militaires en tant qu'enjeu de santé publique générale: étude des épidémies de typhus du Sud-Ouest de la France sous le Premier Empire (1808–1814), in: Revue Historique Des Armées 303 (2021), pp. 38–50; Jean-Marc Lafon, Morts et destin de Jean-Gaspard René. Lectures croisées du supplice d'un général napoléonien capturé par les insurgés espagnols, in: Walter Bruyères-Ostells et al. (ed.), Des chairs et des larmes. Combattre, souffrir, mourir dans les guerres de la Révolution et de l'Empire (1792–1815), Aix-en-Provence 2020, pp. 213–228.

12 Archive du Service de Santé des Armées [SSA], Carton No.18, Österreichische Staatsarchiv [OeSta], Kriegsarchiv KA/ [Zentralstellen] Zst- [Hofkriegsrat] HKR- [Hauptreihe] HR Akten, Carton No. 3403.

13 Baron Percy, Journal des campagnes, Paris 2002, pp. 78–81.

14 OeSta-KA/AFA [Alte Feld-Akten], Carton No.1458, Anweisung an die Sanitätscompagnien.

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Compagnie d'infirmiers in France.[15] Even taking into account their late appearance, the study of memoirs does not clarify their actual role on the battlefield besides rumours of soldiers from these *compagnies d'infirmiers* pillaging and looting from those they were supposed to pick up.[16]

In this context, soldiers who were unable to find their way to the ambulance—a word, which, at the time, described a fixed first-aid point outside of the specific and very limited exception of Larrey's *ambulances volantes*—on their own, were, more often than not, helped by their fellow soldiers away from the battlefield. This practice, while officially forbidden in the French army[17] and severely controlled in the Austrian one,[18] is constantly present in memoirs.[19] Furthermore, qualifying the practice as strictly informal would be misleading. Despite the existence of stories from the Napoleonic propaganda exalting the courage of Général Valhubert, who, wounded mortally at Austerlitz, refused to be brought to an ambulance for fear of diverting men from the fight—the very reason why the practice was forbidden in the first place—the interdiction never applied to officers.[20] Friedrich Mändler, a corporal of the Bavarian army allied to the French, was ordered during a small-scale battle on 24th April 1809 near Landshut, to make sure that no more than the strictly necessary number of men were diverted from fighting to help the wounded—a sign that a number of them were to be diverted in the first place—but still diverted two soldiers to carry a lieutenant to the nearby town, abandoning his own post to accompany them.[21] He saw no contradiction in doing this because the order was clearly not meant to apply to officers. Other texts mention an organisation at the regiment level of the evacuation of soldiers by their fellow combatants, thus showing the peculiar positioning of such practices.[22]

Once the battle had ended, the variety of actors involved did not diminish. Picking up the wounded and giving them first aid was again taken up by civilians, members of the military health services, and soldiers, as well as non-combatants following the army. These included musicians and *cantinières*, whose role in

15 SHD, GR Y C 1.

16 François-Joseph Jacquin, Carnet de route d'un grognard de la Révolution et de l'Empire: texte inédit, Paris 1960, pp. 70–71.

17 Alexandre Goujon (ed.), Bulletins officiels de la Grande Armée, recueillis et publiés par Alexandre Goujon, vol. 3, Paris 1820, p. 119.

18 OeSta-KA/AFA, Carton No. 1458 (cf. note 14).

19 Jean Morvan, Le soldat impérial, Paris 1904.

20 Ibid., pp. 272–273.

21 Friedrich Mändler, Erinnerungen aus meinen Feldzügen in Österreich, Tyrol, Russland, Sachsen und Frankreich in den Jahren 1809 bis 1815 und Episoden aus meinem Garnisonsleben, Nürnberg 1854, pp. 14–16.

22 Jean-François Boulart, Mémoires militaires du général Baron Boulart sur les guerres de la république et de l'empire, Paris 1892, p. 217.

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giving first aid, both as improvised surgical aids to military surgeons[23] and on their own[24] is well documented in memoirs. While *Sanitätscompagnie* in Austria and organised parties of soldiers and *Compagnies d'infirmiers* in France did pick up the wounded on the battlefield, recourse was also made to civilians, both officially requisitioned[25] and voluntary.[26] For example, on the battlefield of Wagram, wounded men were abandoned for days on the fields, difficult to find under the full-height crops.[27] In this context, French *Conseillers d'Etat* who were present in Vienna at the time rented carts and went to the battlefield to pick up some of these wounded men, though they were quickly overwhelmed by the unexpected scale of the task.[28]

The reliance upon formal and informal modes of care was also a major characteristic of the care provided to wounded soldiers in military hospitals. Hospitals were organised along evacuation lines that included temporary hospitals in the immediate vicinity of the army and more permanent structures behind the lines. Because of the location of the battles, the Austrians more often used their own hospitals, the French using captured Austrian hospitals and those of their Bavarian or Saxon allies. The use of requisitioned civilian hospitals was a very frequent occurrence.[29] When hospitals were founded during a campaign, convents, castles, and other large buildings were frequently used, with regulations allowing their requisition in both France and Austria. In such cases, monks or nuns from the requisitioned convent would often be put to the task of caring for the wounded.[30] Beyond the case of fully requisitioned hospitals, it should also be noted that while personnel were, in theory, made up of soldiers and members of the army's medical services and administration,[31] local civilians helping in hospitals were frequently mentioned in sources.[32] Supply contracts and requisitions made it possible in both Empires to provide hospitals with

23 Paul-Irénée Jacob, Journal et itinéraire de dix années de campagne (1800–1814). Extraits choisis et présentés par P. Julien, in: Revue d'histoire de la pharmacie 18, 189 (1966), p. 86.
24 Philippe-René Girault, Les campagnes d'un musicien d'Etat-Major pendant la République et l'Empire, Paris 1901, pp. 175 and 211.
25 SHD, GR 2 C 92.
26 Capitaine Robinaux, Journal de route du Capitaine Robinaux 1803–1832, Paris 1908, p. 155.
27 SHD, GR 2 C 93.
28 Ibid.
29 SHD, GR 2 C 90.
30 Annett Büttner, Die konfessionelle Kriegskrankenpflege im 19. Jahrhundert, Stuttgart 2013; for a particular example from the Napoleonic Wars, see Wilhem Meier, Erinnerungen aus den Feldzügen 1806 bis 1815: Aus den hinterlassenen Papieren eines Militärarztes, Karlsruhe 1854, p. 49.
31 SHD, GR Xr 12; Brambilla, Reglement für die Kaiserliche Königliche Feldchirurgen in Kriegszeiten (cf. note 1).
32 See, for example, Niederösterreischische Landesarchiv (St. Pölten), KrA VUMB I K 143, No. 860. I thank M. Michael Wenzel for having provided this document.

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equipment.[33] It should also be noted that, along with official hospitals set up by the belligerent armies, private hospitals were erected behind army lines by enterprising[34] or voluntary[35] local civilians, which means that some wounded were taken care of entirely outside of official military health services, even in the case of hospital care.

As a preventive measure before a battle, when the army moved, or when peace was signed, hospitals were evacuated, either totally or partially. The evacuation of hospitals mobilised the organisational capacity of the army's health service administrations, and the regulations concerning evacuation, in France as in Austria, aimed to ensure a certain continuity of care and supplies for the wounded.[36] Civilians in the regions that they crossed were called upon to contribute, having to provide accommodation and submit to various requisitions.[37] The soldiers' journeys across Europe were sometimes very long. After defeats, in particular, evacuations were often carried out in disorder, with the theoretically non-transportable wounded being moved, and it was sometimes the regiments themselves that transported their wounded soldiers.[38] Thus, in the case of evacuation, both formal and informal modes of care included the civilian populations of Europe in the journeys of wounded men.

The main step of wounded men's journey involving both formal and informal modes of care (including the civilian population) was, however, the housing of convalescent men. After Wagram, almost half of the wounded present in Vienna were housed in this way.[39]

Finally, it should also be noted that the long-term treatment of soldiers whose wounds incapacitated them did not always end up at institutions such as the *Hotel des Invalides* in France or Austria's *Invalidenhäuser:* civilians also cared for demobilised soldiers. These examples demonstrate the permanent co-existence of formal and informal modes of care for injured and sick soldiers, as well as the involvement of civilians at each step of wounded men's journey. In this context, it

33 OeSta-KA/Zst-HKR-HR Akten, Carton No. 3218.

34 Pirquet, Journal de Campagne (cf. note 2), p. 88.

35 Hauptstaatsarchiv [HStA] Dresden, 10026 – Geheimes Kabinett, Loc. 02548/48, Dr. med. von Drions zu Meidling bei Schönbrunn [bei Wien] im Jahre 1809 an sächsischen Verwundeten geleistete Dienste und desselben beanspruchte.

36 SHD, GR Xr 12; Brambilla, Reglement für die Kaiserliche Königliche Feldchirurgen in Kriegszeiten (cf. note 1).

37 For the effect of months-long evacuations on a local population, see Peter Schuchhardt, Die Elberfelder Bilderhandschrift. Bilder und Dokumente aus napoleonischer Zeit, Herne 2004, pp. 14–16.

38 François Dumonceau, Memoires du général comte François Dumonceau, vol. 2, Bruxelles 1958, pp. 347–348.

39 SHD GR 2 C 93. For a description of the effect of such a large number of billeting on the city of Vienna, see Caroline Pichler, Denkwürdigkeiten aus meinem Leben, vol. 2, 1798 bis 1813, Vienna 1844, pp. 157–158.

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is necessary to further explore the relationships between civilians, surgeons, patients, and the state that these various encounters mapped out. It is helpful to evaluate the centrality of informal and civilian-based modes of care in the quality of medicine in armed conflicts during the Napoleonic Wars.

2. Interactions of Formal and Informal Modes of Care

While a large number of wounded men were treated directly by military health services, they did not represent the entirety of the journey of wounded men, and moreover, even in this context, the involvement of civilians and informal modes of care is well documented. As seen in the previous part of this article, civilians worked at military hospitals, in variably formalised capacities, and evacuations necessitated the requisition of civilian resources to be carried out. This observation goes beyond the simple acknowledgement of the role of formerly requisitioned civilians, at the margin of otherwise state-run military health services. Non-state modes of care were not marginal, nor always overshadowed by state modes of care. They were present on the same level, and were sometimes more effective. The housing of wounded men in civilian homes shows the complexity of these interactions. Housing sick and wounded men in civilian homes was used by military health services in two main cases. The first was that of superior officers, whose care generally entirely took place outside of hospitals, and in civilian homes, though not without the involvement of military surgeons. The case of Général Thiébault, wounded at the battle of Austerlitz, was particularly exemplary of this dynamic: initially taken care of by both Larrey and Percy while housed in a civilian home, he then remained there after the peace was signed and the French army left the region. Frequently visited by an Austrian surgeon, his day-to-day care was taken charge of by the mistress of the house, who had surgical training.[40] While superior officers represented a very small number of wounded men, the fact that their care was provided outside of military hospitals, and frequently for a long time, taken charge of by civilians, is indicative of the central place of such modes of care in the provision of military medicine at that time.

The second main use of civilian houses was to reduce the overcrowding of hospitals by sending convalescent or lightly wounded men to be treated in civilians' homes.[41] The other main objective was to provide convalescent men with a less dangerous environment for recovering their health than the hospital, as explained by this quote from Capitaine Gervais' memoirs:

40 Paul Thiébault, Mémoires du Général Baron Thiébault, vol. 1, Paris 1893, pp. 481–497.
41 Baron Percy, Journal des campagnes, Paris 2001, p. 78.

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> "Every day brought with it improvement. After eight days, I started to be able to stand next to my bed; eight more days later, I ventured to walk a few steps in the room. As soon as I was able to walk around it, the physician told me: 'My friend, you are careful, you've got money, I can get you lodging in town. I advise you to get out of here. Your wound only needs cleanliness now. If, in your state, you were to catch a fever, it could be detrimental to you.'
> I accepted this proposal with pleasure; as I left [the hospital] I was given back all my things and all my money, nothing was missing. I was well housed, I walked as much as my strength would allow, and each day, as I breathed the good air, I felt appreciably better."[42]

The surgeon, here, advised his patients to get out of the hospital, representing the hospital as a fundamentally dangerous and pathogenic environment. The mode by which Gervais obtained housing did not seem here to be fully regular. The possibility to get out of the hospital was linked with Gervais' ability to pay ("you have money; I can get you lodging in town"), and there was no mention of official billeting. The role of money for securing medical care inside of the military services, to obtain a better level of care, is also documented in other memoirs, such as those of Chevillet, who mentions paying a nurse in a hospital to receive more attention in his treatment.[43]

A picture of the medical care of wounded men during the Napoleonic Wars that only considered institutional modes of care, and money-based interactions providing quality of care at its margins and interstices, would be incomplete. The already cited case of Pierre-Martin Pirquet is a particularly illustrative case of informal care in action. While part of his care was indeed carried out in the aforementioned for-profit non-state-run hospital, the role of pre-existing social networks, in his case aristocratic solidarities, was central in allowing him to be taken care of outside of the military health services.[44] Such interactions were not unique to aristocrats. Wounded in 1813, Georges Bangofsky was taken care of by

42 Capitaine Gervais, Souvenirs d'un soldat de l'Empire: à la conquête de l'Europe, Paris 2002, p. 224. Original text: "*Chaque jour apportait du mieux. Au bout de huit jours, je commençai à me tenir debout près de mon lit ; huit autres jours plus tard, je me hasardais à faire quelques pas dans la salle. Aussitôt que j'en pus faire le tour, le médecin me dit :-Mon ami, vous êtes prudent, vous avez de l'argent ; je peux vous faire avoir un logement en ville. Je vous conseille de sortir d'ici. Votre plaie n'a plus besoin que de propreté. Si, dans votre état, une fièvre vous arrivait, cela pourrait vous être préjudiciable. J'acceptai avec plaisir cette proposition ; on me remit, en sortant, tous mes effets et argent, auxquels rien ne manquait. Je fus bien logé, je marchais autant que mes forces le permettaient, j'éprouvais chaque jour, en respirant le bon air, un mieux sensible*".

43 Jacques Chevillet, Ma Vie militaire, 1800–1810, par J. Chevillet, trompette au 8e régiment de chasseurs à cheval, 1906, p. 304.

44 Pirquet, Journal de Campagne (cf. note 2), pp. 90–95.

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his wife's extended family near Deux-Ponts—today, Zweibrücken, Saarland.[45] The building of such networks of solidarity during the course of the war was also an element that should be taken into account. An example of such networks is given by the testimony of the baker, E. Seyffert, from Leipzig, who wrote fifty years after the battle. He tells the story of a soldier from Baden who was billeted in his house before the battle, and who, helping the bakers in making bread, is described as looking "more like a baker" than a soldier.[46] This shows a certain amount of soldierly integration into civilian life even during wartime. During the battle, the soldier, wounded, was found by the bakers, brought to hospital, where the bakers brought him food every day until his eventual death. Such an interaction shows with particular clarity the blurred boundaries of civilian and military society, and the building of networks during wars which had a very real effect on the care given to wounded soldiers.

More broadly, cases of voluntary help to wounded men on the battlefield of the Napoleonic Wars are frequently present in memoirs and other sources.[47] The fact that non-insurrectionary conflicts are the subject matter here very likely influenced these relations and should be kept in mind. Even during the campaigns studied here, cases of violence on wounded soldiers, though rare, were not unheard of.[48] Similarly, the larger context of violence exercised by soldiers on civilians should also not be forgotten,[49] as the voluntary nature of the help given was sometimes relative, and provided under the threat of requisition.[50] It was not always the case, however, and instances of civilians picking up wounded men

45 Georges Bangofsky, Les Etapes de Georges Bangofsky, officier lorrain, fragments de son journal de campagne (1797–1815), recueillis par son petit-neveu, Alexandre de Roche du Teilloy, Paris et al. 1905, p. 76.

46 E. Seyffert, Erinnerungen an kleinere Ereignisse aus den Tagen der Völkerschlacht von einem Augenzeugen (Bäcker-Obermeister und Stadtverordneten E. Seyffert in Leipzig), in: Emil Wilhelm Robert Naumann (ed.), Die Völkerschlacht bei Leipzig: nebst Nachrichten von Zeitgenossen und Augenzeugen über dieselbe, im Auftrage von dem Vereine zur Feier des 19. October, Leipzig 1863, pp. 356–365.

47 Thiébault, Mémoires (cf. note 40), pp. 483–484; Lieutenant Chevalier, Souvenirs des guerres napoléoniennes, Paris 1970, p. 98; Colonel Lataye, Le journal de marche du colonel Lataye 1805, in: Carnet de la Sabretache 1 (1893), p. 143.

48 See, for example, Johann Carl Meißner, Leipzig 1813: Tagebuch und Erinnerungen an die Völkerschlacht, Kassel 2001, p. 66.

49 See, for example, Charles-Louis Cadet de Gassicourt, Voyage en Autriche, en Moravie, et en Bavière fait à la suite de l'armée française pendant la campagne de 1809, Paris 1818, p. 67; and for an analysis of the question, see Ute Planert, Der Mythos vom Befreiungskrieg: Frankreichs Kriege und der deutsche Süden. Alltag – Wahrnehmung – Deutung 1792–1841, Paderborn 2007, p. 182.

50 Coignet mentions such a case about the inhabitants of Lützen in 1813 although it does not stop him from praising their courage. See Jean-Roch Coignet, Cahiers du capitaine Coignet, Paris 2001, p. 303.

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from the battlefield,[51] providing variably competent first aid,[52] food and shelter[53] or even hiding them from enemy soldiers are frequently present in sources.[54] Soldiers attributed the help given to them by civilians frequently to charity,[55] which was often also mentioned by civilians or by local authorities,[56] in particular when criticising the lacking care provided by military health services.[57] Other motivations were also identified such as Francophilia and the quality of humanity shown by civilians, as Captain Robinaux noted when he wrote: "The citizens of this town, well disposed towards the French, followed us on the battlefield to pick up our wounded and alleviate their distress; I will never forget the acts of humanity that the inhabitants of Chemnitz provided to us."[58]

Military health services functioned with the help of informal modes of care—provided by both soldiers and the local civilian population, and included formal and informal aspects used by civilians every step of the way. As such, a stark separation between formal and informal modes of care, as well as directly state-run and non-state-run ones, is inadequate to understand the workings of these military health services at the beginning of the nineteenth century. These modes of care were deeply immersed into one another, working in synergy, and as such, were all but inseparable, if not indistinguishable. Quality medical care necessitated the use of informal modes of assistance, or, at the very least, of non-directly state-run ones. This is not to say that efforts towards rationalisation and increased state control were absent, but that they were not without tensions and conflicts. In the regulations, medical memoirs and reform projects, ambitions to rationalise medical practice—the medicalisation of war and militarisation of medicine—are clearly identifiable.[59] The states studied in this essay responded in part to these impulses by reforming their health services, in particular by setting

51 SHD, GR 2 C 93.

52 For example, bankers in Leipzig rescued a French soldier whose arm had been destroyed by artillery but their efforts, which included putting tobacco in the wound, also included the use of warm water which made the bleeding worse: E. C. Härtel, Mitteilungen von E. C. Härtel, Buchhalter der Sparkasse und Leihhauses zu Leipzig, in: Naumann, Die Völkerschlacht bei Leipzig (cf. note 46), p. 372.

53 Schuchhardt, Die Elberfelder Bilderhandschrift (cf. note 37), pp. 14–16.

54 Ludwig Wilhelm Gottlob Schlosser, Erlebnisse eines sächsischen Landpredigers in den Kriegsjahren von 1806 bis 1815, Leipzig 1846, pp. 87–89.

55 Léon Routier, Récits d'un soldat de la République et de l'Empire, Paris 2004, p. 107; Vincent Bertrand, Mémoires du Capitaine Bertrand, Angers 1909, p. 224.

56 Meißner, Leipzig 1813 (cf. note 48), pp. 61–62.

57 OeStA-KA-AFA, Carton No. 1533, 9/978a.

58 Capitaine Robinaux, Journal de route (cf. note 26), p. 155. Original text: "*Les bourgeois de cette ville, bien disposée pour les Français, nous suivaient au champ de bataille pour y ramasser nos blessés, et les soulager; je n'oublierai jamais les actes d'humanité que nous prodiguèrent les braves habitants de la ville de Chemnitz.*"

59 Cooter, Medicine and Modern Warfare (cf. note 3).

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increasingly precise standards of hygiene and ambulance supplies,[60] and by attempting to take into account the specific characteristics of the type of warfare being waged in Europe at the time (ambulance regulations of 1813 in France,[61] new regulations for Austrian hospitals in 1815).[62] However, examining military medical care "on the ground" also paints a picture of official care provision that relied heavily on makeshift solutions, on the country's resources, on housing the wounded in the homes of local people, and on the recruitment of a temporary workforce with varying qualifications to provide care. Moreover, among some surgeons, there was a certain mistrust of attempts at rationalisation, which were seen as incompatible with the realities of war, and in particular those of combat. Even amongst military surgeons, quality medical care did not necessarily mean care organised and rationalised by the state.

The conflict between Larrey and Coste and Percy regarding new regulations on stretchers and dressing stools to be provided to the Grande Armée in 1813 is particularly telling in this matter.[63] Larrey, at the time the head surgeon of the Grande Armée, had suggested new, extremely precise regulations concerning the type of supply to be sent by the authorities to the army. A report was asked by the ministry from Coste and Percy, who were the Paris-based inspectors of the military health services, regarding those proposed regulations. Their answer—which had to be requested twice, as they at first carefully avoided answering the question—is, firstly, very entertaining to read. It revealed their not-so-carefully hidden hostility towards Larrey and a very explicit expression of doubt towards the possibility of a rationalisation by the state of the military health services. They wrote:

> "The model of stretchers provided by the administrator is approved by Larrey next to his own. While the first [model] offers more advantages, as even Mr Larrey admits, it should not be forgotten that his [model] has the advantage of being less costly. But nobody ignores that precautionary stretchers, which are not constantly and conveniently where needs must; are far less frequently put to use than those that this very same need forces to obtain everywhere, at the very moment they are needed."[64]

60 SHD, GR Xr 12; Brambilla, Reglement für die Kaiserliche Königliche Feldchirurgen in Kriegszeiten (cf. note 1).

61 SHD, GR Xr 12.

62 Revidirter (cf. note 1).

63 SSA, Carton No. 10, Dossier No. 20: Note sur les brancards et les tabourets à pansements.

64 Ibid. Original text: "*Les brancards dont l'administrateur a fourni les modèles, est admis par M. Larrey en concurrence des siens. Si le premier offre plus d'avantages, de l'aveu même de M. Larrey, on ne doit pas oublier que les siens ont celui d'être moins coûteux. Mais personne n'ignore que les brancards de précaution, qui ne se trouvent pas constamment et à point nommé partout où la nécessité en demande ; sont d'un usage bien moins fréquent que ceux que cette même nécessité fait se procurer partout au moment même du besoin.*"

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A case study provides an even better understanding of the practical implications of this complex intermeshing of formal and informal modes of care. The experience of the wounded men from the Napoleonic armies housed in civilian homes in Dresden in June of 1813, which is particularly well documented, will now be further explored.

3. Dresden, 1813

In June 1813, the Napoleonic army, which had suffered huge losses of manpower during the retreat from Russia in the previous months, was made up of the survivors of this disaster, and of fresh new recruits, often quite young, conscripted quickly by the Empire. The army was not a solid fighting force: Stéphane Calvet estimates that up to 40 per cent of those new recruits fell prey to fevers before firing a single shot.[65] The youth and inexperience of those conscripted also had more psychological consequences, and the widespread nature of self-inflicted wounds to escape military service is well known for the campaign.[66] In this context, Napoleon tasked Larrey to perform one of the first known examples of medico-legal expertise on a large scale, by studying the cases of hand wounds and determining if they were voluntarily self-inflicted. The stakes were high, as Napoleon had threatened to execute the guilty. Larrey famously concluded that he could not determine guilt on an individual basis, and offered an alternative hypothesis—that of a lack of training of the recruit leading to accidental wounds—which stopped any punishment from being enacted.[67] The physician and historian Jean Marchioni has since shown that Larrey's alternative explanation did not make sense, and that he more likely than not knew it.[68]

The study into self-mutilation produced an unusually precise and well-preserved register that recorded the wounded men treated in and around Dresden in civilian homes in June 1813, and documented the diverse modes of care that they received.[69]

The register included 1,750 wounded men being taken care of in the city.[70] A csv database has been constructed from this register, allowing for some statistical

65 Stéphane Calvet, Leipzig, 1813: La guerre des peuples, Paris 2013.
66 Ibid.
67 This outcome likely satisfied Napoleon, since the scale of the problem rendered such severity unviable.
68 Jean Marchioni, Place à Monsieur Larrey chirurgien de la garde impériale, Paris 2003, pp. 390–416.
69 HStA, Dresden, 10036 – Finanzarchiv Loc. 35083, Rep. 54b, No. 0146 A and b Begutachtung der in Privatwohnungen untergebrachten Verwundeten der französischen Armee.
70 Approximately the same number were also treated in the surrounding villages.

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information regarding these wounded men. Each group of fifty houses was inspected by a civil servant from the Saxon court, who was often, although not always, accompanied by a physician or surgeon. This mode of control already shows the involvement of civilian authorities in the care of wounded soldiers. All those soldiers were housed in civilian homes, but their mode of accommodation varied. The average number of injured people housed per house was six, which is a large number, although there may be several dwellings per house, as these were sometimes multi-storey buildings. This average, however, covers important disparities, the median being two persons, and the maximum number of persons housed at the same address being 74. The latter number shows that at this stage, the distinction between home and hospital accommodation was partly blurred. The 1,750 cases presented here, however, include both injured people housed in the Dresden Altstadt and those housed in the Neustadt district. Their situation was quite different. In the Altstadt, the average number of wounded per house was slightly above two, with the most populated house housing 27 people. In the Neustadt, the average number of injuries per house was 13, the maximum was 74, and the median was 15. That is, 1,497 injured, or 85.5 per cent of the total, in the Neustadt. This difference in housing conditions was largely a difference in rank: those with the highest ranks were more likely to be in the city centre than others. This is particularly visible in the graph below which shows the housing district by rank level. While 93 per cent of the ordinary soldiers were housed in the Neustadt, 98 per cent of the officers were housed in the city centre. The proportion is reversed. The vast majority of officers were housed in the old town, in accommodations where they were often alone, while most ordinary soldiers were housed in the suburbs, in accommodations where the average occupancy was around 13 people and the median was 15. These housing arrangements, which can be read in this database, are consistent with the descriptions of other towns and villages in memoirs. Thus, about Quasnitz near Leipzig in October 1813, master tailor Johann Gottlob Oertel wrote: "That night, I also had to take in twelve wounded Prussian soldiers from the Landwehr in my house, it was the same everywhere in our village."[71]

This difference in accommodations also shows a contrast in the degree of civilian participation in providing care, which was also likely to be mediated by class differences. While housing an officer was a relatively low imposition, that might even be desired by a well-off family as a safeguard against other modes of war depredations, the establishment of quasi hospitals further away from the city

71 Johann Gottlob Oertel, Lützschena, Hänichen und Quasnitz. von Schneidermeisster und Auszügler Johann Gottlob Oertel in Quasnitz, in: Naumann, Die Völkerschlacht bei Leipzig (cf. note 45), p. 301. Original text: "*In dieser Nacht hatte auch ich, wie überall in unsern Dörfern dergleichen aufgenommen werden mussten, zwölf blessierte preußische Landwehrmänner in meinem Hause.*"

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centre appears to be a more direct expression of the power of the Napoleonic army over the civilian population. There does not appear, at first glance, to be any form of informal action taken by civilians in this particular context, although a closer look at the source reveals a more nuanced reality.

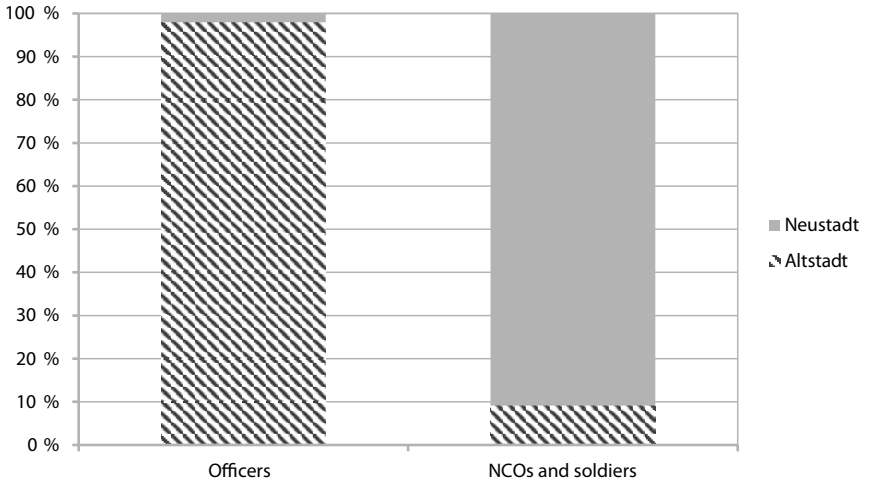

Fig. 1: Housing of lightly wounded and convalescing soldiers in Dresden in June 1813. Source: HStA, Dresden, 10036-Finanzarchiv Loc. 35083, Rep. 54b, No. 0146 A and b Begutachtung der in Privatwohnungen untergebrachten Verwundeten der französischen Armee.

This is visible in the variety of medical care those wounded men received. While some of these men were close to being fully healed, others required extensive and long-term medical care, leading to the question of how they went about getting access to it.

The database on the wounded of Dresden in June 1813 provides some information on this question, but with limitations.[72] Indeed, the information concerning the methods of care received was filled in very unevenly by the Saxon commissioners who had visited the houses where the wounded received care. The information was not explicitly required by the form that the commissioners had to fill out, and when this information was provided, it was in the 'observations' section, which contained a wide variety of other information. Of the 1,750 cases, care was explicitly mentioned only 60 times, and of those 60 cases, only 39 included details of how the care was accessed. This represents 2.2 per cent of cases only, and so is far too few to draw any conclusions about the frequency of this or that mode of access to care. It is enough, however, to note the variety of this care. Wounded soldiers staying with local people could be treated by the 'regimental

72 Built from the information in HStA, Dresden, 10036 (cf. note 68).

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surgeon' or, more generally, by a 'French surgeon', who came to see them at home. The wounded could go to the hospital every day to be bandaged by the military medical staff. In these cases, civilians were only involved in housing the wounded, and this could still be qualified as a formal mode of care. The treatment could also be given by a 'civilian surgeon' and it was sometimes specified that he was "paid by the wounded". Finally, in a number of cases it is specified that the wounded "bandage themselves". Here the role of soldiers in organising their own care is visible, as well as the close interaction of civilians and soldiers in the context of medical care.

Among the wounded for whom the method of care is not recorded, it is quite possible that some of them did not receive any care at all. For example, Commissar Charles de Spilner stated, with regard to house group 101–150 in the Altstadt, that "all the wounded were regularly bandaged", but he and his colleagues also regularly wrote notes such as "for four days not bandaged". This provoked criticism by the inspectors of the conditions in which the wounded were treated showing another mode of implication of civilian society. Finally, frequent mention was made in the register of soldiers who were not wounded at all, or were wounded but were healed completely, and yet refrained from going back to their regiments. Some wounded soldiers also had no official billeting order and were living in civilians' home under informal—and somewhat unclear—circumstances. Thus, the complexity of interactions between formal and informal modes of care which coexisted in the same city is here quite visible, and the quality of medical care implicates the constant co-occurrence of these different modes of care.

4. Conclusion

This paper has been concerned with examining the complex interactions between formal and informal modes of care as well as between state and non-state actors and the military and civilian populations in the treatment of wounded men during the Napoleonic Wars. Civilians participated in every step of the wounded men's journey from preparations of the battle—by furnishing bandages and charpie—to the housing of convalescent men, including a frequent presence on the battlefield itself. They were engaged in both formal modes of care—pressed, requisitioned, and billeted into contributing to the treatment of wounded men—and informal ones, which included voluntary action that often qualified as charity and lucrative enterprises of private hospitals.

The central point is that formal and informal modes of care were not separated nor were they always clearly distinguishable. While a movement towards further state control of military medicine can certainly be identified during these wars,

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its reach should not be overestimated, and it is not without its doubters even amongst military surgeons. During these campaigns, military health services only worked within the larger background of networks of care based both in the interactions between soldiers and the local civilian population. This is also visible in the representations of the quality of medical care, which included, from surgeons as well as patients and even military authorities, non-state-run modes of care. This produced medical spaces outside strictly formal settings, in civilians' homes, which, while still often (though not always) involved state actors, blurred the lines between the military and civilian worlds. These spaces were the *loci* of encounters between soldiers and civilians, extending the reach of the Napoleonic Wars sometimes far beyond the front lines or evacuations routes. This development could be further studied by paying close attention to the care given to sick soldiers and the consequence of epidemic diseases in broadening the reach of war in the civilian world.

This observation tells us something about the relationship between the state and non-state structures at a time when the state was in the process of being expanded, and about the state itself. We should not overestimate its power and efficiency, and ought to take into account other existing modes of functioning, without dismissing them to the margins (which would be anachronistic). The presence of informal modes of care, and their importance, shows the limits of the Napoleonic state's reach, whether in terms of its authority, personnel, or even the ability to reliably obtain information concerning wounded soldiers. It is also important to observe the way in which non-state and state actors interacted without casting these two elements as artificially separate spheres.

Furthermore, this essay offers a degree of nuance to the theme of the militarisation of medicine and medicalisation of war. While much research has been dedicated to these major phenomena, focusing mainly on the relationships between soldiers, medicine, and the state, less attention has been given to the role of civilians in these interactions.[73] The role of civilians in military medical care, although it did not run counter to state policies, and was even used by it, should be taken into account, well into the nineteenth century.

This observation also opens further fields of research as to the question of voluntary help offered to wounded soldiers in war. While coercion and the threat or reality of violence was far from absent from the help provided by civilians to wounded soldiers, frequent references were also made to charity, and to the social networks established before or during the war as motivations of care. The massification of conflicts during the Napoleonic era, however, also raises the question of help provided by ordinary people to complete strangers, and the recognition of their common humanity as people capable of suffering. Further re-

73 Cooter, Medicine and Modern Warfare (cf. note 3).

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search would be required to better integrate these events and reflection towards the early history of battlefield humanitarianism.[74]

74 John F. Hutchinson, Champions of Charity: War and the Rise of the Red Cross, Boulder 1997.

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Modes of Professionalisation

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Vojtěch Szajkó

The Professionalisation of Military Physicians in the Habsburg Monarchy, Prussia, and the Ottoman Empire (1660–1830)

The history of military healthcare is located on the border between military history and the history of science and technology. Over the past quarter century, modern military historians have acknowledged the significance of health and medicine in war, particularly following the publication of John Keegan's book *The Face of Battle: A Study of Agincourt, Waterloo and the Somme (1976)*. Health and medicine in warfare began to be explored from the perspective of combat experience and their contribution to military efficiency. By contrast, historians of medicine, apart from a few exceptions, have been reticent to deal with military topics, which are regarded as unfashionable and somewhat reactionary. Many historians of medicine seem to think that war is something exceptional, or else outside ordinary human experience. Historians of science have so far been remarkably reticent about discussing war. The reason for this lies, apparently, in the extensive contribution of science and technology to human slaughter. Although many intellectuals have spoken about the ways in which military metaphors have shaped the perception of reality, historians of science still look at the military affairs in general as something "vulgar".[1] For them, war is just organised violence, which may be conducted differently, according to different technologies, but its meaning (if it has any) is regarded (or rather disregarded) as uncomplicated and not important.

Thus, for many scholars, the problem of how to conceptualise the relationship between war and medicine remains unsolved.[2] One attempt to conceive of the

1 For example: Susan Sontag, Illness as Metaphor and AIDS and Its Metaphors, New York 1978; Scott L. Montgomery, Codes and Combat in Biomedical Discourse, in: Science as Culture 2, 3 (1991), pp. 341–390; Emily Martin, Flexible Bodies: Tracking Immunity in American Culture-from the Days of Polio to the Age of AIDS, Boston 1994.

2 Mark Harrison, Medicine and the Management of Modern Warfare: an Introduction, in: Roger Cooter et al. (eds.), War, Medicine and Modernity, 1860–1945, 1999, pp. 1–27, here pp. 1–7; cf. Mark Harrison, Medicine and the Management of Modern Warfare, in: History of Science 34, 4 (1996), pp. 379–410, here pp. 379–380.

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relationship was put forward by historian Roger Cooter.[3] Roughly twenty-five years ago, he developed an interesting discussion on the medicalisation of warfare and militarisation of medicine. By 'medicalisation', he meant the gradual extension of medical authority into new areas such as discipline and administration, together with the growing authority of physicians in the planning and leadership of military operations. Medicalisation was a complex of interconnected changes undergone by the armed forces of most industrialised countries from the middle of the nineteenth century. For Cooter, militarisation implied the adaptation of medicine to the needs of the military. Sometimes, it applied only to certain countries, especially Prussia or later imperial Germany, in which the military exercised an overwhelming political influence.[4]

The history of military healthcare is also bound up with a large literature on questions of professionalisation and institutionalisation.[5] This chapter situates the professionalisation and institutionalisation of military physicians within a long series of changes in European armies from 1500 to 1800, what we might call modernisation. Taking into account the approaches of the "new military history", the professionalisation and institutionalisation of military physicians in the Habsburg Monarchy, Prussia, and the Ottoman Empire are used as a lens through which the socio-cultural context of war is examined.[6] These polities were

3 Roger Cooter, Discourses on War, in: Studies in History and Philosophy of Science 26, 4 (1995), pp. 637–647, here pp. 637–638.

4 Harrison, Medicine and the Management of Modern Warfare: an Introduction (cf. note 2), p. 4.

5 In the second half of the twentieth century, the professionalisation and institutionalisation of military physicians across the armies of different states were described, for example, by Jean-Baptiste-Eugène Rieux, Joseph Hassenforder, Centenaire de l'École d'Application du Service de Santé et du Val-de-Grâce, Paris 1951; Friedrich Ring, Zur Geschichte der Militärmedizin in Deutschland, Berlin 1962; Heinz Müller-Dietz, Der russische Militärarzt im 18. Jahrhundert, Berlin 1970; Neil Cantlie, A History of the Army Medical Department, 2 vols., Edinburgh 1974; Rose C. Engelman, Robert J. T. Joy, Two Hundred Years of Military Medicine, Maryland 1975; Nelson D. Lankford, Status, Professionalism and Bureaucracy: The Surgeon in the British Army, 1860–1914, Indiana, Diss. 1976; Nelson D. Lankford, The Victorian Medical Profession and Military Practice: Army Doctors and National Origins, in: Bulletin of the History of Medicine 54, 4 (1980), pp. 511–528; John Shepherd, The Crimean Doctors: A History of the British Medical Services in the Crimean War, 2 vols., Liverpool 1991; Richard A. Gabriel, Karen S. Metz, A History of Military Medicine, 2 vols., New York et al. 1992; John S. Haller, Farmcarts to Fords: A History of the Military Ambulance, 1790–1925, Carbondale 1992; Harold D. Langley, A History of Medicine in the Early U. S. Navy, Baltimore, London 1995.

6 New Military History resulted from a revival of the research interest in military history that has sprung up worldwide approximately in the last third of the twentieth century. Since then, there have been a growing number of papers that are more in line with modern trends in contemporary historiography. Military history is thus interpreted within the context of the history of society, culture, thought, economy, science, and technology, etc. It has brought about a rethinking of military history. Cf. Ivan Šedivý, Fenomén moderní války [The Phenomenon of Modern War], in: Jana Čechurová, Jan Randák (eds.), Základní problémy studia moderních a

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selected for analysis because they had the same type of government (absolute monarchy) and different cultural, especially religious traditions: a preponderance of Roman Catholics in the Habsburg, of Protestants in the Prussian, and of Muslims in the Ottoman sphere. A comparison of how armed forces' medical practitioners and the quality of military medicine changed over the early modern era in these empires permits new insight into a key question raised by Cooter's pioneering work: Who benefited from medicine in war? Was it primarily the ruling and military elites who concluded that, for demographic and economic reasons, it was impossible to wage war with immeasurable loss of life? Or rather, was it the rank and file soldiers whose chances of survival were greatly improved with the arrival of professional military physicians—whether or not they were actually conscious of this fact? Could it be that military physicians themselves used the professionalisation and institutionalisation of their occupation in a purely pragmatic effort to equal their civilian counterparts in terms of education and social standing?

1. Military Medical Staff and Military Medicine

Individuals working in military medicine were always faced with challenges related to combat (movement, locating the injured, massive influx of injured soldiers, lack of time and material, specific injuries), geography (specific climatic conditions depending on where the army was deployed, favourable to the spread of diseases), and hygiene and epidemiological conditions (epidemics due to high concentrations of people in confined spaces and high mobility causing more death than actual combat). Medical personnel, who had at a certain point become a direct part of military organisations, had to work with precision and had to be able to coordinate their activities with the needs of the army. However, efforts to provide medical care to any soldier were constantly confronted with military and organisational constraints as well as scientific and technical limitations. Army surgeons came to value practical knowledge of anatomy more than the theoretical reflections of their university peers.[7]

War surgery, now simply one of the many branches of military medicine, is one of the oldest medical fields. Even during the Napoleonic Wars, war surgery and military medicine were largely synonymous and easily interchangeable, as most interventions performed by military physicians were of a surgical nature.

soudobých dějin [Basic Problems in the Study of Modern and Contemporary History], Prague 2014, p. 687.

7 Leo Klein, Alexander Ferko, Charakteristika a perspektivy oboru válečné chirurgie [Characteristics and Perspectives of War Surgery as a Branch of Medicine], in: Vojenské zdravotnické listy 74, 5/6 (2005), pp. 151–154, here pp. 151–152.

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Specific wounds, a mass influx of the injured and insufficient time for careful diagnosis and treatment, combined with a high risk of secondary complications, played in favour of radical surgical solutions (such as amputation or exarticulation).[8] In its modern form, military medicine is defined as the sum of knowledge, practical skills, and abilities related to medical care in emergency or wartime conditions. It also includes knowledge of what roles and capacities armies have, as well as how their activities are coordinated with those of other organisations. Military medicine differs from regular medicine in that military physicians work under highly specific conditions and in other special circumstances. Their primary task is, and always has been, to provide medical care to people wounded in war with the aim of reducing soldier mortality and invalidity so that as many of them as possible are able to return to civilian life or military service.[9]

The division of medicine into internal and external, established in the Middle Ages and the early modern period, was also reflected in military medicine. Doctors of medicine, graduates of medical schools at universities, practised internal medicine. These individuals were called "physicians" and enjoyed immense prestige. External medicine, on the other hand, focused primarily on surgical interventions (bloodletting, resetting of broken bones, extraction of boils and ulcers) and gradually became the domain of barbers, blacksmiths, etc. External medicine was seen as a second-rate part of medicine, performed mainly within a guild system by barbers, who started to call themselves surgeons or barber-surgeons. Surgeries and other medical treatments provided them with an additional source of income on top of their primary occupation. While internal medicine proceeded in a more cautious way, often through specific dietetics,[10] the interventions of a surgeon or a barber-surgeon were often more radical. However, the two professions tended to collaborate when faced with a bedridden patient.[11]

The distinction between physicians, on the one hand, and surgeons and barber-surgeons, on the other, extended to European armies, too. While social elites had their own physicians, soldiers were treated by surgeons and barber-surgeons who were engaged by armies only during military campaigns. Practitioners of external medicine were considered second-rate professionals even in

8 Exarticulation is the removal of a limb through a joint, i. e., without cutting the bone as in an amputation. See Martin Vokurka et al., Velký lékařský slovník [The Large Medical Dictionary], Prague 2015, p. 287.

9 Joseph Palma, Certification in Military Medicine, in: Military Medicine 168, Supplement 1 (2003), pp. 59–65, here p. 61.

10 Dietetics is the science of correct and suitable nutrition. M. Vokurka, J. Hugo et al., Velký lékařský slovník, p. 217.

11 Lutz Tallot, O felčarovi [About a Feldsher], in: Měsíčník Ciba 1, 3 (1934), pp. 69–70.

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armies, although military medicine made the greatest progress in terms of surgery (driven by the mass deployment of firearms). Due to the low status of surgeons and barber-surgeons, the profession tended to attract adventurers and dubious characters without the necessary qualifications. Over time, they earned the name of sawbones or feldsher which carried negative, even pejorative connotations.[12] While university-educated doctors of internal medicine held decision-making positions within the organisation of military medicine, there was simply not enough time for their learned disputations in wartime.[13]

The French Revolution (1789–1799) gave rise to a new type of army—a citizen army whose members respected the burden of military service but came to expect high-quality military healthcare. Heavy losses caused by advanced combat technology pushed military and political authorities to improve the quality of military medicine, as the return of soldiers from battlefields became a crucial economic factor afterwards.[14] Neither military nor medical circles could have anticipated the changes that awaited both armies and medicine in the nineteenth century. The first improvement concerned alleviating the tensions between physicians, surgeons, and feldshers, which also affected military medicine and precluded the application of the latest efficient treatments. At the turn of the eighteenth and nineteenth centuries, some military medics still did not use ligatures[15] or tourniquets,[16] making amputations—arguably the most common surgical intervention for those wounded in battle—a traumatic and risky operation. Bleeding would be stopped by pressure or cauterisation.[17]

12 The term 'feldsher' (*Feldscherer* or *Feldscheer* in German) came into use in the Swiss armed forces in the fourteenth century and derives from the German word for shearer (*Scherer*). These people also performed surgical interventions that were prohibited for university-educated physicians. They would join armies during military campaigns to cut the hair and shave the beards of soldiers as well as to perform surgeries. Cf. Ottův slovní naučný [Otto's Encyclopedia], vol. 9, Prague 1895, p. 74.

13 Tallot, O felčarovi (cf. note 11), pp. 69–70.

14 Richard A. Gabriel, Between Flash and Steel. A History of Military Medicine from the Middle Ages to the War in Afghanistan, Lincoln, NB 2016, pp. 129–131.

15 A ligature is a surgical suture tied around an anatomical structure (typically around a damaged or bleeding vessel) to prevent bleeding. The use of ligatures in amputations had already been described in detail by the French surgeon, Ambrois Paré (1510–1590). Ligatures became more widely used after the discovery of a method to stop bleeding for long enough to allow the surgeon to perform the ligature. This occurred in France in the eighteenth century after the introduction of the first efficient tourniquet. Cf. Roy Porter, Dějiny medicíny. Od starověku po současnost [History of Medicine. From Antiquity to the Present], 2nd edn., Prague 2013, pp. 216–217.

16 A tourniquet is a device for blood vessel compression in order to stop the flow of blood. Porter, Dějiny medicíny (cf. note 15), p. 53.

17 Cauterisation was used to stop bleeding during amputations. The surgeon would use a heated metal device and apply it to the bleeding tissue. See Gabriel (cf. note 14), pp. 51–52, 77 and 132.

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In the course of the nineteenth century, cosmological theorising in medical science was finally defeated by the principle of empirical observation. Doctors embraced modern methodological procedures, rejected outdated theories of disease, and defined the requirements for the proof of new medical findings, thus laying the groundwork for modern science-based medicine, which military physicians were able to transfer to the army context. Only a handful of armies entered the nineteenth century with a systematised medical service, but most large armies could boast of this innovation by the end of it. In most cases, medical services took the form of independent medical units capable of taking care of large numbers of injured and sick patients. The impetus for this progressive change was wars waged with the most efficient weapons brought about by the industrial revolution and scientific and technological progress.[18]

During the eighteenth and early nineteenth centuries, at least in European armed forces, medical officers started to play an increasing role in the maintenance of discipline and morale. The regimental military officer closely monitored the mental and physical health of the men in his unit and was the principal intermediary of propaganda in matters of health and morals. Hygienic rituals (such as adherence to personal hygiene or maintaining cleanliness in the military quarters), themselves, formed part of the new forms of discipline.[19]

However, it took armies and military medicine a long time to reach the state described in previous paragraphs, which included professional military physicians and the institutions that provided them with a relevant education. The process of professionalisation and institutionalisation of the military physician as an occupation took place in many countries at the end of the early modern period (approximately in the eighteenth century), and its national variations share certain characteristic traits and tendencies that shall be explored in more detail with examples from the Habsburg Monarchy, Prussia, and the Ottoman Empire.

2. The Habsburg Monarchy

The first voices calling for a regular field medical service were not heard in the Habsburg Monarchy until towards the end of the seventeenth century. They were usually an extension of the pragmatic thinking of military leaders and all the other members of the Habsburg court who had to deal with the army. These people increasingly realised that a renewal of the army's fighting potential

18 Gabriel (cf. note 14), pp. 129–131.

19 One of the most important tasks of medical officer's work was detecting malingering men. Harrison, Medicine and the Management (cf. note 2), p. 3.

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through military medicine was cheaper and easier than the recruitment of fresh forces. However, it is far too early to talk about a professionalisation of military medicine at this point. The only moment that brought an improvement in the standing of military medical personnel was a special clause in agreements on prisoner exchange.[20] For example, the treaty concluded between the Holy Roman Emperor Leopold I and French king Louis XIV in Basel in 1692 stipulated that "physicians, pharmacists and barbers caring for the sick and injured in the army or hospitals" must not be considered prisoners of war and must be released unharmed if taken prisoner by the enemy. Prince Eugene of Savoy (1663–1736), a field marshal in the service of the Habsburgs famous for his many victories against the Turks and the French, correctly grasped the importance of having a regular field medical service, and set about introducing it in his armies. Prince Eugene created organisational statutes for the medical service, but its activities remained highly inefficient due to a lack of necessary material and properly trained personnel.[21]

More significant changes in military medicine in the Habsburg Monarchy came with the reforms of Maria Theresa and Joseph II, implemented in 1740–1790 as part of their "enlightened absolutism". In the eyes of these Habsburg rulers, military medicine had to be subjected to state regulation. Targeted, top-down reforms were meant to introduce order in this area of activity, while improving the expertise of medical and surgical personnel. Unqualified feldshers were to be booted out of the army. In addition to empathy and compassion for wounded and sick soldiers, felt in particular by Joseph II, who had personal experience with military campaigns in the War of the Bavarian Succession (1778–1779), the main motivations for these reforms were purely pragmatic: the armed conflicts, strategy, and tactics of the time created pressure to maintain the highest number of men possible in battleworthy condition.[22]

Maria Theresa entrusted the reorganisation of the healthcare system (including military medicine) in all her territories to the Dutch physician, Gerard van Swieten (1700–1772).[23] His task was to improve the education of army

20 Leopold Schönbauer, Das österreichische Militärsanitätswesen, Vienna 1948, pp. 9–10.

21 Daniela Claudia Angetter, Krieg als Vater der Medizin. Kriege und ihre Auswirkungen auf den medizinischen Fortschritt anhand der 2000-jähriger Geschichte Österreichs, Vienna 2004, pp. 18–19.

22 'Battleworthy' is a term used for the part of an army left once military operational losses, including all soldiers incapable (even temporarily) of battle, have been accounted for. Military operational losses include killed soldiers as well as men that are wounded, sick, missing, or taken prisoner. See Boris Cezarevič Urlanis, Války a evropské obyvatelstvo [Wars and the European Population], Prague 1963, p. 17.

23 Van Swieten is credited with improving the quality of physician education in general. He reintroduced clinical training to education and laid the foundation for the "Vienna School of

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physicians and feldshers and thus elevate the prestige of these occupations. In 1746, the Habsburg ruler put all military physicians and feldshers, as well as the provision of medicines, under the supervision of an "imperial protomedic" (*Protomedicus*).[24] This position would, naturally, be assumed by van Swieten, who was well aware of the deficient professionalism of the Habsburg army's medical cadre, as illustrated by his lapidary statement that "more soldiers have been killed by awful feldshers than by the ravages of disease". Indeed, medical interventions such as bloodletting could have also been prescribed by commanding officers, that is, people without any medical education whatsoever. Officers of the imperial army would sometimes even appoint their servants to provide medical services as feldshers, occasionally promoting them to regimental surgeons. The Habsburg army also recruited feldshers in France.[25] By requiring each regiment to have a regimental feldsher (*Regimentsfeldscher*) and a sub-feldsher (*Unterfeldscher*), Maria Theresa managed to tie medical personnel directly to regiments and companies, which had been a problem up until then because physicians and feldshers would move around the army as they pleased, neglecting their official duties.[26]

In 1750, van Swieten initiated another important change, namely that all physicians and feldshers who wished to work in the army had to sit an exam at the Medical School of the University of Vienna. At the same time, no sub-feldsher could be accepted into the army and assigned to a regiment without graduating from a special school set up in the capital of the Habsburg Monarchy and headed by Professor Franz Joseph Jaus (1696–1761).[27] If commissioned officers were dissatisfied with their appointed feldsher, they had the right to send him back to Vienna, where he would be tested by van Swieten himself. In 1752, the Habsburg army dropped the word 'feldsher' altogether, replacing it with the term 'surgeon' (*Chirurgus*).[28] This was probably part of wider preparations for the standing army

Medicine". Werner E. Gerabek, Swieten, Gerard van, in: Neue Deutsche Biographie, vol. 25, Berlin 2013, pp. 729–730.

24 An imperial *Protomedicus* was the highest-ranking physician in the Habsburg Monarchy. The position, which carried the title, "k. k. Hofrat", was usually held by the monarch's personal physician. Rudolf Bruppacher, Militärmedizin in der Aufklärung, Zürich, Diss. 1967, pp. 31–32.

25 Schönbauer, Militärsanitätswesen (cf. note 20), pp. 11–12.

26 Christopher Duffy, The Army of Maria Theresa: The Armed Forces of Imperial Austria, 1740–1780, New York 1977, p. 132.

27 Elisabeth Herrmann, Beiträge zur Geschichte des Lehrkörpers der medizinischen Fakultät der Universität Wien im 18. Jahrhundert, Vienna, Diss. 1981, pp. 63–65.

28 František Dohnal, Karel Král, Vybrané kapitoly z vojenské historie pro příslušníky zdravotnické služby [Selected chapters from The History of Military Medicine for Members of the Medical Service], 1. díl [1st part], Brno 2008, p. 22.

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and permanent reserves in the Habsburg Monarchy in 1753.[29] In addition to surgeons—who were specialised in external medicine—the army also had a smaller number of university-educated physicians, known as field medics (*Feld-Medici*), who specialised in internal medicine. However, the Habsburg army did not have any independent medical units until 1799, so physicians, surgeons, and the means of transport were divided among troop formations.[30]

The institutionalisation of the profession of military physician took another step forward in 1768, after Maria Theresa founded the first educational institute for military medicine in the Habsburg Monarchy in Brussels. But this school never established itself as an important institution. Its growth was hampered by the small number of graduates and its narrow geographical scope of activity. Students always consisted of only one sub-surgeon (*Unterchirurg*) from each regiment of the imperial army deployed in the Habsburg Netherlands. A much more important development was the establishment of a garrison hospital in Gumpendorf (now part of Vienna) in 1770, which was the first permanent military hospital in the Danubian monarchy. Furthermore, the hospital also set up an educational institute devoted to internal and military medicine (*Lehranstalt für die Behandlung der inneren Krankheiten und zur Erlernung der Militär-Arzneimittellehre*) in 1775, which organised six-month training courses for regimental surgeons (*Regimentschirurgen*). In the early 1770s, van Swieten's pupil and successor as Maria Theresa's personal physician, Anton von Ströck (1731–1803), became the driving force of military medicine reforms. Among Ströck's successes, we may number the foundation of the education institution at the Gumpendorf garrison hospital and a decision made by the Aulic War Council (*Hofkriegsrat*) in 1776 requiring that the medical corps of the imperial army only accept qualified doctors with degrees in medicine or surgery.[31]

The physicians and surgeons of the imperial army were subject to subordination with all the consequences that came with it. Their commanding officers were soldiers. Maria Theresa succeeded in exempting both of the medical professions from physical punishment, which before that had included caning for high patient mortality rates. However, the overall prestige of military physicians did not improve and nor did their financial remuneration or status within the army. The promotion of staff surgeons (*Stabschirurgen*) to the rank of captain (*Hauptmann*) and regimental surgeons to the rank of lieutenant in 1754 remained, for a long time, the only significant improvement in the standing of medical personnel within the imperial army. While these two types of surgeons

29 Military service was voluntary in the Habsburg Monarchy until 1773, when a conscription system was introduced.

30 Bruppacher, Militärmedizin (cf. note 24), p. 31.

31 Herbert Hirt, Die historische Entwicklung der Sanitätsschulen Österreichs, Teil 1: Von den Anfängen bis 1938 und die Übernahme in die Deutsche Wehrmacht, Vienna 1986, p. 10.

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were promoted to lower officer ranks, other medical personnel were, at best, given non-commissioned officer grades.[32] Maria Theresa's reforms implemented by van Swieten simply failed to go far enough to radically change the profession, but it can still be concluded that in the period, approximately 1746–1776, the Habsburg Monarchy and its army initiated a process of professionalisation and institutionalisation of military medicine that would be continued during the independent reign of Joseph II (1780–1790).[33]

In 1781, Joseph II managed to transform the military medicine education institute at the Gumpendorf garrison hospital into a Military Surgery Academy, offering a two-year course focused on anatomy, medicine, and surgery. The Academy was set up to achieve two effects: (1) provide uniform-quality and professionally trained medical and surgical staff to all types of imperial forces; (2) support higher medical education in the field of surgery, thus fostering progress in this field.[34] However, the most important decision made by Joseph II in the area of military medicine was the foundation of the Josephinian Military Academy of Surgery in Vienna for the training of military physicians. The institution, also known as the *Josephinum,*[35] was the fruit of the initiative of Joseph II's personal doctor, the Italian-born Giovanni Alessandro Brambilla (1728–1800)[36] who became its first head when the institution opened in 1785. Starting in 1796, a degree from the *Josephinum* carried the same weight as a university education. In practical terms, this meant that military physicians and surgeons who graduated from the Academy were awarded the academic titles of doctor or

32 Determining the precise rank of physicians in the Austrian army is very difficult prior to 1848, when a reorganisation of military medical services greatly improved their position. Daniela Claudia Angetter, Das österreichische Militärsanitätswesen: Gestern – Heute – Morgen, Vienna, Master thesis 1993, p. 6.

33 Salomon Kirchenberger, Geschichte des k. und k. österreichisch-ungarischen Militär-Sanitätswesens, in: Paul Myrdacz (ed.), Handbuch für k. und k. Militärärzte, Bd. II/I, Vienna 1895, pp. 58 and 61.

34 Joseph II's reforms also concerned academic, clinical, and practical medicine in general. In 1783, the study of surgery was put on the same level of prestige as medical studies and graduates were who therefore were awarded the title of doctor of surgery. The Vienna General Hospital was founded a year later (1784). Cf. Schönbauer, Militärsanitätswesen (cf. note 20), pp. 11–12.

35 I refer to the institution as the *Josephinum* throughout this paper. The most recent work devoted to its history is Brigitte Lohff, Die Josephs-Akademie im Wiener Josephinum. Die medizinisch-chirurgische Militärakademie im Spannungsfeld von Wissenschaft und Politik 1785–1874, Vienna 2019.

36 G. A. Brambilla's contribution to the professionalisation of military medicine in the Habsburg Monarchy included a set of rules and instructions for the *Josephinum* teaching staff and for all medical and pharmaceutical personnel of the imperial army. According to Brambilla's regulation published in 1788–1789, the highest-ranking member of the military medical service was the protosurgeon, who was at the same time a *k. k. Hofrat*, head of *Josephinum*, and a general inspector of military hospitals. The first person to hold this position was G. A. Brambilla himself. See Kirchenberger, Geschichte (cf. note 33), p. 7.

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master. While this boosted the prestige of surgery, it also laid the foundation for a conflict with civilian medical schools, especially the one in Vienna.[37] G. A. Brambilla also convinced the Emperor to create permanent military hospitals charged with providing medical care to soldiers in both peacetime and in wartime.[38]

The *Josephinum* was the first purely military educational institution open to the general public in the Habsburg Monarchy with a direct impact on the education of army medical personnel.[39] It had an extensive library and scientific collections, including impressive anatomical models. Although its foundation as well as its scientific and teaching activities followed the ideas of science and society characteristic of the Enlightenment, the *Josephinum*, while playing a crucial role in medical reforms in the multi-ethnic Habsburg Monarchy, became the target of fierce criticism from civilian doctors who either could not stand the idea of military medicine studies being on an equal footing with medical education at civilian universities or took issue with G. A. Brambilla. Some critics completely rejected that there might be a need for a special educational institution for military physicians. After the accession of Francis II, who ordered a review of military medical care, G. A. Brambilla was sent into retirement in 1795. This, however, did not silence the critical voices, and all teaching activities at the *Josephinum* were discontinued from 1820 to 1824.[40]

Brambilla's retirement marked the end of the era of enlightened reforms in military medicine in the Habsburg Monarchy. Despite all these reforms, the quality of medical care in the imperial army was very poor and underappreciated. It tended to function better during wartime but was not sufficiently extensive.

37 A sort of prototype institution was the garrison hospital No 1 in Vienna attached to the *Josephinum*.

38 Kirchenberger, Geschichte (cf. note 33), pp. 10–15, cf. Schönbauer, Militärsanitätswesen (cf. note 20), pp. 12–15.

39 The *Josephinum* offered study in either the "long" or the "short" course. The long course took two years and was intended primarily for physicians who had served in the army for 6–8 years. Graduates received the title of master of surgery or doctor of medicine, and there was the option of sitting both exams at the same time. The short course took one semester and was intended for civilian applicants who had graduated from at least a lower grammar school. After completion of this course, they were sent to the army to serve as sub-surgeons (*Unterchirurgen*). After six to eight months of practical experience, they became eligible to sign up for the long course. Cf. Angetter, Militärsanitätswesen (cf. note 32), pp. 7–8.

40 Although the teaching at the Academy was reinstated in 1824 through the efforts of the military physician, Johann Nepomuk Isfordink (1776–1841), who reformed its study programmes, it never regained the eminence that it once held. This second period of the *Josephinum's* history ended in 1848, when the teaching was stopped again, only to be reopened once more in 1854. In this third phase, the *Josephinum* had the status of a military academy until 1874, when it was dissolved for good. See Joachim Moerchel, Das österreichische Militärsanitätswesen im Zeitalter des aufgeklärten Absolutismus, Frankfurt am Main 1984, pp. 406 and 410.

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The population had a chance to assess the level of Austrian military medicine during the Napoleonic Wars. Although care was also delegated to the general population and civilian doctors, not every soldier could be treated. Almost until the end of the Napoleonic Wars, the Austrian army did not have any special units that would provide first aid to the wounded on the battlefield and take them out of combat zones. Thorough treatment was available only behind the frontlines, but the wounded had to seek it on their own initiative during the battle.[41] The quality of the Austrian army's medical service remained rather poor in both professional and organisational terms, and there were also struggles with understaffing, insufficient means of transport, and medical supplies.[42]

The biggest success of military medicine professionalisation and institutionalisation in the Habsburg Monarchy (processes tied primarily to enlightened reforms and culminating approximately in the last third of the eighteenth century) was the creation of the *Josephinum* and the scientific and teaching achievements of this institution[43] that made it a model for military medical schools abroad, such as in Prussia. Prussia, whose rulers were among the great rivals of the Habsburgs, took the issue of military medicine in a remarkable direction.

3. Prussia

Frederick William of the House of Hohenzollern, Elector of Brandenburg and Duke of Prussia, who ruled Brandenburg-Prussia from 1640 to 1688, started to build a standing army in the 1640s. The army gradually became a hallmark of Brandenburg-Prussia. After his victory over the Swedish army at Fehrbellin on 28th June 1675, Frederick William earned the epithet "the Great Elector". The victory marked the beginning of the Prussian military tradition and also laid the foundation for an organised and state-funded system of Prussian military medicine. Up until then, military medical care had been provided privately and on a limited scale and was available not only at wartime but also during periods of peace. After the Battle of Fehrbellin, Frederick William ordered the governor of the March of Brandenburg, where the fighting took place, to organise medical care for the wounded. During the Great Elector's reign, every large town of

41 Dohnal, Král, Vybrané kapitoly z vojenské historie (cf. note 28), p. 22.

42 Tomáš Jiránek, Zdravotní poměry a zdravotní péče v armádě habsburské monarchie v dlouhém 19. století [Medical Conditions and Medical Care in the Army of the Habsburg Monarchy in the Long 19th Century], in: Theatrum historiae 2 (2007), pp. 335–336.

43 The institution's teachers and researchers included surgeons Jan Nepomuk Hunčovský (1752–1798) and František Piťha (1810–1875), ophthalmologists Friedrich Jäger von Jaxtthal (1784–1871) and Carl Stellwag von Carion (1823–1904) or gynaecologist Josef Chiari (1817–1854). See Lohff, Josephs-Akademie (cf. note 35), pp. 369–376.

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Brandenburg-Prussia started to keep a garrison medic (*Garnisonsmedicus*), who treated officers suffering from internal diseases and issued instructions during outbreaks of highly contagious diseases, but was not in touch with military units' feldshers, whose services were used mainly during field campaigns. While descriptions of the organisation of the Brandenburg-Prussian army's medical service survive in archives, there is no detailed information about the qualification requirements for people working as garrison medics and feldshers.[44]

After the creation of the Kingdom of Prussia in 1701, King Frederick I (ruling 1701–1713, previously the last Elector of Brandenburg and also the last Duke of Prussia)[45] realised that his army, consisting in 1705 of a total of 19 foot regiments and 16 mounted regiments, needed more than six regimental feldshers. This was one of the many shortcomings of the Prussian military medical service noted by the physician and former soldier, Jan Abraham de Gehema (1647–1715), a native of Danzig, who moved to Berlin in 1695. De Gehema studied medicine in Leiden in the Netherlands, and his experience of eleven field campaigns led him to the conclusion that there were three weaknesses to be eliminated: (1) Every army (consisting of 20.000–30.000 men) is often served by only one medic (*medicus*); (2) Regiments and even individual units often have many uneducated feldshers; (3) Stocks of medicine mostly include unusable medicaments. These shortcomings were gradually addressed, and De Gehema became the first reformer of Prussian military medicine. However, he failed to notice a fundamental problem: at the turn of the seventeenth and eighteenth centuries neither Brandenburg nor Prussia had a single institution devoted to the systematic education of military medical personnel.[46]

The Kingdom of Prussia only started to pay to the professionalism of military physicians the attention it deserved under Frederick William I (ruling 1713–1740), when their medical training was also institutionalised. An important step in this process was the creation, in 1716, of the post of first surgeon general[47] of the Prussian royal army, to whom all army feldshers were subordinated, and the

44 Paul Myrdacz, Das deutsche Militär-Sanitätswesen. Geschichte und gegenwärtige Gestaltung, in: Paul Myrdacz (ed.), Handbuch für k. und k. Militärärzte, vols. 2/6, Vienna 1896, p. 3.

45 Frederick I, son of Frederick William (the "Great Elector"), declared himself the King in Prussia (König in Preußen) in 1701. Cf. František Stellner, Fridrich Veliký. Cesta Pruska k velmocenskému postavení [Frederick the Great. Prussia's Path to Great Power Status], Prague 1998, p. 11.

46 Myrdacz, Das deutsche Militär-Sanitätswesen (cf. note 44), p. 4.

47 The second-most-important post within the Prussian military medical hierarchy was the position of general field medic (*Generalfeldmedicus*), held by the military physician and chemist, Johann Theodor Eller (1689–1760). J. T. Eller became professor at the *Collegium medico-chirurgicum* and was the first head of the Charité Hospital. He also served as personal physician to Frederick William I and Frederick II, the Great. Cf. Manfred Stürzbecher, Eller, Johann Theodor, in: Neue Deutsche Biographie, vol. 4, Berlin 1959, p. 456.

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appointment of Ernst Konrad Holtzendorff (1688–1751) to that role.[48] He initiated the foundation of the Anatomical Theatre (*Theatrum anatomicum*) as part of the Prussian Academy of Sciences in Berlin in 1713. It was extended in 1714 to include a military and civilian hospital. Holtzendorff was also appointed personal surgeon to Frederick William I and member of the Prussian Academy of Sciences. He gained a great deal of experience as the regimental feldsher of the royal guard and went to study medicine in many countries. He was able to skilfully leverage the contacts that he had established as a courtier and during his travels abroad in the implementation of reforms of the Prussian medical services, including the study of all, including military, medicine. Holtzendorff is largely responsible for the practice of sending a Prussian army physician—at state expense—to study and gain experience abroad: in 1716–1718, three regimental feldshers studied medicine in Paris; and in 1737–1739, rank-and-file feldshers were able to acquire hands-on field experience in the Austrian and Russian imperial armies during their campaigns against the Ottoman Empire. Holtzendorff was also behind a much more important event in 1724, when Frederick William I authorised the foundation of an institution called *Collegium medico-chirurgicum* in Berlin.[49]

It was an educational institute providing initial and further training for medical personnel of the Prussian army. The school had eight experienced army feldshers teaching all branches of medicine and surgery and was linked to the aforementioned Anatomical Theatre. Holtzendorff followed a simple postulate: the positions of feldsher in the Prussian army were filled by barber-surgeons and barbers, who had to prove that they were trained in the discipline. Unfortunately, not all of them fulfilled this requirement, and it was therefore necessary to unify their education. This could only be achieved by setting up a proper training course at an institution run by the state. The above postulate concerned only theoretical training. Practical training for feldshers[50]—following another proposal by Holtzendorff—would be provided by the Charité Hospital in Berlin,

48 Hermann Frölich, Holtzendorff, Ernst Konrad, in: Allgemeine Deutsche Biographie, vol. 13, Leipzig 1881, p. 12.

49 *Collegia* had been founded in many cities across the Holy Roman Empire since the twelfth century as institutions exercising oversight over medical and pharmaceutical occupations. In general, the mission of these authorities was to promote the development of internal medicine and to improve and standardise surgical training. The Collegium medico-chirurgicum in Berlin evolved from the Collegium medicum created in the same city in 1685. See Myrdacz, Das deutsche Militär-Sanitätswesen (cf. note 44).

50 It is worth noting that in Prussia—unlike in the Habsburg Monarchy—the pejorative term 'feldsher' had not disappeared. As a result, it is impossible to define a sharp boundary between academically trained doctors and feldshers. The distinction only became clearer at the beginning of the nineteenth century.

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whose foundation in 1727 was again approved by Frederick William I.[51] Charité was a hospital focused on the training of military physicians. However, the facility provided medical care to civilians too.[52]

In the Kingdom of Prussia, the first third of the eighteenth century also brought about a resolution of the issue of central supervision of all medical care, including military medical care. From 1725 onwards, the qualification and quality of the medical and nursing occupations were supervised by the Higher College of Medicine (*Ober-Collegium medicum*),[53] later incorporated into the organisational structures of the Charité Hospital. For example, a surgeon in Prussia would need to possess an apprenticeship certificate, have served at least seven years with the master of the relevant guild or as a feldsher in the army, and have passed the examinations required by the statutes of the *Ober-Collegium medicum* to obtain a licence. Once the *Collegium medico-chirurgicum* had been established, the admission of new feldshers into the Prussian army no longer depended on the discretion of the commanders, but was regulated by a royal decree according to which each applicant first had to report to the surgeon general and then pass the required examinations at the *Collegium medico-chirurgicum*. Nevertheless, barbers without medical training still served in infantry and cavalry companies; fortunately, the scope of their activities was now limited and they were not allowed to administer medicines to patients.[54] Serious mistakes were to be prevented by a rule, applicable within the Prussian military health system until 1843 that every seriously wounded man had to be transported to the regimental feldsher, who was to be the first to assess his condition. The position of surgeon general as the head of the medical service, reporting not to the army's high command but directly to the king (to whom he also submitted an annual report on the state of military healthcare), had become established as early as the first half of the eighteenth century. A number of rules concerning medical care were included in the 1726 Prussian Infantry Regulations, which is evidence of the fact that the professionalisation of the military medical occupation in the Prussian army continued during the eighteenth century. The duties of the regimental feldsher mentioned in the Prussian Infantry Regulations include travelling to garrisons with a large number of wounded or sick, to improve their

51 This medical facility was created by converting a plague hospital from 1710.

52 Jack Edward McCallum, Military Medicine: From Ancient Times to the 21st Century, Santa Barbara 2008, pp. 149–150.

53 The High *Collegium Medicum* was chaired by the Prussian Minister of State, and its members comprised leading Prussian healthcare figures, including the surgeon general of the army.

54 Detlef Rüster, Das Berliner Collegium medico-chirurgicum. Eine Aus- und Weiterbildungsstätte des 18. Jahrhunderts, in: Zeitschrift für ärztliche Fortbildung 81 (1987), pp. 5–11.

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treatment (especially by dietary interventions) and, in the event of an outbreak of a serious disease in the garrison, to consult with the competent town physician.[55]

The reign of Frederick William I is also where the roots of the proverbial militarisation of Prussian society lie. Nicknamed "Soldier King" (*Soldatenkönig*), this Prussian ruler reformed his country's administration to limit spending and fill the coffers as much as possible. Prussia thus became a prosperous state, although most of its revenue (about 80 per cent) was invested in the army, which numbered 80,000 men and ranked first in Europe in terms of training and discipline. There is no doubt that the reforms in military healthcare were an integral part of Frederick William I's concept of the military state geared towards building a strong army.[56]

His son, Frederick II, the Great, ruling 1740–1786, built an army of 186,000 men in peacetime and 218,000 in wartime, but the provision of medical care within the army was still based on the same principles. The changes that took place in the military medical system were cosmetic and chiefly organisational. The professors of the *Collegium medico-chirurgicum*, whose numbers had increased, and the regimental feldshers would be sent to Paris for advanced training. Company surgeons were recruited from among barbers, and their training was handled by the surgeon general in cooperation with regimental feldshers. In wartime, the Prussian army recruited medical personnel from abroad, but all twelve French feldshers recruited in 1744 were discharged after a few years of service. The influx of graduates from the *Collegium medico-chirurgicum* was slow: as a result, the Prussian medical service was struggling with a shortage of physicians and feldshers during the First Silesian War (1740–1742), the Second Silesian War (1744–1745), and the Seven Years' War (1756–1763). Their numbers did not increase during the War of the Bavarian Succession (1778–1779) either. A completely new post of general staff field medic (*Generalstabsfeldmedicus*) was introduced to act as liaison to the king in the event of war and provide information about the functioning of infirmaries, and an ingenious system of military medical personnel peer testing was developed. Military medicine in Prussia also began to produce important figures, such as Johann Leberecht Schmucker (1712–1786), Johann Christian Anton Theden (1714–1797), and Johann Goercke (1750–1822). In succession, each of them occupied

55 Myrdacz, Das deutsche Militär-Sanitätswesen (cf. note 44), pp. 9–10.

56 In terms of size, the Prussian army ranked fourth in Europe during the reign of Frederick William I, but the Prussian king avoided war. It was only in 1715 that Prussia, as an ally of Russia and its coalition partners, entered the Northern War (1700–1721) against Sweden and its allies. Building a strong Prussian army was made difficult by the fact that 20 per cent of the soldiers died annually from various diseases. See Adolph Leopold Richter, Geschichte des Medicinalwesens der königlichen preussischen Armee bis zur Gegenwart, Erlangen 1860, pp. 110–111.

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the following three important posts: (1) personal physician to Frederick II; (2) surgeon general of the Prussian army, and (3) head of the Charité Hospital.[57]

Frederick William II, ruling 1786–1797, who succeeded his uncle Frederick II on the throne, was not an ardent follower of the Enlightenment (he found its ideological content as difficult to stomach as the consequences of the French Revolution), but it was during his reign that the principle of humanity, manifested in the service status of medical personnel, can be said to have penetrated the Prussian military health system. Company feldshers ceased to be obliged to tend to soldiers' hair and were exempt from corporal punishment by subaltern officers. Punitive power over the medical staff of the Prussian army was now wielded by regimental commanders, but it was limited by the fact that the surgeon general, as the person in charge of the medical service, was now directly responsible to the king.[58]

In 1795, the aforementioned Johann Goercke played an extremely important role as the founder and first head of the Pépinière, a specialised and completely independent Prussian institution for the training of military physicians based in Berlin. Goercke was able to draw lessons from the Battle of Valmy (20th September 1792),[59] in which the French revolutionary army defeated the Prussians, who also failed in terms of the provision of medical care. The Pépinière soon established itself as a successful educational institution and in 1818, was named the Friedrich Wilhelm Institute of Medicine and Surgery (*Medicinisch-chirurgisches Friedrich-Wilhelms-Institut*).[60] Students at the Pépinière were gaining practical experience at the Charité Hospital. In the meantime, however, the importance of the *Collegium medico-chirurgicium* had declined and it was dissolved in 1809. Its library was taken over by the Pépinière, and the teaching of military medicine, including practical training carried out at the Charité, was transferred in 1811 to the Medical and Surgical Academy of the Army (*Medizinisch-Chirurgische Akademie für das Militär*), which was part of the Medical School of the University of Berlin founded in 1809 by King Frederick William III of Prussia (who reigned 1797–1840). The Medical School of the University of Berlin now had two surgery clinics as a result of these changes. The first served the students

57 Franz-J. Lemmens, Friedrich II. von Preußen und seine Ärzte, in: Wehrmedizinische Monatsschrift 56, 1 (2012), pp. 25–29, cf. Georg Fischer, Kriegschirurgie unter Friedrich dem Grossen, in: idem (ed.), Chirurgie vor 100 Jahren. Historische Studie über das 18. Jahrhundert aus dem Jahre 1876, Berlin et al. 1978, pp. 300–335 (reprint of the original 1st edition from the year 1876).

58 Myrdacz, Das deutsche Militär-Sanitätswesen (cf. note 44), p. 13.

59 J. Goercke travelled to a number of European countries, learning about military medical care, as well as the organisation and functioning of military medical schools. He also visited the *Josephinum* in Vienna and probably drew most inspiration from its structure. Manfred Stürzbecher, Goercke, Johann, in: Neue Deutsche Biographie, vol. 6, Berlin 1964, p. 520.

60 Myrdacz, Das deutsche Militär-Sanitätswesen (cf. note 44).

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of civilian medicine, while the second served students of military medicine. The second surgery clinic was linked to the Charité Hospital, where physicians and surgeons worked not together but separately, and a distinction was drawn between civilian and military surgeons. There was strict demarcation between the study of civilian and military medicine at the Medical School of the University of Berlin, with education separated along this line. A notable difference was that German, and not Latin, dominated in the teaching of military medicine.[61]

As a result, a two-track system of sorts developed in the training of physicians for the Prussian army, which only disappeared in 1895 with the merger of the Friedrich Wilhelm Institute of Medicine and Surgery and the Medical and Surgical Academy of the Army into a single and purely military institution called the Kaiser Wilhelm Academy for Military Medical Education (*Kaiser-Wilhelms-Akademie für das militärärztliche Bildungswesen*).[62]

There were also frictions in Prussia between universities, which provided medical education that was mainly based on theory, and military medical academies, which focused on clinical practice. The integration of the study of military medicine into the structures of the University of Berlin was something rather unique and exceptional (also because the study of military medicine was operated autonomously), and any further attempts to link the two fields were unpopular and strongly opposed by both sides, although university representatives were the more critical. Eventually, the University of Berlin completely absorbed the Charité, which became not only a purely civilian hospital, but above all a university hospital. Today it is one of the largest university centres of medical science in Europe.[63]

Just as the Habsburg Monarchy, Prussia also adhered to the principle that studying at military medical academies was free of charge, or—more precisely—paid for by the state.[64] However, recruits had to serve for several years with the

61 Richter, Geschichte (cf. note 56), pp. 118–119.

62 Separate medicine courses were still held at the *Collegio medico-chirurgicum* shortly after its dissolution, as the University of Berlin did not start teaching until 1810. The University of Berlin was renamed (in honour of its founder) the Friedrich Wilhelm University in 1828 and Humboldt University after World War II. The Charité Hospital has been part of all of these universities, although it is now a joint institution of Humboldt University and the Free University of Berlin. Cf. Sandra Krämer, 300 Jahre Berliner Charité. Die Pest, die Weiße Frau und eine weitgreifende Kabinettsorder, in: Deutsches Ärzteblatt 107, 8 (2010), pp. A331–A334.

63 Krämer, 300 Jahre (cf. note 62); Myrdacz, Das deutsche Militär-Sanitätswesen (cf. note 44), p. 13.

64 In 1795, costs related to studying at the Pépinière, including accommodation, would be to a great extent borne by the state. Student families were required to purchase clothing and some teaching aids. The students, nicknamed *Pfeifhähne* (literary "whistling rooster", a German corruption of the French *pépinière*), also received armed military training with the Guards Infantry Regiment in Berlin. Among the most prominent graduates of the Friedrich Wilhelm Institute of Medicine and Surgery (which continued the tradition of the *pépinière*) was the

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army, which they joined as military physicians after graduation. For example, the graduates of the Prussian Pépinière "signed up for" eight years of army service. Their career progressed slowly. No significant improvements in the position of medical personnel in terms of rank and career occurred in European armies until 1830.[65] It is evident that a by-product of the professionalisation and institutionalisation of the military medical occupation was the easier access to education with the prospect of a better life. However, service in the army also carried many risks, first and foremost the permanent risk of the outbreak of war with all its negative consequences and the emergence of epidemics of malignant diseases within military units.

4. The Ottoman Empire

No country saw such a distinct development of military medicine and its organisation as the Ottoman Empire, and later Turkey. Nowhere else was there such a sharp contrast between, on the one hand, modern, science-based medicine, which had been spreading from Western Europe, and, on the other, the wisdom of ancient classical and Arab medical authorities (Galen, Abu Bakr al-Razi, Ibn Sina/Avicenna) as well as the religious teachings of Islam. This basic characteristic was also reflected in the Ottoman military medical sector, which showed few similarities to military medicine in Western or Central Europe. The exception was the distinction between physicians and feldshers, which the Ottoman civilian and military medicine defined in the same way. People practising the surgeon's craft were organised in guild-like organisations, and it was therefore possible to secure an apprenticeship in this field. By contrast, physicians studied in madrasas, higher Islamic religious schools, usually associated with mosques. The length of study was typically five years. This state of affairs lasted until the nineteenth century, when the Ottoman Empire underwent reforms that also affected its education system.[66]

The development of medicine in the Ottoman Empire from the late fourteenth century to the sixteenth century was also shaped by the influx of Jewish physi-

German physician and physicist, Hermann von Helmholtz (1821–1894), who served as dean of the institute from 1878 to 1879. See Peter Kolmsee, Unter dem Zeichen des Äskulap. Eine Einführung in die Geschichte des Militärsanitätswesen von den frühesten Anfängen bis zum Ende des Ersten Weltkrieges, Bonn 1997, p. 133.

65 Otto Schickert, Die militärärztlichen Bildungsanstalten von ihrer Gründung bis zur Gegenwart. Festschrift zur Feier des hundertjährigen Bestehens des Medizinisch-Chirurgischen Friedrich-Wilhelms-Instituts, Berlin 1895, pp. 32–33.

66 Emil Knorr, Entwickelung und Gestaltung des Heeres-Sanitätswesens der europäischen Staaten, Hanover 1880, pp. 786–787.

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cians from German lands, France, Italy, and Spain, who lived under the sultan's patronage in Constantinople. Perhaps the most important of these was Moses Amon (1490–1554), who served as personal physician to Sultan Suleiman I, the Magnificent (reigned 1521–1566). At the beginning of the seventeenth century, a large group of Jewish physicians were already working in the sultan's palace, some of them even attaining the title of Pasha, reserved for high government officials and military dignitaries.[67] In the Ottoman armies that threatened Southeastern, Eastern and Central Europe in the late Middle Ages and early modern period, only the Janissaries[68] had access to medical treatment, as they had their own medical corps. These corps had auxiliary unit status and included Muslim and Jewish surgeons, who accompanied the Janissaries on their campaigns and were also responsible for moving wounded and sick combatants to mobile hospitals located behind the battle lines.[69]

Most of the other units in the Ottoman army had no access to regular medical care. Military healthcare in the Ottoman Empire during the sixteenth to eighteenth centuries was primitive. This resulted in high numbers of deaths through soldiers being killed in battle or losing their lives to infectious diseases. However, the sultan did always pay attention to the welfare of his warriors, though he did so in a somewhat peculiar way compared to other European rulers: the wounded were paid a financial remittance of 40 to 50 *kuruş*—a kind of pain and suffering allowance, which in Turkish was called *merham beha*—and were expected to use it to pay for their own emergency medical or surgical treatment.[70] The families of those killed in combat were granted financial support in the form of a pension.[71]

Even at the turn of the eighteenth and nineteenth centuries, the Ottoman Empire still applied the principle that on military campaigns, regular medical treatment was only available to the Sultan (the presence of a physician depended on his own decision); later, the commanders of individual armies, who usually carried the title of grand vizier, also received it. An organised medical service, which would be an integral part of the army and provide adequate medical, or at

67 Nil Sari, Turkey and its international relations in the History of Medicine, in: Vesalius 7, 2 (2001), pp. 86–93, here p. 87.

68 The Janissaries were the elite units of the Ottoman infantry. They would be formed from the non-Muslim, Christian population of the Ottoman Empire. The Janissary corps gradually became an important political force. It was abolished by Sultan Mahmud II in 1826. See Gábor Ágoston, Firearms and Military Adaptation: The Ottomans and the European Military Revolution, 1450–1800, in: Journal of World History 25, 1 (2014), pp. 85–124, here pp. 119–120.

69 Sari, Turkey (cf. note 67).

70 Today a sub-unit of the Turkish lira, the *kuruş* was—in the last third of the seventeenth century, when its minting began—a large silver coin. Until 1844 it was the standard unit of currency in the Ottoman Empire.

71 Rhoads Murphey, Ottoman Warfare 1500–1700, London 1999, p. 130.

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least surgical, treatment to the wounded and sick existed, at most, in a very rudimentary form in the Ottoman Empire.[72]

Only in the nineteenth century did medical science in the Ottoman Empire come into closer contact with medicine in other European countries, specifically France, Italy, and Austria, with French and Italian becoming the languages, through which Ottoman physicians began to absorb modern foreign scientific knowledge. Around the second quarter of the nineteenth century, many foreign physicians were invited to come to the Ottoman Empire to teach modern medicine or practise it directly in the service of the state (e. g., at the sultan's court or in medical institutions run by the state). After the Crimean War (1853–1856), the Ottoman Empire also increased medical cooperation with the British.[73]

The first Ottoman attempts to establish a stable military healthcare system were made in the late eighteenth and early nineteenth centuries. It was then that Sultan Selim III (who reigned 1789–1807) took steps to create a new, modern army modelled on other European armies. In 1799, Selim III established the post of head of the military medical and surgical institutes (hospitals) and appointed his personal physician to it. He also increased the number of chief physicians and surgeons, and set up an infirmary under the direction of the English staff physician, Witton, in what is now northwestern Bulgaria. These processes were prompted by the war with Russia (1787–1792), in which the Habsburg Monarchy was also involved, and in particular by the beginning of the Napoleonic Wars, during which Selim III undertook a campaign in Syria in 1799. The Sultan's attempts at a reform of the army, however, ended in failure, as their implementation met with the disapproval of the Janissaries, who ultimately deposed Selim III under the pretext of protecting Islamic faith and traditions.[74]

His reform attempts, however, left their mark on Ottoman military healthcare. Selim's personal physician, Mustafa Behçet Efendi (1774–1834), initiated the establishment of a modern medical school with a hospital in Constantinople (Istanbul) in 1805,[75] which produced physicians and surgeons for the Ottoman army and navy.[76] Unfortunately, the hospital was not rebuilt after a fire in 1822.

72 Knorr, Entwickelung (cf. note 66), pp. 815–816.

73 Sari, Turkey (cf. note 67), pp. 87–88.

74 Ludwig Friedrich Ciriacy, Versuch einer militärischen Beschreibung des osmanischen Reichs in besonderer Darstellung seines Kriegswesens, und der topographisch-militairischen Beschaffenheit seiner europäischen Provinzen, Berlin 1824, pp. 84–85.

75 Mustafa Behçet Efendi became personal physician to three successive sultans: Selim II, Selim III, and Mahmud II. He studied medicine, probably in the madrasa at the Suleiman Mosque in Constantinople. He served as chief physician several times. In addition to Turkish, he had command of Arabic, Persian, English, German, and French. See Ciriacy, Versuch (cf. note 74), pp. 84–88.

76 Throughout this paper, I use the historical term 'Constantinople', as the city's name was not officially changed to Istanbul until 1930.

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The systematic professionalisation and institutionalisation of the military physician as an occupation in the Ottoman Empire can thus only be traced back to the second quarter of the nineteenth century, when it began in the context of the transformation of tertiary education. Very little is known about the qualifications required of Ottoman military medics before this period, as only general principles—such as the recommendation that physicians and surgeons should be recruited into the army services if they proved their competence and passed some kind of examination by military dignitaries—were applicable in the military medical sector. Documents showing the hierarchy of military medical personnel have also survived.[77]

It was only during the nineteenth century that medicine, including military medicine, in the Ottoman Empire abandoned its classical and Arabic foundations, and moved in a modern direction. Influences coming from the Habsburg Monarchy (later Austria), Prussia (later Germany), and France played an important role in this process, which was part of the reform efforts of Sultan Mahmud II.[78]

Three areas became the primary focus of Mahmud's reforms: medicine and health, the armed forces, and the technical sciences. Many Western physicians were invited to the Ottoman Empire to take up prestigious posts at the newly emerging medical schools and to help reform tertiary education.[79] On 14th March 1827, the Military School of Medicine (*Tıphane-i Âmire*) opened in Constantinople. Its foundation was forced on Sultan Mahmud II by the aforementioned Mustafa Behçet Efendi. It was the first medical school in the Ottoman Empire, modelled on European universities, but run by the army. The school included a modern hospital, which elevated the standard of medical care.[80] The processes of professionalisation and institutionalisation of the military physician as an occupation in the Ottoman Empire thus had a major impact on the civilian health sector. The Military School of Medicine is considered to be the direct predecessor of today's Faculty of Medicine at Istanbul University. In 1919,

77 Knorr, Entwickelung (cf. note 66), p. 816.

78 Sultan Mahmud II (who reigned from 1808 to 1839) is one of the most important figures in the modern history of the Ottoman Empire. From 1826 onwards, Mahmud II implemented major reforms in a number of sectors. The armed forces saw the foundation of the Military School of Music (1831) and the Military Academy (1834) in Constantinople. The new army was called the *Asakir-i Mansure-i Muhammediye* [The Victorious Soldiers of Muhammad]. Cf. Klaus Kreiser et al., Dějiny Turecka [History of Turkey], Prague 2010, pp. 154–157.

79 Yilmaz Bilsel et al., The Impact of Western Physicians on the Modernization of Turkish Surgery and Medicine, 1827–1936, in: World Journal of Surgery 34, 9 (2010), pp. 2240–2246, here p. 2240.

80 Hassan Kamal, Encyclopaedia of Islamic Medicine with a Greco-Roman Background, Cairo 1975, p. 305; cf. Rhoads Murphey, Ottoman medicine and transculturalism from the sixteenth through the eighteenth century, in: Bulletin of the History of Medicine 66, 3 (1992), pp. 376–403, here p. 379.

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Turkey also began celebrating National Medical Day on 14th March, which continues to this day.[81]

Teaching at the Military School of Medicine—of which Mustafa Behçet Efendi was the first head—took place based on European textbooks, with French, Italian, and Turkish as the languages of instruction. The school offered a six-year course in medicine (mostly in French) or surgery (mostly in Turkish). The students included not only Ottomans (for the most part Muslims), but also Armenians, Arab Christians, Bulgarians, and Greeks. A significant part of the teaching staff did not come from the Ottoman Empire and did not profess Islam. Just as with the Habsburg Monarchy and Prussia, the costs of studying at the school were borne by the state.[82]

In 1832, Mehmed II gave permission for the establishment of an independent School of Surgery (*Cerrahhane-i Amire*), which in 1836 merged with the Military School of Medicine to form one institution named the Medical School (*Mekteb-i Tıbbiye*), which was renamed the Imperial School of Medicine (*Mekteb-i Tıbbiye-i Şahane*) in honour of Sultan Mahmud II in 1839.[83] Throughout their existence, all these educational institutions were located in Constantinople. In 1836, as part of the merging of the schools, the education of physicians was combined with the education of surgeons. Surgery in the Ottoman Empire thus broke out of a form of guild organisation and became a full-fledged part of both military and civilian medicine.[84]

81 Nuran Yildirim, View of the History of the Istanbul Faculty of Medicine, in: Nuran Yildirim (ed.), A History of Healthcare in Istanbul, Istanbul 2010, p. 274–307, here p. 274.

82 Johann Strauss, Language and power in the late Ottoman Empire, in: Rhoads Murphey (ed.), Imperial Lineages and Legacies in the Eastern Mediterranean: Recording the imprint of Roman, Byzantine and Ottoman rule, London et al. 2017, pp. 115–142, here p. 122.

83 The Imperial Medical School was originally located in the Galatasaray district of Constantinople, but moved closer to the Golden Horn around the mid-nineteenth century. Over time, Turkish became the language of instruction, and in the 1960s, the study of Pharmacy was added. In 1898, during the reign of the last Ottoman Sultan Abdülhamid II, a completely new Gülhane Military Medical Academy (*Gülhane Askeri Tıp Akademisi*), with an associated hospital, was founded in Istanbul as a result of the German medical mission's activities in the Ottoman Empire, while the original Imperial School of Medicine merged with the civilian medical faculty in 1909. A notable scientist and teacher at these schools was the German-Austrian botanist and pharmacist, Friedrich Wilhelm Noë (1798–1858). See Yildirim, Istanbul Faculty (cf. note 81), pp. 277–280.

84 The reforms of Ottoman healthcare between 1839 and 1850 were aided by the Austrian military physicians, Jakob Anton Neuner, Karl Ambros Bernard, Lorenz Rigler, and Sigismund Spitzer, all graduates or teachers at the *Josephinum* in Vienna. See Knorr, Entwickelung (cf. note 66), p. 817.

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5. Conclusion

The efforts to institutionalise and professionalise war medicine in the Habsburg Monarchy, Prussia, and the Ottoman Empire undoubtedly brought economic, social, and demographic benefits to the rulers and military elites. While in the first two countries, these efforts were based on a thought-out calculation in the spirit of Enlightenment absolutism, in the Ottoman case, they were the result of the sultan's attempts at reform, which were a necessary prerequisite for the modernisation of the state. We should not forget, however, that an important motive for ensuring soldiers' good health was also the ruler's desire to have an instrument of power: an army that was as strong and as numerous as possible. This is clearly illustrated by the reforms of military healthcare implemented in Prussia under Frederick William I.

Thanks to the professionalisation and institutionalisation of the military physician as an occupation, the combatants now had a better chance of surviving war. However, it is questionable whether this was due to a better organisation of the medical service rather than to the development of medical science, whose progress over the period 1660–1830 certainly cannot be described as revolutionary. Professionalisation meant the emergence of a distinct professional group of qualified military physicians and surgeons, who could pursue military careers and at the same time conduct scientific activity in the field of military medicine. Institutionalisation included the establishment of military medical schools and hospitals, with these facilities then becoming enablers of the professionalisation of the military physician or surgeon as an occupation. Both processes began in Prussia with the establishment of the *Collegium medico-chirurgicum* in Berlin (1724) and continued in the Habsburg Monarchy with the opening of the *Josephinum* in Vienna (1785). The Ottoman Empire did not have its Constantinople-based Military School of Medicine until 1827. Capable physicians (G. van Swieten, G. A. Brambilla, E. K. Holtzendorff, Johann Goercke, and Mustafa Behçet Efendi) and prominent rulers (Maria Theresa, Joseph II, Frederick William I, Frederick II the Great, and Mahmud II) were instrumental in both processes. Neither professionalisation nor institutionalisation would have been successful without their contributions and involvement. Army physicians and surgeons gradually became the equals of their civilian counterparts, although—as the developments in the Habsburg Monarchy show—there were heated disputes between schools of military medicine and universities over the quality of their education. The Ottoman Empire was not affected by this problem since the modern form of education in medicine in general lacked continuity with previous developments. The divergence of the paths that professionalisation and institutionalisation followed in the European countries mentioned above and in the Ottoman Empire, which absorbed impulses from abroad, clearly

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resulted from cultural, social, religious, and geographical differences. However, in general, this implies that the professionalisation and institutionalisation of military physicians, and thus their systematic education and training, started in the eighteenth century, perhaps even slightly earlier. Both processes formed an integral part of the medicalisation of warfare and militarisation of medicine, well before the period that Professor Cooter identified as decisive.

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Brigitte Lohff

Competing Interests: The Medical-Surgical Education from 1775 to 1824 at the *Josephinum* in Vienna

The sigh of regret about the Josephs-Akademie as "an institute so offended and so completely abandoned by all its defenders" did not come just before the final closure of the Academy for the training of military physicians in 1874, but already nine years after the opening of the *Academia caes. Reg. Josephina Medico-Chirurgica* (short: *Josephs-Akademie* or Joseph's-Academy).[1] With the opening of the *Josephs-Akademie* on 7th November 1785 in the specially built world-famous Viennese *Josephinum*, the goal was to be achieved after many years of effort to impart solid basic medical knowledge to all field surgeons in the Habsburg army in the future. The fact that this hope was not fully realised can be deduced from the above-mentioned sigh expressed by Johann Adam Schmidt, Professor of Anatomy, Surgery and Ophthalmology at the Academy.[2]

This chapter deals with historical debates over how military medicine could be taught best. It analyses the emergence, the development, and the consolidation of a military medical institution, namely the *Josephinum*. The establishment of such an academic institution was eyed with suspicion in the second half of the eighteenth century, because the long-lasting differentiation between and conflicts over internal versus external medicine, scientific medicine, and the non-academic artisanal surgery, remained alive during this era. This dualism hindered the acceptance and recognition of a new military medical institution. In the following decades, the educational institution underwent various changes and reforms. This chapter focuses on these reforms, their initiators, and their motives for promoting change. These reforms formed the basis for constant criticism and rejection.

Historians have deservedly rated the Joseph's-Academy as one of the most important and earliest governmental institutions for military medical training in

1 Johann Adam Schmidt, Apologie der k.°k. Josephs-Akademie, in: Joseph Exerel, Matthias Edler von Saballa (eds.), Medicinische Chronik vols. 3, book 2, 1794, pp. 1–29, here p. 3.

2 See for biographical information on Adam Schmidt (1759–1809) Brigitte Lohff, Die Josephs-Akademie im Wiener Josephinum- die medizinisch-chirurgische Militärakademie im Spannungsfeld von Wissenschaft und Politik 1785–1874, Vienna 2019, pp. 40–42.

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the world, but the burdensome struggles of the Academy for its survival and recognition are underexplored. The present contribution will shed light on the institution's troubled beginning, and the forces which sought to undermine the existence and mission of the *Josephinum*. Despite emerging at the behest of the Sovereign, the progress of the Academy was dependent on external factors. These included serious legal hurdles to reshape and constantly improve the military surgical education, the modification of curricula as well as study programmes and degrees as a product of quality controls, and the composition of the professorial curia. A close historical re-examination of the early decades of the Joseph's-Academy highlights the resistance with which the institution was confronted in the light of traditional knowledge and already anchored scientific institutions. With this in mind, the Habsburg state's sponsor of the Academy may be viewed as progressive, even though the supporters of the Joseph's-Academy had to fight for its very existence. Additionally, this chapter takes a closer look at the original concept of regulated training for prospective military surgeons and shows that the vehement discussions that flared up about this in the 1790s ultimately contributed to the improvement of the education. It also became clear from an early stage that the institution would always confront changing demands and changing approaches to the education of military surgeons.

1. The Pioneers of the Josephs-Academy from 1775 to 1785

In the first half of the eighteenth century, there was no regulated procedure for the medical care of wounded soldiers in the Habsburg army. Surgical interventions were performed by barbers.[3] Care and nursing were mainly provided by merciful friars.[4] Before trainees, sub-surgeons, masters of surgery, and also doctors of surgery were qualified for service in the Habsburg army at the Academy, there was a precursor institution at the Gumpendorf Military Academy in Vienna. The background for the Academy in Gumpendorf, as well as for medical study in general, was the reorganisation of the entire education system by Gerard van Swieten (1700–1772) on the orders of the Habsburg ruler, Maria Theresa. This also initiated the first steps towards better medical services for

3 Cf. Michael Sachs, Geschichte der operativen Chirurgie, vol. 4: Vom Handwerk zur Wissenschaft. Die Entwicklung der Chirurgie im deutschen Sprachraum vom 16. bis zum 20. Jahrhundert, Heidelberg 2003; Georg Fischer, Chirurgie vor 100 Jahren, Leipzig 1876.

4 Carlos Watzka, Zum Süd-Nord-Wissenstransfer im Gesundheitsmanagement der frühen Neuzeit: Der Hospitalorden des heiligen Johannes von Gott (Barmherzige Brüder) und die Etablierung eines Netzwerkes von Krankenhäusern in der Habsburger Monarchie, in: Sonia Horn et al. (eds.), Wissensaustausch in der Medizin des 15.–18. Jahrhunderts, Vienna 2007, pp. 219–252.

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soldiers.[5] By the decree of Maria Theresa, it had been prescribed since 1753 that in future all those who wished to be regimental surgeons in the Habsburg army,[6] had to take the necessary surgical examinations with the first imperial *Protomedicus*.[7] Initially this meant examinations with Gerard van Swieten.[8]

A decisive improvement in military surgical education also took place in 1775 when the Viennese Gumpendorf Garrison Hospital[9] was opened as a *Lehranstalt für die Behandlung der inneren Krankheiten und zum Erlernen der Militär-Arzneimittel*.[10] This building had been acquired by Maria Theresa in 1754 for the military education of the aspirants of the *Genieschule* (Engineering school; from 1760, renamed military academy). The former monastery on this site was transformed into a hospital for soldiers. With the expansion of the Engineering school, parts of the former buildings became available and, based on an expert opinion by the *Protomedicus* Anton von Stoerck (1731–1803), the surgical training school for regimental surgeons was established there.[11] After only a few years, an extension was built to add a separate school building. This building housed a library, lecture halls, and a room for surgical instruments, bandages, and apparatuses in order to provide the necessary demonstration material for the teaching unit, "Bandages and Instruments".[12] After the renaming of this institution in 1781 to the *Chirurgische Schule für Feldärzte*, plans were already in progress for a separate edifice for the students of military surgeons,[13] and as early as 1st October 1785, the staff and the pupils could move from the Gumpendorf School to the Vienna *Josephinum*. Thus, within ten years, a small educational

5 Cf. Theodor Puschmann, Die Medizin in Wien während der letzten 100 Jahre, Vienna 1884; Brigitte Lohff, Gedanken zum Begriff 'Wiener Medizinische Schule', in: Daniela Angetter et al. (eds.), Strukturen und Netzwerke – Medizin und Wissenschaft in Wien 1848–1955 [650 Jahre Universität Wien – Aufbruch ins neue Jahrhundert], Vienna 2018, pp. 41–72.

6 Joseph Kallbrunner, Aktenstücke zur Geschichte der Sanitätshofdeputation 1753–1776, in: Die österreichische Zentralverwaltung, Vienna 1925, p. 376.

7 A *Protomedicus* was the first/superior medical representative of the state. Mostly he was also the personal physician of the emperor or empress. He was responsible for the sanitary regulations and the legal requirements of medical education.

8 See, for the previous history, Johann Habart, Robert Töply (eds.), Unser Militärsanitätswesen vor hundert Jahren, Vienna 1896, pp. 25–34.

9 Habart, Töply, Militärsanitätswesen (cf. note 8), p. 26; Salomon Kirchenberger, Geschichte des k. k. österreichisch-ungarischen Militär-Sanitätswesens, Vienna 1895, pp. 4–11 (Handbuch der k. k. Militärärzte, vol. 2, part I).

10 Salomon Kirchenberger, Chronologie der Josephs-Akademie. Separatdruck aus Dr. Wittelsdörfer, Der Militärarzt, 1885, p. 1.

11 Quoted from Markus P. Swittlack, Josephinum-Aufklärung, Klassizismus-Zentrum der Medizin, Vienna 2014, p. 135.

12 Giovanni Alessandro Brambilla, Rede auf den Tod des Kaisers Joseph II im April 1790, Vienna 1790, p. 4.

13 On the prehistory of the Josephinum's construction, see Swittlack, Josephinum (cf. note 11), pp. 232–327.

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institution had been transformed into a spacious training facility for up to 400 trainees.[14]

"Only the need of the health care of the armies of a great nation to trust better hands, has moved the knowing and charitable Emperor Joseph, first to build a small school in Gumpendorf and soon thereafter the Academy in the Währingergasse."[15] These words from the Military Sanitary Commission of 1795 summarise what was intended on the part of Emperor Joseph II to fulfil his responsibility for the medical care of his soldiers.[16] This duty, developed through the Enlightenment, held that it was the monarch's responsibility to protect the health of his subjects, including that of soldiers, and to provide them with good medical care by better-trained surgeons.[17] The founding of a specialised academy for regimental surgeons became part of this imperial educational reform. Appropriate decrees were to provide the legal framework to ensure good care for the wounded in the context of military challenges:[18] "To the extent that warfare became a specialized art, governments worked to prepare better young soldiers, both noblemen for extraordinary roles and those who were to serve them" was written in a study on military education at the end of the nineteenth century.[19] First and foremost, this concerned the art of engineering, which was to be taught in the so-called school of genius.[20] These requirements could also be applied to the training of field surgeons. Already with the expansion of the Gumpendorf School, Joseph II specified on 3rd April 1781:

> "My intention is by no means that the surgeons, who are to be trained here, should only be taught the shallow of each of the specified sciences and that they should merely be dispatched from here with the knowledge of artificial words and a hasty and shallow doctrine. Rather, I want them to grasp their knowledge thoroughly and return to the regiments equipped with it."[21]

14 For the annual admission of the pupils, see Lohff, Josephs-Akademie (cf. note 2), pp. 74–78.

15 For the protocol of the final report of the Military Sanitary Commission from 2nd May 1795, see Habart, Töply, Militärsanitätswesen (cf. note 8), p. 60.

16 The secretary was the already mentioned Johann Adam Schmidt.

17 Brigitte Lohff, "…, dass eines der größten Erfolge der wahren Sittlichkeit und Politik die Herstellung einer besseren Medizin sein wird." Leibniz Vorstellung zur medizinischen Versorgung, in: Michael Kempe (ed.), Der Philosoph im U-Boot. Praktische Wissenschaft und Technik im Kontext von Gottfried Wilhelm Leibniz, Hannover 2015, pp. 87–111.

18 Vocelka, Karl, Glanz und Untergang der höfischen Welt. Repräsentation, Reform und Reaktion im habsburgischen Vielvölkerstaat, Österreichische Geschichte 1699–1815, ed. by Herwig Wolfram, Vienna 2001.

19 Rudolf Otto von Ottenfeld, Oscar Teuber, Die österreichische Armee von 1700 bis 1867 – Militärbildungs-anstalten, Vienna 1895, p. 680.

20 Die kaiserlich-königlichen Militär-Erziehungs-Anstalten mit bes. Rücksicht auf die Vorschriften für den Eintritt in dieselben, Vienna 1859.

21 "*Meine Absicht geht keineswegs dahin, dass den Chirurgen, die hier formirt werden sollen, nur die Oberfläche von einer jeden der angegebenen Wissenschaften beigebracht und sie blos mit*

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The completion of this goal was consistently pursued by Joseph II with the cooperation of his private surgeon and *Protochirurg*, Giovanni Alessandro Brambilla (1728–1800). It would be achieved with the founding of the *Josephs-Akademie*. Part of the prehistory of the academisation of military surgery also derives from the close relationship between the former Archduke Joseph, later Emperor Joseph II, and Brambilla. The intermediary between them both was Count Lacy. Count Franz Moritz Lacy (1725—1801),[22] born in Russia, had fought on the Austrian side in the Seven Years' War. In his military career, Lacy was appointed *General-Feldzeugmeister* (general field marshall) in 1759 and *Hofkriegsrat* (aulic war councillor) in 1763.[23] He succeeded in unifying and streamlining the internal organisational structures of the army, so that for both Maria Theresa and Joseph II he was the decisive advisor on all questions concerning the military.[24] In 1769, he was appointed *Hofkriegsratspräsident* (president of the Aulic War Council), and as "Minister of State and Conference",[25] Lacy was well informed about all governmental decisions.[26] After his resignation from the presidency of the Aulic War Council in 1774, he remained Joseph II's most important advisor on military matters.[27] Therefore, it was obvious that the expansion of the Military Medical School in Gumpendorf and the founding of the Academy took place with Lacy's support and advice. The decision to commission the former regimental surgeon Brambilla to draw up a concept for a military medical school, which was presented in 1784 *Instruktion für die k.u.k. Professors der chirurgischen Militärakademie*, was probably also reviewed by Lacy.

Brambilla acquired his first surgical knowledge at the hospital of Pavia.[28] For five years from 1751 onwards, he served as an *Unterchirurg* (sub-surgeon) in the Habsburg infantry. In 1757, he passed the prescribed examination for employ-

der Kenntniss der Kunstwörter und einer übereilten und seichten Lehre von hier abgefertigt werden. Ich will vielmehr, dass sie ihre Kenntnisse gründlich fassen und mit solchen versehen zu den Regimentern zurückkehren." Quoted from Puschmann, Medicin in Wien (cf. note 5), p. 99.

22 https://military-history.fandom.com/wiki/Franz_Moritz_von_Lacy, 06.03.2022.

23 The guns = stuff was under the command of the *Generalfeldzeugmeister*, an older term for the supreme commander of the artillery.

24 Kunisch, Johannes, Lacy, Franz Moritz Graf von, in: Neue Deutsche Biographie 13 (1982), p. 382.

25 The title of 'Minister of State and Conference' was given individually to members of princely cabinets to distinguish them from the other councils and to indicate their particularly strong position within the government.

26 Michael Hochedlinger et al. (eds.), Verwaltungsgeschichte der Habsburgermonarchie in der Frühen Neuzeit, vol. 1, 1, Vienna 2019, p. 670.

27 Ibid. (cf. note 26), p. 670.

28 Cf. Wilhelm Böcking, Rede bei der Todtenfeyer des Joh. Alexander Reichsritter von Brambilla, ehemaligen Directors der K. K. Josephinischen Medicinischen Chirurgischen Academie, Vienna 1801 – Detailed biography of Brambilla and architectural history of the Josephinum, Swittlack, Josephinum (cf. note 11).

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ment as a regimental surgeon with *Protomedicus* Gerard van Swieten.[29] In the *k.u.k. Infantry Regiment Count von Lacy No. 22*, Brambilla was assigned the post of regimental surgeon. With Lacy's appointment as Aulic War councillor in 1763, Brambilla became the private surgeon to Archduke Joseph in the same year.[30] In this position, he accompanied Joseph on his various official journeys.[31] Both visited the hospitals—especially in France—in order to be informed about military medical training.[32] The emperor appointed Brambilla chief surgeon (*Protochirurg* in 1778)[33] with which he had reached the highest hierarchical level in military surgery.[34] He was now the supreme authority for all surgeons salaried in the army. In the document *Reglement für die Kaiserlich-Königlichen Feldchirurgen in Friedenszeiten*, which Joseph II commissioned from Brambilla in 1789, the hierarchical order within the various surgically active persons becomes abundantly clear: "After the Protochirurgus follow the professors of the Academy, who have the title of k.k. Councillors; they are permanent members of the Academy, and they must only be licensed Doctors of Surgery by the same Academy. Next in order are the staff surgeons, regimental surgeons […]."[35] Then follows an enumeration of all the surgical personnel at the various military branches up to the interns at the Joseph's-Academy, "who are already qualified to wear uniforms, and especially those who are in the pay".[36] Brambilla also chaired the Military Sanitary Commission, toured the military hospitals, visited the garrison hospitals, and advised the Aulic War Council on relevant matters. For the project of building up military surgery in Austria, the prominent director at the *Josephs-Akademie* had the full support of Joseph II.[37] Along the way, the extended military surgical school at the Gumpendorf Hospital from 1781 to 1785 already provided for the Habsburg field surgeons to become masters of surgery.

29 Van Swieten was the president of the Medical Faculty since 1753, Lohff, Wiener Medizinische Schule (cf. note 5), p. 46.

30 Two years later, in 1765, Joseph was crowned Holy Roman Emperor, and until the death of his mother, Maria Theresa, on 29th November 1780, they both reigned. Thereafter, Joseph II reigned alone as monarch of the Holy Roman Empire of the German Nation until his death on 20th February 1790.

31 Swittlak, Josephinum (cf. note 11), pp. 77–207. Since 1776, Brambilla was mentioned more often in the newspapers, cf. Reichspostreiter from 19th April 1776.

32 Concerning the development of surgery in France, see Lohff, Josephs-Akademie (cf. note 2), p. 12.

33 The change of the title of chief surgeon to that of *Protochirurg* (proto-surgeon) was made by decree, dated 4th June 1783, Brambilla, cf. Tod des Kaisers (cf. note 12), p. 18.

34 Hof- und Staatsschematismus der röm. kaiserl. Haupt- und Residenzstadt Wien, Vienna [=HSS] 1779, p. 377; since 1776, Brambilla held the title of *Hofjagdchirurgus* (the Court Hunting Surgeon); cf. HSS 1776, p. 327.

35 G. A. Brambilla, Reglement für die k. und k. Feldchirurgen in Friedenszeiten, Erster Theil, Vienna 1789, pp. 7–8.

36 Ibid., p. 8.

37 Swittlack, Josephinum (cf. note 11); Lohff, Josephs-Akademie (cf. note 2).

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Shortly before Brambilla took over the directorship of the newly founded Academy, a position which paid 4,000 florins per year,[38] the emperor awarded him the title of count and a feudal estate, which brought in an additional 6,000 florins annually.

Brambilla headed the Academy for ten years. He withdrew from this position after a lot of criticism of his leadership style and his apparent lack of understanding of the meaning of an academic education. On 12th November 1795, his directorship at the Academy ended with his retirement.[39] He lived the last years on his estate in Carpiane/Pavia and died in Padua on 29th July 1800 from a "blister burn" (ischuria) while fleeing from Napoleonic troops.[40]

2. The Legal Framework for the Practice of Military Surgery

The *Verfassung und Statuten der josephinischen medizinisch-chirurgischen Akademie samt der Ordnung bei Beförderungen zu Magistern und Doktoren der Chirurgie* (Constitution and Statutes of the Josephinian Medical-Surgical Academy together with the Regulations for Promotions to Magisters and Doctors of Surgery) written by G. A. Brambilla in 1786 implied that the Academy was endowed with all the rights of a university of the Empire, and was also under the personal protection of the monarch. The staff of the Academy had to perform three tasks: 1) training of sub-surgeons and masters of surgery; 2) as an academic society, to contribute to the furthering of medical science; and 3) as a sanitary commission, to be called upon to advise and decide on matters of military hygiene.

According to Brambilla's calculations, there were approximately 2,000 surgeons employed in the army during peacetime in the 1780s.[41] This increased many times over during war-related deployments. The principles decreed in the Theresian legislation were intended,[42] as mentioned, to regulate the taking up

38 Cf. § 13 in: Karl von Bundschuh, Handbuch aller seit dem Militärjahre 1767: als dem Anfange des in der k. k. bestehende Militär-Oekonomie-Systems, Vorschriften, 9. Abth.: Von den Feldärzten, Prague 1822, p. 468.

39 Kurze Nachrichten, in: Gothaische gelehrte Zeitungen, 17th August 1785, p. 536.

40 Nekrolog, in: Salzburger Intelligenzblatt, 9th October 1800, pp. 650–651.

41 Brambilla, Tod des Kaiser (cf. note 12), p. 4; Swittlak reports that for the year 1780, Brambilla and chief field surgeon Thaddeus Bayer estimated a need for 200 sub-surgeons, 50 senior surgeons, and 5 staff surgeons. In addition, 10 physicians for the hospitals and 50 orderlies were planned. As early as 1782, the target number of medical personnel was 557, with a mobilisation strength of 402,645 men; Swittlak, Josephinum (cf. note 11), p. 134.

42 Bundschuh, Von den Feldärzten (cf. note 38), p. 463.

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and exercise of such activity within the army.[43] On 12th October 1776, one year after the opening of the *Lehranstalt*, it was decreed that "in peacetime, no individual shall ever be employed as a field physician who has not studied anatomy. Even in times of war, every effort must be made to obtain such 'subjects' as field physicians".[44] Basic anatomical knowledge could also be acquired at the medical-surgical schools in Innsbruck,[45] Graz, Olmütz [Olomouc, Czech Republic], or Lemberg [Lwiw, Ukraine] or also from an initiated university medical study. On 21st August 1782, the same regulation on basic knowledge of anatomy was extended to the sub-surgeons to be employed in the army.[46] Initially, the examination on this skill had to be conducted at the Faculty of Medicine by the *Protomedicus.* After 1775, it was transferred to the director of the Gumpendorf School. With the expansion of the *Lehranstalt* as the Gumpendorf *Schule für Feldärzte* in 1781, Brambilla had succeeded in tying the practice of surgery within the Habsburg army even more closely to the Viennese school. This professional monopoly had been fully implemented after the founding of the *Josephs-Akademie.* Already with the decree of 31st August 1781, a member of the army could only be transferred to the *Schule für Feldärzte* in Gumpendorf and later to the Academy for study via the Aulic War Council. At the same time, no one was allowed to be appointed regimental surgeon within the Habsburg army "before he has heard the entire medical-surgical course of instruction at the Josephs-Academy, which lasts 2 years, and has been declared capable by it".[47]

When the Gumpendorf School was upgraded by the decree of 17th February 1781, attendance at the so-called "small course" became a prerequisite for being assigned to a regiment within the Habsburg army as a sub-surgeon. The new Viennese training school, plus its required entrance examination, became the *conditio sine qua non:* "[O]n 21st August 1782, it was added by the Aulic War Council that the regiments should only accept such individuals as sub-physicians [-surgeons] for whose admission they have provisionally consulted with the chief surgeon […] or are able to prove because of the new apprenticeship completed in Vienna."[48]

43 Karl von Bundschuh, Rücksichtlich der Feldärzte bestehende Anordnung, in: Karl von Bundschuh, Zusammenstellung derjenigen Dienstespflichten, welche den in der Linie dienenden k. k. Regiments-, selbständigen Bataillon- und Corps-Commandanten etc. obliegen, Prague 1826, p. 32 (§44).

44 Bundschuh, Von den Feldärzten (cf. note 38), p. 463 (§ 1).

45 Until 1782, a Medical Faculty existed at the University of Innsbruck in addition to Prague, which, however, was then transformed into a *Medicinisch-Chirurgisches Lyzeum* during the Josephinian reform; cf. Heinz Huber, Geschichte der Medizinischen Fakultät Innsbruck und der medizinisch-chirurgischen Studienanstalt (1673–1938), Vienna 2010, pp. 46–58.

46 Bundschuh, Von den Feldärzten (cf. note 38), p. 463.

47 Ibid.

48 Ibid.

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The "small course" initially offered lasted only six months. Civilians could apply for a place as well as graduates from the former schools of surgery or those who had learned their craft under the guidance of a regimental surgeon and submitted an appropriate letter of recommendation. An apprentice/intern had only to fulfil the conditions to be admitted to a two-year course to begin the master's degree programme after successfully completing the small course. Admission to this two-year Magister course could only be granted by examination by the Chief of Staff of the Main Garrison Hospital No I, or by the respective Director of the Joseph's-Academy. A successfully completed master's course was now a prerequisite for employment as a regimental surgeon.

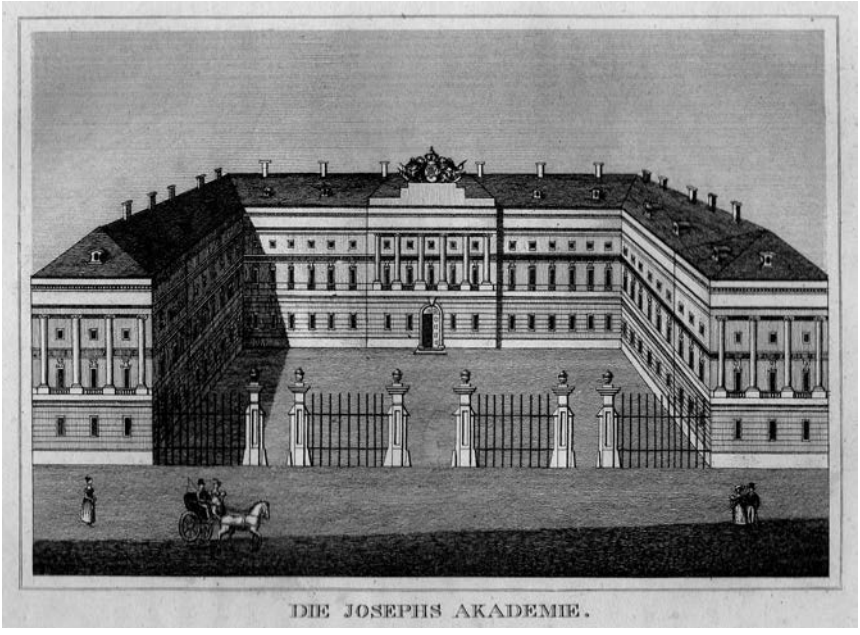

Fig. 1: Engraving of the Josephs-Akademie by Johann Konrad Friederich, 1834[49]. Source: Copyright by Brigitte Lohff

To advance in the new surgical school or academy from sub-surgeon to master of the subject, the candidate had to demonstrate six years of hospital experience, pass another entrance examination, and then attend the two-year course. The title of *Magister* (Master) was awarded after a "rigorous examination" in anatomy, physiology, physics, and pathology and another examination consisting of

49 Engraving *Josephs-Akademie* by Johann Konrad Friederich (Pseudonym Carl Strahlheim) in: C. Strahlheim, Die Wundermappe od. sämtliche Kunst- u. Natur-Wunder des ganzen Erdballs, Frankfurt 1837, in the private property of the author.

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questions on surgery, instruments, and bandaging, as well as *materia medica*, chemistry, botany, and forensic medicine. In a practical part, the candidate had to demonstrate his diagnostic knowledge and be able to discuss the basic principles of therapy.[50]

The title of 'Doctor of Surgery' could also be obtained at this institution. One could be appointed if one was already an experienced field surgeon/battalion surgeon, and had passed another viva at the Academy. To be eligible for the "doctor's examination", the candidate had to be one of the best who had completed the two-year master's degree programme—including eight years of hospital experience. In addition, passing a strenuous examination to obtain the title of 'Master' was required, as well as an additional public "operation" (on a cadaver) with practical and theoretical examination questions. After this, the title of 'Doctor of Surgery' could be conferred.

The goal of these graduation and examination regulations was, as Habart and Töply described it in 1884: "to educate intelligent physicians trained in all medical and military subjects as practitioners, as leaders and organizers of the military medical service."[51]

The special position of graduates of the Joseph's-Academy in the practice of their profession was laid down in Brambilla's *Verfassung und Statuten der josephinischen medizinisch-chirurgischen Akademie:*

> "We hereby decree to all our high and lower authorities that the masters and doctors of surgery promoted by this academy shall be recognized in this capacity in all our territories and countries, shall be entitled to practice their art in all places, both military and civilian, and shall also be able to hold all public and princely offices and conditions appropriate to surgery."[52]

The regulations for practising as a field surgeon were based on the imperial regulations for wound physicians and barbers.[53] In particular, they concerned the use of "internal substances", i. e., medicaments. In the directives and laws, especially from 1770 onward, it was generally stipulated for wound physicians: "In all severe treatments, for which they lack sufficient strength or aids, they […] are not to initiate and administer any internal cures without the advice of a [*medicus*]."[54] Even then, however, the wound physician was only allowed to use

50 Kirchenberger, Sanitätswesen (cf. note 9), pp. 61–65.

51 Habart, Töply, Unser Militärsanitätswesen (cf. note 8), p. 36.

52 G. A. Brambilla, Verfassung und Statuten der josephinischen medizinisch-chirurgischen Akademie samt der Ordnung bei Beförderungen zu Magistern und Doktoren der Chirurgie, Vienna 1786, p. 12.

53 Theresianische Gesetzgebung, Sammlung Vorschriften und Gesetze von dem Jahr 1770 bis 1773, vol. 6, Vienna 1786, pp. 15–19.

54 Instruktion für Wundärzte und Bader, in: Theresianische Gesetzgebung, vol. 6 (cf. note 53), p. 16 (§ 3).

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"harmless remedies".[55] This decree was reaffirmed by Joseph II in 1783: "All civil wound physicians are still forbidden, according to the previously existing sanitary directives, to administer internal cures where a doctor is present".[56]

The discussion in the eighteenth century about what was allowed or forbidden for a wound surgeon also concerned the work of the regimental surgeons. In this respect, it was also dealt with in the Theresian legislation and confirmed by a court resolution of 17th February 1783: "Everything that is allowed to civilian wound surgeons and bathers for internal diseases shall not be forbidden to military wound surgeons."[57] However, regimental surgeons were permitted "to practice their skills in the quarters where they lie, even on civilians, but they do not thereby receive any authority to settle, but remain subordinate to the regiment, which is mobile from one place to another".[58] This resolution was significant in the context of the Empire's large size and multi-ethnic population. Medical care in the Empire was not available to civilians at the same standard everywhere. Therefore, regulations had to be created that allowed regimental surgeons to practise therapeutic measures that were not allowed in relation to civilian wound-physicians by decree. This context also explains the designation of the Gumpendorf School as *Lehranstalt für die Ausbildung von Feldchirurgen.* At the same time, however, competition between civilians and military personnel with regard to their medical-surgical activities on site was to be avoided.

3. Confrontation and Reform Efforts at the Josephs-Academy

Joseph II's aim in providing targeted education at the *Josephs-Akademie* was to ensure that the future licensed surgeons would not be "dispatched from here with a hasty and shallow doctrine", and that they would return to their regiments well-trained.[59] This goal was also connected with the efforts that wound medicine or surgery be raised to a better level. By contrast, van Swieten's intention in reforming medical education was not so much to elevate surgery to a medically taught subject.[60] The eventual delinking of surgery from the craft profession of the barber or feldsher succeeded due to Joseph II's willingness to reform military medical education. An important step on the way to the equality of surgeons with physicians resulted from the emperor's decree of 21st September 1783:

55 Ibid, p. 17 (§5).
56 Decree, 21st August 1783, in: Handbuch aller unter der Regierung des Kaisers Joseph des II. für die k. k. Erbländer ergangenen Verordnungen und Gesetze, vol. 1, Vienna 1785, p. 445.
57 Ibid.
58 Theresianische Gesetze, vol. 1 (cf. note 53), p. 513.
59 Puschmann, Medicin in Wien (cf. note 5), p. 99.
60 See Fischer, Chirurgie (cf. note 3), p. 211.

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> "The surgical subject is a free study just like the medical one; and those surgeons who distinguish themselves with special ability, and pass both the theoretical and practical examinations in their entirety with skill and general favour, shall not only be granted the diploma of a *Chirurgiae Magiftri*, but they shall also be duly graduated as *Doctores Chirurgia*, and shall have equal rank with the *Medicis* in the faculty at all *consiliis* and public meetings […]."[61]

A further step followed with the court decree of 3rd March 1785: "the surgical profession, like the medical profession, is a free one. Therefore, it is to be allowed to all examined surgeons, practised in hospitals and provided with certificates – they may be of the civil or military class […]."[62] The politically intended equivalence of the civilian and military medical profession was to be a constant topic of dispute—also on the part of the military—in the turbulent quarrels between the medical faculty and the Academy until the closure of the *Josephs-Akademie* in 1874. One side felt that the Academy's graduates lacked sufficient medical knowledge, while the other lacked insight and knowledge of the issues of the military. In addition, from the beginning until shortly before the Academy's closure, the military had reservations about appointing field physicians with doctorates as officers.[63]

For the education of the future masters and doctors of surgery at the Academy, the following chairs were established: one each for anatomy, for pathology, for surgical operations, for botany and chemistry,[64] and for theoretical and practical medicine, to which were added a prosector and a teacher for the intern.[65] Classes were held in the rooms of the Academy, including a well-equipped library, the exquisite collections of medical, biological, and zoological specimens, along with the world-famous wax models for teaching and demonstration purposes.[66] The Main Garrison Hospital No. 1 in Vienna, which was architecturally connected to

61 Cf. Handbuch Verordnungen (cf. note 56), p. 446.

62 Hofdekrete betr. Medizinische Fakultät vom 3. Hornung 1785, in: Theresianische Gesetzgebung (cf. note 53), p. 513.

63 Lohff, Josephs-Akademie (cf. note 2), p. 351.

64 Joseph Plenck was responsible for the subject of botany and chemistry, which improved the knowledge of *materia medica* (pharmacy). A detailed description of all the rooms for teaching as well as for the instructional materials of the Academy as well as of the Garrison Hospital was recorded by G. A. Brambilla in his so-called "Appendice". These *Appendice – Alla Storia della Chirurgia austriaca militare in cui trattasi dell'erezione degli Spedali, della Fabbrica dell'Accademia Gioseffina, e de' Gabinetti n essa contenuti, con loro Piani, e con quelli degli Spedali di Campagna dell'ultima Guerra contro il Turco* were translated from Italian into German by Barbara Peitinger and examined in her master thesis, cf. Barbara Peitinger, Giovanni Alessandro Brambillas Appendice – Eine Quelle zur Geschichte des Gesundheitswesens im Josephinismus, Vienna, Master thesis 2011.

65 'Prosector' was an occupational name for the 'dissector' of an anatomical/pathological institution who was responsible for the dissection of a cadaver.

66 About this exceptional collection, see Sonia Horn, Alexander Ablogin (eds.), Faszination Josephinum. Die anatomischen Wachspräparate und ihr Haus, Vienna 2012.

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the *Josephinum*, would house the practical training, in which the students also had to serve.[67] The first appointed teachers had many years of military surgical experience and, at the suggestion of Brambilla and with the approval of Joseph II, received additional specific training in France and England at the expense of the state.[68] Upon assuming the professorship, the teachers were appointed staff surgeons.

The pupils, who were educated under a scholarship at the Academy or at state expense by the military, contributed their share to the costs by serving in the hospital as well as by guiding visitors through the collection in the *Josephinum.* However, according to the order issued by Joseph II on 21st October 1783, anyone was also free to apply for a place at the Academy at their own expense or with a scholarship.[69] Only "nationals" could receive a grant to study at the institution. If someone was sent to the Academy for education at state expense and failed the exam or behaved inappropriately, the scholarship had to be paid back. All students educated at the Josephs-Academy at state expense had to commit themselves to military-surgical service in the army for several years. Only then were they allowed to establish themselves as surgeons. If they did not fully comply with this obligatory period, they had to reimburse the scholarship on a pro rata basis.[70]

However, there was a serious problem with the equivalence of training in the Academy's curriculum: the doctorate of surgery. This, as already mentioned, was awarded when a regimental surgeon, as a graduate of the master course, ranked one among the best in the examinations. After an additional examination, the doctoral degree was awarded. Thus, the study requirements set out by the Josephine training regulations were not comparable with the conditions for a university-based study of medicine: "A *Medicinae Studiosus* must have completed the whole of philosophy, but especially the study of *Historia naturalis* and *Physices experimentalis*; then in the first year he can take Anatomy, Chemistry and Botany, because these subjects are closely related to Physique and *Historia naturali* and are necessary for the following ones."[71]

Even for the study of wound medicine at the medical-surgical schools and at the University of Vienna, the two-year study of philosophy, *historia naturalis* and

67 On the premises of the hospital and the care provided there, see Ludwig Wittelshöfer, Wiens Heil- und Humanitäts-Anstalten, ihre Geschichte, Organisation und Statistik, Vienna 1856, pp. 268–277.

68 About the biographies of the professors of the Academy, see Chap. 2.2, 5.1, 6, in: Lohff, Josephs-Akademie (cf. note 2).

69 Kirchenberger, Chronologie (cf. note 10), p. 3.

70 Bundschuh, von den Feldärzten (cf. note 38), p. 464 (§ 7).

71 Quoted from Angetter, Strukturen und Netzwerke (cf. note 5), p. 160.

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physices experimentalis was required.[72] If an equalisation of the doctoral studies was the goal, equality in the prerequisites for the studies had to be ensured. With the teaching of chemistry and botany and physiology at the Academy, a part of the requirements for the teaching of *Historia naturalis* could be fulfilled. However, "philosophy" was completely missing.

In 1784, Brambilla had elaborated the initial teaching concept in the instructions for the professors and had specified for each subject the time and scope of the subject matter, the conduct of the pupils as well as that of the professors. The teacher of the understudies had the task of instructing prospective sub-surgeons in discipline, order, punctuality, obedience, and adherence to the rules of the military. Brambilla's ideas of appropriate knowledge transfer for aspiring masters of surgery are exclusively spread out in these instructions, over which he also reserved control with regard to strict adherence to the teaching content and implementation.[73] Thus, it is said in Regulation XX: "It is believed that it is not necessary to prescribe to the professors in particular the divisions of their lectures, but one is content to prescribe to them only the order of it in general, [if the director of the institute finds something] to improve, he will make the necessary changes."[74] How often a subject was to be taught, with what content, and what didactic materials were to be made available, depended on Brambilla's views. The professors were not allowed to deviate from the prescribed material. It was against these interventions in the course material that the Joseph's-Academy's professors resisted a few years after the opening of the Academy; they had grave doubts about Brambilla's conception of the necessary teaching content for prospective military surgeons.

4. The 1795 Reform of Military Surgical Education

The *Josephinum* was built in the immediate vicinity of the 1784 Vienna General Hospital (*Allgemeines Krankenhaus* – AKH) for reformed medical training.[75] This close proximity was a source of conflict, which was also repeatedly raised by the university in the discussions about the closure of the *Josephs-Akademie* in the

72 Gustav Kopetz, Österreichische politische Gesetzeskunde oder systematische Darstellung der politischen Verwaltung in den deutschen, böhmischen und galizischen Provinzen des österreichischen Kaiserthumes, vol. 1,1, Vienna 1807, p. 327 (§ 381).

73 Brambilla himself had written a whole series of excerpts on surgical topics, on the medical clinic, on materia medica, or on basic scientific knowledge, which were prescribed as obligatory teaching and examination material.

74 G. A. Brambilla, Instruktionen für die Professoren der k. k. chirurgischen Militärakademie, Vienna 1784, p. 13.

75 Bernhard Grois, Das Allgemeine Krankenhaus in Wien und seine Geschichte, Vienna 1965.

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following 90 years. Initially, the two institutions coexisted peacefully. For example, the director of the General Hospital in Vienna, Johann Peter Frank (1749–1820), proposed that physicians at the AKH adopt a reorganisation of medication similar to the one suggested in a prize paper written in 1795 by then teacher and later Joseph's-Academy's Professor of Gynaecology and Obstetrics Wilhelm Schmitt (1760–1820)[76]: "The regional government therefore allowed that the new military *pharmacopoeia* drafted a few years ago by the Military Medical Commission here, which our hospital physicians and wound physicians had also declared to be sufficient except for a few things concerning the treatment of so many women in childbirth and children, would be used as a basis for the ordinary prescriptions."[77]

However, just a few years after the opening, the professors of the Academy became increasingly disgruntled. They criticised above all the outdated, partly faulty teaching material and the lack of teaching content appropriate for modern military medical training. Johann Nepomuk Hunczovsky (1752–1798), president of the Academy from 5th July 1796 to 21st June 1797, complained that teaching at the Academy had become chaotic, along with a "complete neglect of several of the most important subjects, everything had to be taught in a dictatorial instruction without order, without appropriate sequencing and succession of steps, and sometimes also with unnecessary repetitions."[78] Without going into detail about the background of the dispute between some of the Joseph's-Academy's professors and certain military physicians, it culminated in 1794.[79] Emperor Franz II found it necessary to convene a commission consisting of members of the *k.k. Militär-Sanitätskommission* (Military Sanitary Commission), the *k.k. Studien-Hofkommission* (Imperial Court Study Commission), the Aulic War Council, and the professors from the Joseph's-Academy.

The results of the commission were recorded on 2nd May 1795 in the *Protokoll der Militär Sanitäts-Commission die Verbesserung der k.k. Josephs-Akademie und des gesammten Militär-Sanitätswesens betreffend* (Protocol of the Military Sanitary Commission concerning the improvement of the k.u.k. Joseph's-Academy and the entire military medical system). The proposed changes were based on three central statements. First, "Medicine and surgery […] are based on the same principles, are not only related, but rather form an inseparable whole. [Con-

76 Cf. Lohff, Josephs-Akademie (cf. note 2), pp. 53–54.

77 Biographie des D. Johann Peter Frank, K. K. Hofrathes, Spitaldirectors und Professors der praktischen Arzneywissenschaft auf der Hohenschule zu Wien […] von ihm selbst geschrieben, Vienna 1802.

78 Letter from Hunczovsky and Plenck to the Aulic War Council, 1st September 1796, in: OeStA [Österreichisches Staatsarchiv]-KA [Kriegsarchiv]-HKR [Hofkriegsrat] 1796/637 fol. 1–5, fol. 2.

79 Cf. Lohff, Josephs-Akademie (cf. note 2), pp. 51–64.

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sequently, it applies] to the soldier, as to the civilian, to unite the *Medicus* and *Chirurgus* in one person."[80] In addition, it was an unnecessary waste of money to employ a staff surgeon in addition to a staff physician in the army. Second, in the future, too, it would not be possible to recruit the required number of military physicians from well-off and wealthy university students alone, "to choose such a hard, neither well-rewarding nor honourable position".[81] Third, studying at the university meant "unrestraint, free will, lack of rules in studying and not studying, lack of discipline, disobedience".[82] Due to the opposite codes of conduct, it is advisable, from the economic point of view and for the "maintenance of good order, that the field doctors […], be educated in an institute for an equal system with regard to the medicine and hospital system!"[83]

All further proposals followed these findings. New lecture halls should be built in the *Josephinum* in order to be able to give parallel lessons for the different years of the lower and higher courses. Likewise, an adequate room with water supply should be made available to the prosecture so that the necessary section courses could be held.[84] A four-year course of study was to be prescribed for the doctorate and a two-year course for the master's degree. This brought the doctoral studies closer to the university education for the doctor of medicine. With regard to the management of the Academy, the board and the director were to be elected annually from the group of Joseph's-Academy's professors and confirmed by the Aulic War Council.[85]

Subsequently, the Joseph's-Academy's professors, under the leadership of Johann Nepomuk Hunczovsky, restructured the teaching with great enthusiasm. The following subjects were to be taught in the future by the five Joseph's-Academy's professors: Botany and Chemistry (Johann Joseph Plenck), Anatomy and Physiology (Wilhelm Böcking), General Pathology and Therapy combined with Remedies and the Art of Reception (Johann Adam Schmidt), Eye Diseases and Venereal Diseases (Schmidt), Special Surgical Pathology, Therapy, and Surgical Operations (Johann Nepomuk Hunczovsky), Special Medicinal Pathology and Therapy (Joseph Gabriel von Gabriely), the art of childbirth, on the diseases of infants and children (Anton Beinl), and on public health/state medicine and forensic medicine (Beinl).[86]

80 Protocol (cf. note 15), p. 58.
81 Ibid., p. 64.
82 Ibid.
83 Ibid., p. 66.
84 The prosecture was an area (room) in the teaching building (*Josephinum* and Garrison-Hospital) where sections could be undertaken.
85 Friedrich Colland, Kurzer Inbegriff von dem Ursprunge der Wissenschaften Schulen, Akademien und Universitäten in ganz Europa besonders aber der Akademien und hohen Schule zu Wien, Vienna 1796, pp. 179–218.
86 Ibid.

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In order to graduate "trained and not half-trained field physicians" from the Academy, instruction was to take place at the bedside, which was not limited to visiting the garrison hospital, but included a *clinicum chirurgicum and medicum* —entirely in the spirit of the van Swieten reform with training at the bedside. In order to be able to carry this out, however, a separate hospital room had to be set up in the Main Garrison Hospital No. 1. In 1796, Hunczovsky informed the Aulic War Council: "For this new study institution, all teachers are more willing to voluntarily give up the amenities than to continue to maintain the advantages granted to them by the *old Schlendrians* [the before practised sloopiness]."[87]

5. Renewed Crises

The reorientation of the Academy is reflected in the changed name: *K. k. Josephs-Akademie der Kriegsarzneywissenschaft und der permanente Feld-Sanitätskommission.* Ranked at the top were now the k.k. supreme field surgeon, Dr. Matthias Mederer (1739–1805),[88] and his assigned secretary from the Academy, Anton Beinl. The director of the Academy also had to deal with the Study Court Commission regarding the education of the military surgeons who intended to receive doctorates.[89] At the beginning of the new century, there was a change in the first generation of professors at the Academy. Anton Beinl (1749–1820) von Bienenberg[90] was appointed permanent director at the end of 1805 and remained in this position until his death in 1820. The construction of the director's position was again overloaded with a wide variety of functions. In addition to the director's duties at the Academy, he served as chief field physician, president of the Permanent Field Sanitary Commission, chairman of the Military Drug Commission, and advisor to the Aulic War Council.

From the *Berichte und Anzeigen an den k.k. hochlöblichen Hofkriegsrat von der permanenten Feld-Sanitätscomisson wie auch der feldärztlichen Josephs-Academie* [Reports and Notifications to the Aulic War Council from the Permanent Field Sanitary Commission and the field physicians from the Joseph's-Academy] it is evident how high the administrative expenses were on the part of

87 Letter from Hunczovsky to the Aulic War Council, 1st September 1796, in: OeStA-KA-HKR 1796/637, fol. 5.

88 Oesterreichischer Militaer-Almanach für das Jahr 1791, Vienna, p. 271.

89 Cf. Study Court Commission, Kopertz, Gesetzeskunde (cf. note 71), p. 308 (§ 357); Helmut Rumpler, Eine Chance für Mitteleuropa. Bürgerliche Emanzipation und Staatsverfall in der Habsburgermonarchie. 1804–1918, Vienna 1997, pp. 111–112.

90 Letter from Hunczovsky to the Aulic War Council, 23rd April 1796, in: OeStA-KA-HKR 1796/297, fol. 3. On the biography and influence of A. Beinl on the Academy, see Lohff, Josephs-Akademie (cf. note 2), pp. 37–40, pp. 83–110.

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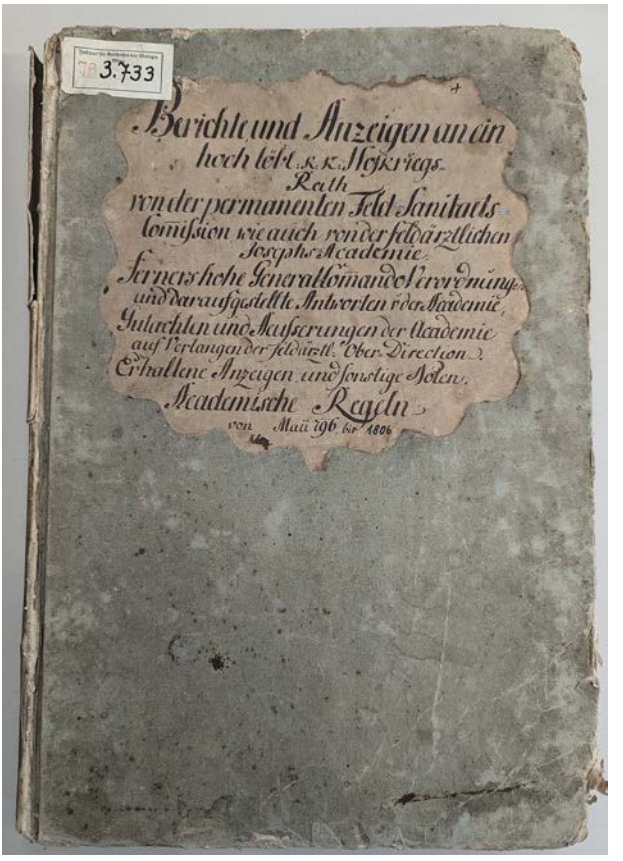

Fig. 2: Cover of *Berichte und Anzeigen, [Mai 1796 bis 1806]*. Source: Josephinian Library, Copyright is with Brigitte Lohff

the directorate of the Academy: for every book order, purchase, leave, absence from Vienna, etc., permission had to be obtained from the Aulic War Council. On the other hand, the agreements from the protocol of 1795 about structural changes in order to offer parallel classes were not followed or only sluggishly implemented.[91] The number of pupils had decreased continuously since the occupation of Vienna by Napoleon in 1805/6 and 1809 and around the Congress of Vienna in 1814/15.[92] The percentage of students who studied at the Academy

91 Carl Heidler, Rede bei der feierlichen Eröffnung mit allerhöchster Entschliessung vom 15. Februar 1854 der medicinisch-chirurgischen Josephs-Akademie am 23. October 1854, Vienna 1854, p. 13.

92 The first occupation of Vienna was from 12th November 1805 to 13th January 1806; the second occupation of Vienna was from 13th May 1809 to 20th November 1809. After the Battle of Aspern and Essling (21st to 22nd May) and the Battle of Wagram (5th to 6th July), the Peace of

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for only a few weeks or months grew, and the percentage of students who left the Academy on their own accord increased dramatically.[93] The glaring shortage of pupils and, consequently, the glaring shortage of surgeon mates, masters of surgery, and doctors of surgery, led to the fact that the role of the Academy as a central educational institution had declined to almost complete insignificance in the years from 1809 to 1816.

In addition, the decline in the value of money put a strain on the state's finances at the beginning of the nineteenth century. Whereas in 1797, 100 florins of banco notes were the equivalent of 92 silver florins, by 1810 the equivalent was only 15 silver florins. The bankruptcy of 1811 was inevitable.[94] Despite the currency devaluation, the Monarchy was again heading for bankruptcy from 1814, when the costly Congress of Vienna had swallowed up another 500 million gulden of taxpayers' money. The costs of the Congress were financed on credit, so to speak, by the citizens, who were able to purchase "anticipation certificates" for taxes to be paid in the future.[95] In 1816, the establishment of an independent Austrian National Bank was intended to bring order to financial policy.[96] In view of the ailing state finances, it was obvious that the Academy would have to be closed down for economic reasons. Despite a high level of national debt, however, the Academy was not closed by decree. Only the teaching came to a standstill from 1818 "in the true sense of the word".[97]

So, the question arose again, how should the training of military surgeons continue? The university professors, including the representatives of the Study Court Commission, pleaded for a radical reduction in the training capacity at the *Josephs-Akademie*. They thus represented the position of the director of the Medical Faculty, Andreas Stifft, who had held this position until 1835 for over 30 years since the reorganisation of the faculty structure in 1802/3.[98] Stifft did not

Schönbrunn was signed on 14th October, and Napoleon's troops left Vienna. Cf. Max Braubach, Von der französischen Revolution bis zum Wiener Kongreß, Munich 1980.

93 Lohff, Josephs-Akademie (cf. note 2), Chap. 4.2.

94 Johann Klockner, Norbert Künstner, Katalog der österreichischen Banknoten ab 1759, 2nd edn., Vienna 2010, p. 56.

95 Thiery Lentz, 1815. Der Wiener Kongress und die Neugründung Europas, Hamburg 2014, pp. 44–46.

96 This was associated with a renewed loss of wealth for private assets. In 1816, 100 florins had a value of only eight silver florins compared to 1800, which corresponded to a loss in value of 96 per cent within 16 years. Cf. Wolfgang Häusler, Geld 800 Jahre Münzstätte Wien, Vienna 1994, p. 164.

97 Johann Traugott Dreyer, Pro memoria über die k. k. medizinisch-chirurgische Josephs-Akademie [1843], in: MUW [Medizinische Universität Wien] -AS-002072, fol. 20.

98 In his position as the emperor's personal physician and as dean of the Faculty of Medicine, Andreas Stifft (1760–1836) purposefully and persistently used his influential position against the Joseph's-Academy for over 30 years. Cf. Neuer Nekrolog der Deutschen, 14, 1 (1836/1838), pp. 406–410.

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at all approve of the fact that the Aulic War Council, in agreement with Emperor Franz I, advocated the upgrading of the Academy to a medical college. The university professors wanted only sub-surgeons and masters to be trained at the Academy. The Aulic War Council and the Joseph's-Academy's professors, on the other hand, advocated better curricula for masters, and an upgrading of the doctoral degree. The Medical Faculty hoped for an exclusive study prerogative for all doctors of medicine, while the Academy wanted a sufficient number of well-trained military physicians who were adequately prepared for the army. From 1817 onwards, several meetings were held between the Study Court Commission and the Aulic War Council concerning the harmonisation of the study of doctors of medicine at the Academy and at the Faculty of Medicine. Two ministries—the Ministry of Internal Affairs, to which the Study Court Commission was subordinate, and the Ministry of War, represented by the Aulic War Council, to which the Academy was subordinate—were now involved in the question of the reorganisation of this College. The core issue concerned a possible equality of the medical doctorate issued by both institutions. This request demanded a fundamental reform of the study requirements. As long as the commissions of the two court chancelleries deliberated, education at the Academy stalled.

6. Reform and New Start in 1822/24

The 15-page *Gutachten über den verbesserten Studienplan der k.k. medicinisch-chirurgischen Josephsakademie samt einem neuen Plane zur Bildung von Medico-Chirurgen von den Professoren der Heilkunde an der k.k. Universität zu Wien* (Report on the improved curriculum of the Joseph's-Academy, including a new plan for the training of medico-surgeons by the professors of medicine at the University), summarised the agreed position of the Vienna Medical Faculty. The professors proposed that, in addition to the civilian doctors of medicine trained at the Faculty, "medico-surgeons may be formed under the conditions laid down in the highest order".[99] On the other hand, on the part of the Joseph's-Academy's professors, it was proposed in their draft:[100] "1. That the field physician of the

99 Gutachten über den verbesserten Studienplan der k. k. medicinisch-chirurgischen Josephsakademie samt einem neuen Plane zur Bildung von Medico-Chirurgen von den Professoren der Heilkunde an der k. k. Universität zu Wien vom 16. April 1818, in: Convolute supplement 3737/ 365 ex Januaris 823, OeStA [Österreichische Staatsarchiv] /AVA [Allgemeine Verwaltungs Akten] /15 A Josephs-Akademie, fol. 1. [= Professor's opinion].

100 The professors of medicine referred to reform proposals that had probably been submitted by Johann Nepomuk Isfordink (1776–1841), since 1814 Professor of General Pathology, Therapy, Materia Medica, and Art of Dispensing. This document has not yet been found in the archives. Regarding Isfordink's biography and directorship, see Lohff, Josephs-Akademie (cf. note 2), pp. 100–103, 113–153.

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Austrian army must be a physician and wound surgeon in one person, […] 2. That the army needs two classes of medical individuals, namely a) independently acting physicians or chief physicians and b) medical assistants. On this it now bases 3. The necessity of a twofold educational institution [training path] of field medical individuals: a) a higher one for the chief physicians and b) a lower one for the field medical assistants."[101]

The sub-surgeon training course would be abandoned. Two years would be set aside for the master's degree and six years for the doctoral degree. For the doctoral degree, two years of basic philosophical studies and four years of medical-surgical studies would be required. That is, they should be granted "equal rights in all respects with those graduated from universities. Furthermore, after a certain number of years of service, they should be entitled to higher medical positions in the civil service".[102] This proposal was vehemently rejected by the University professors in their report:

> "[T]hat there can only be one organisation of the educational institutions for physicians, […]. In order to achieve this unity, the hitherto isolated educational institution for field physicians must come into organic connection with the other medical educational institutions of the Monarchy, operate according to the same principles and laws, and carry out its work under the same overall direction."[103]

The University professors had to concede, however, that at present, it was not possible for the Faculty of Medicine "to supply as many doctors of medicine as are necessary to meet the needs of the entire bourgeoisie and the army".[104] As an interim solution, therefore, *medico-surgeons* "who must be made fit to practice internal and external medicine", were to be trained at the University. Thus, in the future, there would be "doctors of medicine and surgery with doctorates as doctors of the first class" and "new doctors, the doctors of the second class" at the Medical Faculty.[105] A detailed study plan was attached for the four-year study of future medico-surgeons.

An additional ground for the medical professors' rejection of physicians trained at the Academy lay in their perception of pervasive preferential treatment toward the military physicians compared to the civilian physicians. They also objected that graduates of the Academy were to be granted the same rights as physicians graduating from universities, combined with the right to practise after leaving the army. For "if one compares these advantages and favours with the lot of physicians studying and graduating from universities, then in the future the

101 Professors' opinion (cf. note 100), fol. 2.
102 Ibid., fol. 3.
103 Ibid., fol. 9.
104 Ibid.
105 Ibid., fol. 10.

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status of field physician will have to be declared brilliant and for the civilian physician a higher level of happiness".[106]

The protocol and the expert opinions were forwarded with all documents for a decision to be made on 29th May 1820.[107] The final decision had to be made on two pending complexes: the organisation plan of the medical-surgical studies for future military doctors from the Joseph's-Academy and the formation of a new class of medical doctor under the name of medico-surgeons at the University.[108] Politically explosive was the decision concerning the equivalence of the doctorate awarded at both institutions, which would mean the equivalence of medical education at the University with that at the Academy. After further meetings of the Study Court Commission, and the Aulic War Commission, as well as the Austrian, Hungarian, and Transylvanian Court Chancelleries, the final imperial resolution was passed on 3rd November 1822.[109] A few days later, the president of the Aulic War Council, Count Heinrich von Bellegarde (1756–1845), announced that Emperor Franz I had decided to fill the position of director and chief field physician of the k. k. Army at the *Josephs-Akademie* with Professor Dr. Johann Nepomuk Isfordink.[110] Thus, the Academy was preserved and retained the right to educate and award a doctoral degree in medicine and surgery. In the course of this process, it was stipulated that in the future:

> "[I]n every respect, as far as the course of instruction, the required previous knowledge of the students, the ordinary and strict examinations for obtaining a diploma and the taxes to be paid for it are concerned, exactly – as it is done at the medical and surgical teaching institutions, at the k u. k universities […] and everything that is prescribed for these, will also be observed at the *Josephs-Akademie.*"[111]

A comparison between the training requirements of 1785 and 1824 illustrates both how much the level of training had increased and how much the skills expected of a military surgeon had expanded within those forty years. As can be seen below, by 1854, there were no longer any differences between the University and the Joseph's-Academy in the study of medicine and in obtaining a doctorate.

106 Ibid., fol. 6.
107 Ibid.
108 Convolute supplement 3737 (cf. note 100), 17th April 1820, in: OeStA/AVA/StHK [Studienhofkommission] Wien 15 A Josephs-Akademie 121 ex octobri 822 VII, fol. 3.
109 The Commission was chaired by Prokop Count Lazansky von Bukowa, Hofratspäsident (court chancellor); from the University, the dean, Ludwig Freiherr von Türkheim, participated.
110 Note from Bellegarde to StHK, 22nd November 1822, in: OeStA/AVA/15 A Josephs Akademie, ad 288 ex Nov. 1822.
111 Note from Bellegarde to Studien-Hof-Kommission, 21st September 1822, in: OeStA/AVA/15 A Josephs- Akademie, ad 209 ex Nov. 1824.

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A COMPARISON BETWEEN THE CURRICULA AND EDUCATIONAL DEGREES IN 1785 VERSUS 1824	
1785	1824
SUB-SURGERY Six months of training plus an examination in anatomy, instruments, and bandages.	PATRONUS CHIRURGICAE/SURGEON 1st year: anatomy, botany, chemistry, & physics 2nd year: physiology, pathology, pharmaceutical commodity knowledge, art of dispensing & dietetics, bandages, and instruments
MAGISTER OF SURGERY Six years of hospital experience/entrance examination Two years of study Examinations in anatomy, physiology, physics and pathology, surgery, instruments and bandages, and Materia medica. [since 1796, forensic medicine, obstetrics, state medicine; since 1802, chemistry, botany]	MAGISTER OF SURGERY High school diploma, obligation to serve in the army for six years 3rd year: medical and surgical clinic, special medical & surgical pathology, therapy of internal diseases; surgical theory; theoretical and clinical ophthalmology; forensic pharmacology; state medicine
DOCTOR OF SURGERY Experienced field surgeon/battalion surgeon; eight years of hospital experience/ excellent exam results on the Magister course. The doctorate could be obtained without further study. The candidate only had to successfully pass another theoretical and practical examination on medical topics as well as a public operation (on a cadaver)	DOCTOR OF SURGERY & DOKTOR of MEDICINE as well as MASTER OF OPHTHALMOLOGY & OBSTETRICS. Five years of study of medicine/The curriculum and exams approximately comparable to those of the university/Writing two anamneses and a thesis/A public examination and public surgical and ophthalmological operation.

Tab. 1: The curricula and educational degrees in 1785 and 1824. Source: Brigitte Lohff

With this clear upgrading of the Academy as a college/university for military physicians, a fruitful and successful decade began under the directorship of Dr. Johann Nepomuk Isfordink, chief army field surgeon, chairman of the Military Pharmaceutical Directorate as well as the Permanent Field Sanitary commissioner. Due to the political upheavals of the *Vormärz* and the revolutionary events of 1848, the Academy was ordered to close on 4th October 1848, and all material and human resources were to be transferred to the University. In 1851, the *Curs für feldärztliche Zöglinge* was installed in Vienna, and in 1854, it was abandoned again. Then on 24th October 1854, the *kaiserlich-köngliche medicinisch-chirurgische Josephs-Akademie* was again ceremoniously opened. Scientifically highly successful and highly praised by the students as a place of aca-

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demic education,[112] the Academy was again criticised by the university professors within twelve years. This led to its final closure on 31st July 1874.[113]

7. Conclusion

Looking at the period from the founding of the Viennese Military surgical Academy to the end of the first third of the nineteenth century, the existence of specialised training of military surgeons was, as expected, influenced by the political situation but also the changing demands on medical and surgical education in general. The success of van Swieten's medical reform had required a rethinking of the training of military surgeons. The new university institution for Applied Wound Surgeons (1791) and the establishment of a Chair of Surgery (1798) at the Faculty of Medicine of the University exacerbated the conflict between the University and the Academy.[114] As a result, the Professors of the Faculty demanded that a doctoral programme for military physicians could be completed at the university. The Joseph's-Academy's professors defended their position that military doctors needed specific military knowledge and had to treat different medical problems than civilian doctors. This, they argued, could only be guaranteed at the Academy. Undoubtedly, the existence of the Academy was additionally threatened by the Napoleonic Wars/First Coalition Wars of 1792–1816 and the economic crisis at the beginning of the nineteenth century. Moreover, the military's demand that it provide a larger number of sub- and field surgeons as soon as possible had to be met. This conflicted with the goals of improved training. Moreover, teaching at the *Josephinum* was temporarily suspended from 1819 to 1824. Due to political and military interests, the *Josephs-Akademie* continued to receive support from Emperor Franz I and the court chancellor, Prince Metternich, which allowed for a renewed reform of education to provide a contemporary curriculum of military medicine.

Compared to medical education at the Faculty of Medicine, the Academy for the multi-ethnic monarchy deliberately admitted interns from all parts of the country because of its multilingualism. In addition, already at the beginning of the nineteenth century, special subjects were obligatorily taught at the Academy, which were later lectured at the University, such as hygiene, ophthalmology, skin disease (venerology), obstetrics, and aspects of public health medicine. Nevertheless, these multiple threats to the Academy's continued existence led to a

112 Brigitte Lohff, Das Josephinum als Ort der Medizin in der zweiten Hälfte des 19. Jahrhunderts, in: Angetter, et al., Strukturen (cf. note 5), pp. 118–151.
113 Lohff, Josephs-Akademie (cf. note 2), pp. 293–330.
114 Lohff, Ort der Medizin (cf. Note 113).

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steady improvement in military medical education and a gradual convergence with university medical studies. At the same time, this paved the way for a unified status for all medical subspecialties and physicians, including surgeon and surgery.[115]

115 In 1868, the unified status of surgery with the other medical disciplines was fully achieved; cf. Entwurf der Grundzüge zur Anbahnung von Reformen des Sanitäts-Wesens der k. k. Armee, in: Der Militärarzt, 30th October 1868, pp. 204–213.

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Daniela Haarmann

Sick Horses and Lost Wars: On the Importance of the Development of a Modern Veterinary System for the Habsburg Monarchy (ca. 1765–1830)

If one could vote for the most famous monument for the military history of the Habsburg Empire, the response would probably be the two equestrian statues of Prince Eugène of Savoyen (1663–1736) and Archduke Karl (1771–1847) at Heroes' Square in Vienna. Of course, both statues intend to glorify these two war heroes, but they would not be as half as glorifying without the two horses. And it is true, yet often neglected, that war heroes and wars depended on horses, and not any horses: healthy, military-prepared horses equipped with professionally forged horseshoes. That the horse's leg and its foot are crucial for the well-being of the animal was recorded by the ancient Greek historiographer, Xenophon, in 360 BC, and the ancient Romans developed horse shoes and sandals to preserve and improve their horses' health.[1] The importance of horses for military success, for mobility and transport, and for individual to economic purposes did not change much until the middle of the eighteenth century (in fact not until the middle of the twentieth century) when the modernisation of military medicine and, with this, veterinary medicine in the Habsburg Monarchy began.

The field of military history has many unanswered questions; its veterinary aspects are one of them. Despite the private research efforts (of better or lower quality) by mostly veterinarians, who tended on the whole to take an institutional and biographical approach, veterinary history is largely neglected.[2] This is even more noteworthy since the history of human and veterinary medicine are not only closely intertwined, but the former is a prominent subject of historic studies as is the field of Human–Animal Studies. Furthermore, zoonotic pandemics and

1 Erwin M. Ruprechtsberger, Hipposandalen und Hufeisen aus dem Ennser Museum, in: Jahrbuch des Oberösterreichischen Musealvereins 120a (1975), pp. 25–36, here p. 25.

2 Exceptions: Angela von den Driesch, Joris Peters, Geschichte der Tiermedizin. 5000 Jahre Tierheilkunde, Stuttgart 2003; Katharina Engelken et al. (eds.), Beten, Impfen, Sammeln. Zur Viehseuchen- und Schädlingsbekämpfung in der Frühen Neuzeit, Göttingen 2007; Daniela Haarmann, Kerstin Weich, Die Geschichte der Tiermedizin, in: Roland Borgards (ed.), Tiere. Kulturwissenschaftliches Handbuch, Stuttgart 2016; Bruce Vivash Jones, The History of Veterinary Medicine and the Animal-Human Relationship, Portland 2021.

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epidemics like Malaria, Swine Flu, COVID-19, and Monkey Pox, as well as the constant threat of poultry plague and BSE (*Bovine Spongiform Encephalopathy*) prove to us daily that healthy animals are an essential and important pre-condition for public health, or what in early modern German lands was called the establishment of a functional "Medical Police" (*Medizinalpolizei*).

Fig. 1: Monument of Archduke Karl at Heroes' Square, Vienna. Source: Copyright is with Daniela Haarmann.

This concept, which implied that the state was responsible for the administration of various kinds of health-related agendas, went together with the process of modernisation and the establishment of veterinary medicine's educational and regulatory systems in the Habsburg Monarchy. This essay explores how these two systems were established in the late eighteenth to the early nineteenth century. In

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doing so, it will show the crucial importance of veterinary medicine for both military and civil society. For this purpose, this chapter is structured in three sections. The first part will elaborate the historical background at the beginning of the veterinary system. The second and third part, however, will discuss why the instalment of a veterinary system was a story of both success and failure. In so doing, this essay deals with a topic that is part of the shared history of Central, East-Central, and Southeast Europe, and formed the basis for contemporary public health conceptions in these regions.

1. The Establishment of a (Veterinary) Medical System

In a letter to Count Rudolph Chotek dated 23rd March 1765, Empress Maria Theresa noted that she had "decided to erect here a school for the curation of cattle diseases, and assigned van Swieten to the task that He shall submit a proposal to Me of the remuneration for this teaching position to be employed teacher, and of his necessary affairs, as of all remaining requirements".[3] The institutional history of veterinary medicine in the Habsburg Monarchy and its successor states started in 1765 when the *k. k. Pferde-Curen- und Operations-schule* (imperial-royal Horse Cure and Operation School) opened its doors for military horse smiths in Vienna. This school was the explicit wish of Empress Maria Theresa and therefore marked the beginning of governmental control over at least military horse medicine. Ten years later, a chair for *Viehseuchenkunde* (Study of Cattle Plagues) was introduced as part of the institute for human medicine at the University of Vienna, and two years later, also on imperial order, a university hospital for cattle and horses opened in the Viennese suburbs.[4] Both were meant to be an additional subject for civil students of human medicine as part of their studies in the prevention and treatment of diseases. These three events laid the ground for further foundations of veterinary schools and chairs in the Habsburg Monarchy in the next decades until approximately 1830, when the closing of some of those schools ended this early "foundation phase".

3 Letter of Maria Theresa to Count Rudolph Chotek (23rd March 1765), Österreichisches Staatsarchiv [Oesta], Allgemeines Verwaltungsarchiv [AVA], Studienhofkommission [StHK], Unterricht Teil 1, box 9, signatur [sign.] 4 Med. Tierarznei, 17 ex 1765: "*Ich habe beschlossen [,] hier eine Lehr-Schule zu Heilung der Vieh-Krankheiten errichten zu lassen, und dem van Swieten aufgetragen, daß Er Mir den Vorschlag wegen Salarierung des zu diesen Lehr-Amte anzustellenden Professoris, und dessen nöthigen Geschäfte, wie auch aller übrigen Erfordernisse einreichen solle*".

4 The school was located at Linke Bahngasse in today's third district, and was home to today's University of Veterinary Medicine until 1996. Now, the University for Music and Performing Arts (*Universität für Musik und Darstellende Kunst*) is located in this area.

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This first decade of the institutional history of veterinary medicine already defined two educational strands: one for military (blacksmiths) and one for civil (human medicine, especially disease control) purposes. Prior developments influenced the foundation of the two main strands. On the military side, it was recent military disasters, most of all the Seven Years' War (1756–1763), that demonstrated the importance of horses, and consequently the need for well-trained blacksmiths. For the civil strand, it was the constant experience of cattle plagues that would lead to food shortages and hunger crises. Additionally, Enlightened Absolutism shaped both the political and conceptual frame in which this process of reforming veterinary and human medicine was embedded.

The state in the form of the central government in Vienna started to perceive health as a matter of state that should be centrally controlled, in part by defining what was "true" and what was "false" medicine. The so-called *Sanitätshauptnormativ* (Chief Medical Regulations) published in 1770, formulated the plan to standardise medical education and (human as animal) disease control on the basis of the principles of Enlightened Absolutism. Until that point, healing practices for humans as for animals were defined according to the paradigm of humoral pathology, as well as religious–superstitious and locally rooted approaches. The man behind this reforming mission was Gerard van Swieten (1700–1772), who in general fought against superstitious beliefs like vampirism and alchemy.[5] The campaign against these irrational beliefs on state and juristic levels was conducted according to the principles beloved by Enlightened Absolutists: rationality, pragmatism, and central control.

Previously, health and healthcare, be it human or animal, had been mostly a topic of private affairs, of local practices, traditions, and superstitions, carried out by barber-surgeons, pharmacists, midwives, and often unqualified quack doctors. Due to the efforts of van Swieten, the enlightened Habsburg state intended to end this "medical pluralism" by reforming and standardising medical education and medical practices.[6] This was even more true for animal health, where the animal healers were even less qualified than those concerned with human patients: shepherds, *Sauschneider* (pig castrators), renderers, stablemen, and blacksmiths but also headmen and lay healers for human diseases.[7] This reform

5 Éva H. Balázs, Hungary and the Habsburgs 1765–1800: An Experiment in Enlightened Absolutism, Budapest 1987, p. 38.

6 Matthew Ramsey defines this term as "[…] the coexistence of different types of medical practitioners and of divergent and sometimes incompatible medical practices and beliefs, which may or may not be limited to certain types of practitioners". Cf. Matthew Ramsey, Medical Pluralism in Early Modern France, in: Robert Jütte, Medical Pluralism. Past – Present – Future, Stuttgart 2013, pp. 57–80, p. 57.

7 For further information, see especially Jutta Nowosadtko, Scharfrichter und Abdecker. Der Alltag zweier 'unehrlicher Berufe' in der Frühen Neuzeit, Paderborn et al. 1994; Jutta Nowosadtko, Milzbrand, Tollwut, Wölfe, Spatzen und Maikäfer. Die gesellschaftliche Verteilung

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of education went hand in hand with the establishment of medical police, which can be regarded as an early form of public health. Today, an essential part of our daily life (as the COVID-19 pandemic reminded us), public health as part of state affairs had roots in Enlightened Absolutism.[8] The basic idea was that the state had the obligation to administer and care for the general health of the community. The aim of van Swieten's reform programme was to establish a centrally controlled homogeneous system of medical education and practice within the borders of the Empire.[9]

Even during the eighteenth century, the concept of what we call today "One Health – One Medicine" was present in the sense that a causality between sick cattle, bad animal products, and sick humans was known. Again, this connection was nothing but a revolutionary development in Vienna, but here, too, van Swieten was most likely inspired by his teacher, Hermann Boerhaave (1668–1738), who earlier taught the importance of studying animal diseases to his students.[10] In this context, one has also to regard the—from our contemporary perspective—often catastrophic hygiene standards in slaughterhouses and their location within populated areas.[11] As a consequence of the awareness of the connection between human and animal diseases, the treatment of cattle diseases as a standard procedure of meat inspection (*Fleischbeschau*) was taken under state control.

At the level of officialdom, animal healing during the early eighteenth century was entrusted to the *k. k. Kurschmied* (Cure Smith). He was responsible for

von Zuständigkeiten bei der Bekämpfung von Viehseuchen und schädlichen Tieren in der Frühen Neuzeit, in: Katharina Engelken et al. (eds.), Beten, Impfen, Sammeln. Zur Viehseuchen- und Schädlingsbekämpfung in der Frühen Neuzeit, Göttingen 2007, pp. 81–100; Peter Wirnsperger, Wernfired Gappmayer, Die Sauschneider. Ein altes, ehrsames Lungauer Gewerbe, Mauterndorf 1990.

8 See most of all, George Rosen, A History of Public Health, Baltimore 1993, 2nd edn., pp. 107–167; for a more comparative approach between countries, see Dorothy Porter (ed.), The History of Public Health and the Modern State, Boston 1994. However, the fact that the Habsburg Monarchy and its successor states are missing in this contribution, emphasises the need for a detailed historic study on the history of public health in East, East-Central, and Southeast Europe.

9 E. C. Spary, Introduction: Centre and Periphery in the Eighteenth-Century Habsburg "Medical Empire", in: Studies and Philosophy of Biological and Biomedical Sciences 43 (2012), pp. 684–690, here p. 684. It is noteworthy that this idea was nothing new. Van Swieten learnt it from his famous Dutch medical professor Herman Boerhaave (1668–1738) who had already reformed the medical education in Leiden, where van Swieten studied medicine. This circumstance led Spary to the following annotation: "For, strikingly, van Swieten's fame as a physician rested precisely upon his *lack* of originality – upon his claim to be the successor to his more famous teacher Booerhaave" – Ibid., p. 684.

10 Jones, History (cf. note 2), p. 278.

11 For further information, see Thimjos Ninios et al. (eds.), Meat Inspection and Control in the Slaughterhouse, Chichester 2014.

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treating and curing sick animals, most of all imperial and military horses.[12] Also stablemen at the imperial court were often approbated to perform the *Roßarzneykunst,* meaning literarily the "healing art of horses", throughout the Middle Ages and Early Modern Period. The German archaezoologist and historian for veterinary medicine Angela von den Driesch introduced to scholarship the term *Stallmeisterzeit* (Stablemen Period) to describe the phase before the institutional period of veterinary medicine that would begin in 1762 with the foundation of the world's first veterinary school in Lyon.[13]

Only three years after the foundation in Lyon, the Horse Cure and Operation School opened in Vienna by the cure smith Ludwig Scotti (1728–1806), who originated from a family of blacksmiths. The intention of this school was not, as the foundation letter of Maria Theresa might suggest, to treat cattle plagues but rather to work with military horses. The school for cattle diseases was founded only ten years later by the trained physician for human medicine, Johann Gottlieb Wolstein (1738–1820). To gain theoretical and practical knowledge about veterinary medicine, he travelled with another physician, Schmid, to the veterinary schools in Alfort (near Paris) in the early 1770s. His *k. k. Thierspital* (royal-imperial Animal Hospital) was opened in 1777 and combined research, education, and treatment. The other two institutions in Vienna—the military horse school and the chair at the Medical Faculty—closed their doors eventually and their teachers became either part of the Animal Hospital or found another position at other medical faculties in the Empire.

The Animal Hospital implemented the same concept as applied for human medicine, whose reform took place parallel to the school of veterinary medicine. These acts laid the ground for the phase of the so-called First Viennese Medical School:[14] Be it human or animal, the sick patients should not only be treated but serve likewise as objects of research and of clinical practice. Previously, studying medicine meant most of all memorising theory. Henceforth, students would turn theory into practice: they had to treat the patients.[15] This led to a reinvention of

12 Driesch, Peters, Geschichte (cf. note 2), p. 110; Alexander Hönel, Querelen von der Gründung bis zum Ende des Habsburgerreiches. Die Schule im Spannungsfeld zwischen militärischen und wirtschaftlich-zivilen Interessen, in: Daniela Haarmann, Veterinärmedizinische Universität Wien (eds.), 250 Jahre Veterinärmedizinische Universität Wien. Verantwortung für Tier und Mensch. Festschrift, Vienna 2015, pp. 24–33, here pp. 26–30.

13 Driesch, Peters, Geschichte (cf. note 2), pp. 85–132.

14 *Erste Wiener Medizinische Schule.* For further information, see, e. g., Erna Lesky, Die Wiener Medizinische Schule im 19. Jahrhundert, Graz / Köln 1978; Paul Pfeiffer, Das Allgemeine Krankenhaus in Wien um 1784. Vor dem Hintergrund der Geschichte des Hospitalwesens und der theresianisch-josephinischen Gesundheits- und Fürsorgepolitik im 18. Jahrhundert, Berlin 2012.

15 Wolfgang U. Eckart, Geschichte, Theorie und Ethik der Medizin, Berlin / Heidelberg, 7th edn., p. 155; William Bynum, Geschichte der Medizin, Stuttgart 2010, pp. 69–70; Pfeiffer, Allgemeine (cf. note 14), p. 47.

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the hospital: it was not a medical space for healing and curation only but also as a space of medical education and research.[16] This concept was realised for the Habsburg Empire in Vienna with the foundation of both the Animal Hospital in 1777 and the General Hospital (*Allgemeines Krankenhaus*) in 1784.[17]

Additionally, and in following the aim to establish a medical system and medical policy, Wolstein did not receive the imperial order to establish a veterinary school only but also to publish a book about cattle disease. This book, *Anmerkungen über die Viehseuchen* (Notes Regarding Cattle Diseases, 1782), became the standard work on how to treat cattle diseases within the Habsburg Monarchy. It was translated into the most important languages of the Habsburg Monarchy and even had to be read out during the Holy Mass so that the illiterate peasants would learn about the book's content.[18] This book, and the veterinary school in Vienna, would lay the foundation of a veterinary system in the Habsburg Monarchy on both the military and the civilian side.

Due to the frequency of plagues and wars, and the adoption of the concept of Enlightened Absolutism on the other hand, the Habsburg Monarchy established the basis for a centralised and modernised medical system in the last decades of the eighteenth century. This system did not distinguish much between animal or human medicine but applied the very same concepts to each domain. However, within veterinary medicine, two strands of education were present from the very start: a military and a civil–medical. These two parts of veterinary medicine would not only shape its institutional history until the end of the Monarchy in 1918 (including even a bloody uprising in 1914) but also would define the question of the institutional focus of the veterinary medicine during the early nineteenth century.[19]

2. A Story of Success

"The purpose of an institute for veterinary medicine, as it shall exist in all imperial-royal states of the Austrian Monarchy as the central point for all veterinary knowledge, and the Normal Education School for all individuals, who want to devote themselves to the study and the execution of the different branches of the veterinary healing arts, is necessary on multiple levels."[20] These lines, published

16 Bynum, Geschichte (cf. note 15), p. 67.
17 Jones, History (cf. note 2), p. 278.
18 Oesta, AVA, StHK, Unterricht Teil 1, box 19, Fasc. 79, 1781 (9th November 1781).
19 Hönel, Querelen (cf. note 12), p. 30.
20 Allerhöchst genehmigter Plan zur Organisirung und Erweiterung des k. k. Thierarzney-Instituts zu Wien, in: Medicinische Jahrbücher des kaiserl.-königl. Staates, vol. 2, Vienna 1824/25, pp. 162–255, here pp. 162: "*Der Zweck eines Thierarzney-Institutes, welches in den*

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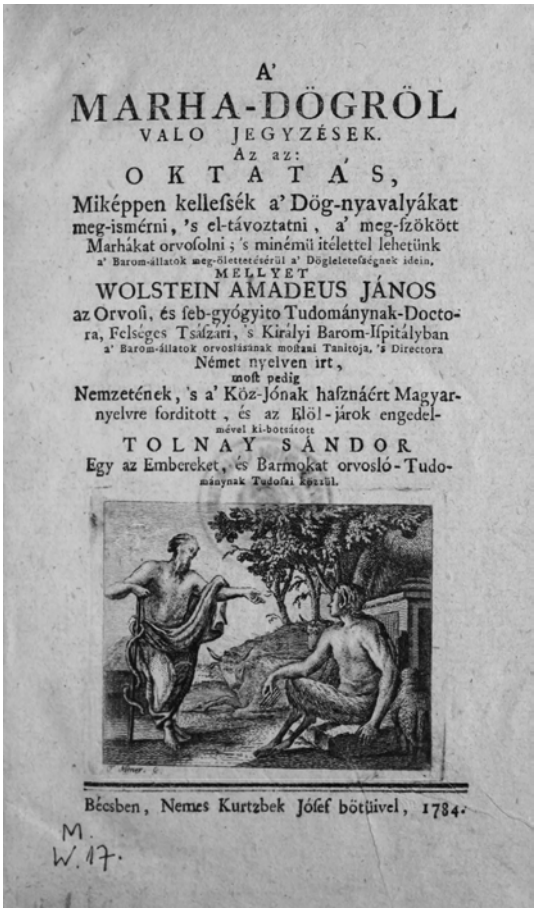
A'
MARHA-DÖGRÖL
VALO JEGYZÉSEK.
Az az:
OKTATÁS,
Miképpen kelleſsék a' Dög-nyavalyákat
meg-ismérni, 's el-távoztatni, a' meg-ſzökött
Marhákat orvoſolni; 's minémü itélettel lehetünk
a' Barom-állatok meg-ſlettetésérül a' Dögleletességnek idein.
MELLYET
WOLSTEIN AMADEUS JÁNOS
az Orvoſi, és ſeb-gyógyito Tudománynak-Docto-
ra, Felséges Tsáſzári, 's Királyi Barom-Iſpitályban
a' Barom-állatok orvoslásának moſtani Tanitoja, 's Directora
Német nyelven irt,
moſt pedig
Nemzetének, 's a' Köz-Jónak haſznáért Magyar-
nyelvre forditott, és az Elöl-járok engedel-
mével ki-botsátott
TOLNAY SÁNDOR
Egy az Embereket, és Barmokat orvosló-Tudo-
mánynak Tudoſai közül.
Bétsben, Nemes Kurtzbek Jóſef bötüivel, 1784.
M.
W. 17.

Fig. 2: The Hungarian translation of Wolstein's book about cattle diseases, translated by one of his students and then founder of the veterinary school in Pest, Sándor Tolnay (1748–1818). Source: Hungaricana, https://library.hungaricana.hu/hu/view/KlasszikusOrvosiKonyvek_271/?pg=0&layout=s, 15.09.2022.

in the *Medicinische Jahrbücher* (Medical Annual Reports) in 1824 on the occasion of the opening of the new Viennese veterinary institute building the previous year, contain two significant items of information.[21] First, veterinary institutes were to exist in all provinces of the Monarchy and form provincial centres of the veterinary system. Second, the veterinary system consisted of different branches

sämmtlichen k. k. Staaten der österreichischen Monarchie der Central-Punct für alles thierärztliche Wissen, und die Normal-Bildungsschule für alle Individuen, die sich mit der Erlernung und Ausübung der verschiedenen Zweige der Thierheilung beschäftigen wollen, seyn soll, ist notwendig mehrfach".

21 The institute is located today in the third Viennese district.

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with different purposes. Both purposes justified the existence of those veterinary institutes. This section highlights the institutional development of the institute in Vienna and in the rest of the Monarchy, as well as healers and their patients.

On 9th November 1781, Emperor Joseph II ordered the establishment of so-called *Filial-Thierarzneyschulen* (affiliated veterinary schools) in every part of the Monarchy.[22] This year can be seen as the "birthdate" of a Habsburg veterinary system that would eventually lay the ground for the veterinary schools and veterinary systems in much of contemporary central Europe.[23] According to this order, henceforth every district had to be staffed with "physicians and surgeons trained in the veterinary arts" (*Vieharzney verständigen Ärzten und Wundärzten*).[24] To that end, the establishment of a chair for cattle plagues at every medical faculty of the Empire was decreed.[25]

To fill these chairs with competent teachers, the "first generation of veterinarians"—all of them trained physicians for human medicine—studied the theoretical and practical aspects of veterinary science and methods of cure in Vienna.[26] After their two years of study, these men went back to their home country to become professors for cattle plagues. This procedure should have guaranteed a certain level of quality and education standards. Also, the curriculum of the future schools (most of all chairs at the medical faculties) was based on the Viennese one.

So, by 1820, we find a monarchy-wide network of standardised veterinary schools, most of them being *Filial-Thierarzneyschulen* of Vienna;[27] only the schools of the Kingdom of Lombardy-Venetia (Milan, Verona, Venice, Pavia, and Padua) were established independently.[28] The two veterinary chairs in Transylvanian Cluj and Sibiu were most likely Viennese foundations, though the known

22 Ibid., p. 163.

23 On the establishment of this veterinary system, see Daniela Haarmann, Das Wiener Thierarznei-Institut und die Entwicklung eines habsburgischen Veterinärwesens, in: Daniela Haarmann, Veterinärmedizinische Universität Wien (eds.), 250 Jahre Veterinärmedizinische Universität Wien. Verantwortung für Tier und Mensch. Festschrift, Vienna 2015, pp. 34–45, especially p. 38.

24 Oesta, AVA, StHK, Unterricht Teil 1, box 19, Fasc. 79, 1781 (9th November 1781).

25 Oesta, AVA, StHK, Unterricht Teil 1, box 19, Fasc. 79, 1781 (9th November 1781).

26 Daniela Haarmann, Ein Berufsstand entsteht. Von den Anfängen tierärztlicher Standesgeschichte mit Ausblick auf das 21. Jahrhundert, in: Daniela Haarmann, Veterinärmedizinische Universität Wien (eds.), 250 Jahre Veterinärmedizinische Universität Wien. Verantwortung für Tier und Mensch. Festschrift, Vienna 2015, pp. 98–106, here p. 36.

27 For a map, see Haarmann, Wiener Thierarzney-Institut (cf. note 23), p. 37.

28 N. Lanzilotti-Buonsanti, R. Scuola Superiore di Medicina Veterinaria di Milano. Annuario per l'Anno Scolastico 1883–84 (Mailand 1884), in: Giancarlo Mandelli (ed.), Due secoli di ordinamenti e statuti. La Scuola Veterinaria di Milano; 1791–1991, vol. 1, Milan 1992, pp. 14–55; Alba Vegettti, Bruno Cozzi, La Scuola di Medicina Veterinaria dell'Università di Padova, Trieste 1996, p. 1, p. 21; Haarmann, Wiener Thierarzney-Institut (cf. note 23), pp. 36–37.

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sources do not allow us to prove this thesis beyond any doubt.[29] However, given that these two cities and their educational system were part of the Habsburg Monarchy, and that almost all the other schools were affiliated with the Viennese institute, it is safe to assume that it was the same case in Cluj and Sibiu. Some of these schools still exist today, including the University of Veterinary Medicine in Budapest and L'viv; others—like the chairs in Prague, Innsbruck, Klagenfurt, Salzburg, or Graz—closed eventually during the nineteenth and twentieth centuries. But as we can see at the four chairs in today's main cities of Austrian federal states, the net of veterinary education covered large parts of the Empire with the exception of the Hungarian parts (in the Kingdom of Hungary only the schools in Budapest, Cluj and Sibiu existed).

The affiliation of these chairs and schools with the faculties for human medicine, and their nominal association with the treatment of cattle diseases, indicated that they were meant to fight against diseases that threatened livestock and, by extension, the food supply and public health. They were not, however, for studying and treating sick pets. They were most likely neither spaces of knowledge production and science, nor—given the role of Habsburg universities as training halls for civil servants—did they have an animal hospital as did the Viennese institute.[30] Yet, not all of them focused exclusively on cattle and livestock; some provided additional courses for horse medicine, some focused exclusively on horses, such as a school in Linz in the 1810s and 1820s.[31] However, schools for horse medicine only were mostly called *Hufbeschlagsschule* (farrier school) and were not—as it is often mistaken—identical to schools for cattle diseases or the veterinary institutes. So, we must differentiate between schools with a more medical approach (cattle diseases, horse medicine) and those with a more artisanal approach (farrier school). However, the first kind of schools were the more common, while farrier schools were largely part of larger, independent institutes like the one in Vienna or Pest.

This leads us to the question: Who instructed and who attended these veterinary schools? To answer this question, we have to first note that there was neither what we would call today veterinary medicine nor veterinarians during the foundation period. Veterinary medicine consisted of the above-mentioned military and civil strands. Both strands also defined the human healers and the animal patients.

The military side intended farriers to be trained in the therapeutic treatment and horseshoeing of (military) horses. The civil side, however, was more complex:

29 Haarmann, Wiener Thierarzney-Institut (cf. note 23), p. 36.

30 Jan Surman, Universities in Imperial Austria 1848–1918: A Social History of a Multilingual Space, West Lafayette, IN 2019, p. 20.

31 Haarmann, Wiener Thierarzney-Institut (cf. note 23), p. 36.

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the range went from students of human medicine as barber-surgeons to stablemen, meat inspectors, shepherds, and hunters.[32] Accordingly, we encounter from a social perspective a very heterogeneous field of medical actors. Not all of them studied the very same courses but the Veterinary Institute in Vienna offered different courses for various kinds of students. For example, we read in the curriculum of 1824 that there was a course specially for meat inspectors, a "popular lesson" (*populäre Unterricht*) on domestic animals for shepherds and on dog diseases for hunters.[33] Students of human medicine, however, had the most intense curriculum. Every student had to complete at least the lectures related to animal diseases and plague prevention, especially those students who aimed at securing public office, such as *Kreisphysicus*—a district physician.[34]

Those "medical bureaucrats", meaning physicians and surgeons in public service (like district physicians), were responsible for enforcing the official measurements against both animal and human plagues.[35] These trained physicians and surgeons formed a unit that was called *Seuchenpolicey* (Plague Police) or *Medizinalpolicey* (Medical Police) or—especially for animal diseases—*Veterinärpolicey* (Veterinary Police).[36] From 1832, we have a detailed overview of the structure of the Veterinary Police in the *Medicinische Jahrbücher*, though it does not represent a strict top-down organisation since the military officers had, of course, no role in the civil administration and vice versa. The important aspects of this unit can best be represented in tabular form:

German Title	Translation	Description of the assigned duties
Hoftierarzt	Veterinarian for the imperial court	Two veterinarians in charge of the animals at court (most likely mainly horses)
Landestierarzt	Provincial veterinarian	For the regional administration and enforcement of veterinarian public health measurements, at least one in every province of the Monarchy with the exception of the Kingdom of Hungary (see below), Silesia, Bukovina, and Vorarlberg
Komitatstierarzt	County veterinarian	

32 Medicinische Jahrbücher 1824/25 (cf. note 20), pp. 163–164.
33 Ibid., p. 171.
34 Oesta, AVA, Unterricht, StHK, Teil 1, Ktn. 19, Fasz. 79 1781 (9.11.1781).
35 Spary, Introduction (cf. note 9), p. 687.
36 See also Caren Möller, Medizinalpolizei. Die Theorie des staatlichen Gesundheitswesens im 18. und 19. Jahrhundert, Frankfurt /M. 2005; Carsten Stühring, Der Seuche begegnen. Deutung und Bewältigung von Rinderseuchen im Kurfürstentum Bayern des 18. Jahrhunderts, Frankfurt/Main et al. 2011.

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(Continued)

German Title	Translation	Description of the assigned duties
Militärgestütstierarzt	Military stud-horse veterinarian	Obligatory part of every cavalry regiment, carrying trade, artillery unit, representative in every military stud of the Monarchy (like Mezőhegyes, Babolna, Cremona)
Grenztierarzt; Kontumaztierarzt	Border veterinarian; quarantine veterinarian	One border veterinarian in every border regiment, and one veterinarian in charge of enforcing quarantine restrictions for cattle that were suspected of having a disease
Bezirkstierarzt	District veterinarian	In Styria, Tirol, and Vorarlberg located veterinarians, paid by the communes and farm owners

Tab. 1: Overview of veterinarians in public, military, or imperial service. Source: Medicinische Jahrbücher des kaiserl. Königl. Österreichischen Staates, vol. 11 or Neueste Folge vol. 2, part 1, Vienna 1832, pp. 14–15.

What is missing in the table above is the office of the *Protomedicus*. The *Protomedicus* was the prior physician within a province or land of the Empire, so he was one of the most influential "medical bureaucrats" and "veterinary bureaucrats". His responsibilities included, among other duties, the administration of an epidemic disease outbreak, as we can read in a collection of medical laws of the Austrian, Bohemian, and Galician lands published in 1819:

> "[In case of the outbreak] of epidemics among humans and animals the county protomedicus has to gain information of the origin, the process, the character and the spread [of the disease] through the district physicians as through other ways [. Furthermore,] he has to make the necessary recommendations for curing, and in case of emergency he has to provide is services in situ to direct the necessary contra measurements himself."[37]

It also fell to the *Protomedicus* to take measures for border protection should an epidemic, either human or animal, break out in a neighbouring country. The only exception was the *Cordon sanitaire* at the Ottoman border in the southeast. In this case, the *Hofkriegsrat* (Aulic War Council) was in charge of disease control.[38]

37 Gustav Kopetz, Österreichische politische Gesetzkunde, oder systematische Darstellung der politischen Verwaltung in den deutschen, böhmischen, und galizischen Provinzen des österreichischen Kaiserthumes, part 1, vol. 2, Vienna 1819, pp. 148–149: "*Bey Epidemien unter Menschen und Thieren hat sich der Landes-Protomedicus, sowohl durch Berichte der Kreisärzte, als auch durch andere Erkundigungsmittel die Kenntniß von der Entstehung, dem Verlaufe, von den Beschaffenheit und Ausbreitung derselben zu verschaffen; die nöthigen Vorschläge zur Heilung zu machen, und sich in Nothfällen selbst an Ort und Stelle zu verfügen, um die nöthigen Gegenanstalten persönlich zu leiten*".

38 Ibid., p. 149.

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Here, we can see again the interference of military with civil medical competences regarding medical police.

It is evident from the above that the main healers practising veterinary medicine were craftsmen, for example, blacksmiths and medical men for human medicine, as the office of the *Protomedicus* illustrates. The independent profession of veterinary medicine did not evolve until the second half of the nineteenth century.[39] Nonetheless, Bruce Vivash Jones has emphasised that during the initial phase, the "medical profession had begun to appreciate that veterinary and human practice were in fact two clinical endpoints for one discipline".[40]

But this result is only true for the civilian line of education and practice. As we have seen, during the late eighteenth and early nineteenth centuries, veterinary medicine served as an auxiliary science of human medicine. On the military line, however, it was less a science but rather a craft with a practitioner who often lacked basic reading skills to understand the relevant literature. Yet, as the table above shows, both medical and artisanal knowledge were important in early veterinarian medicine. After all, its prime goals were to control animal plagues and to improve the health of military horses. Thus, by the middle of the nineteenth century, there was a military veterinary network that spanned from Vienna to the military border zones of the Empire.[41] There was a study programme for military students in Pest and L'viv comparable to Vienna.[42]

That said, the main two patient groups in this early phase of veterinary medicine were horses and cattle. However, during the first quarter of the nineteenth century, the range of patients became more manifold. Sometime in the early 1800s, dogs became another patient category. This had two reasons: firstly rabies, which was carried and transmitted by (homeless) dogs in the streets of cities, became a public health concern, and secondly, the developing mass phenomena of dogs as pets of the middle class.[43] While the first cause was still part of public health and disease prevention, the second was the result of a social development. The political, cultural, and economic strengthening of the middle class and the consequent imitation of noble characteristics included the keeping

39 Haarmann, Berufsstand (cf. note 26), pp. 99, 101.

40 Jones, History (cf. note 2), p. 277.

41 Alexander Hönel, Katrin Tschachler, Das österreichische Militärveterinärwesen 1850–1918. Tierärztliche Tätigkeit zwischen Empirie und Wissenschaft, Graz 2006, p. 29.

42 For the school in Pest, see János Perényi, 225 éves a magyar állatorvosképzés / 225 years of Hungarian Veterinary Education, Budapest 2012; for the school in L'viv: Р. Кравців, Львівська державна академія ветеринарної медицини імені С. З. Ґжицького (1784–2000).

43 Haarmann, Berufsstand (cf. note 26), p. 102. The idea of animals as acting parts of city histories becomes more and more a topic in the different disciplines in the Human–Animal Studies; see, e.g., Clemens Wischermann (ed.), Tiere in der Stadt, in: Informationen zur modernen Stadtgeschichte 2 (2009); Thomas Almeroth-Williams, City of Beasts: How Animals Shaped Georgian London, Manchester 2019.

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of dogs as companion animals or pets.[44] So, the 1820s witnessed not only an increase in the number of publications on dog health but also the opening of a dog hospital in Vienna as part of the Veterinary Institute.[45]

Most interestingly, even though dogs were also important to the military, they were evidently of no interest to the military side of veterinary education and practice in this period. A reason for this might have been that—in comparison to horses—dogs were easy to breed and not expensive to keep. However, as much as dogs became a subject of the human–animal relationship, and the efforts of individual service dogs in contemporary times has been lauded (e. g., the service dogs involved in the rescue missions after 9/11), the social–cultural aspect of dogs in warfare is largely unstudied.[46]

Vienna was the centre of veterinary education and policy which reflected the capital's preeminent status within the Empire. Students went there to learn the veterinary art and then to impart the knowledge within their home country, as founders of veterinary schools, as veterinary bureaucrats, or as practising veterinarians in the countryside. However, the latter was hardly successful, leading to the (short-term) failure of this early phase of a veterinary system.

3. A Story of Failure

As quickly as the schools, institutes, and chairs were founded and established across the Habsburg Monarchy, they were soon dissolved. The history of institutionalised veterinary medicine seemed to have ended even before it really began. But why was this first foundation period of the institutional history of veterinary medicine ultimately a failure, at least on a short-term view? The reasons for this are multi-layered and related to the existing state of medical knowledge, structural issues, ongoing conflicts between the civil and military line, as well as the image problems of the profession as animal healer.

A key reason is to be found in a proper lack of modern knowledge of anatomy, physiology, biology, immunology, and pathogens.[47] Consequently, the lay civil healers, the stablemen and blacksmiths, and the trained physicians in military, imperial, and state service, all suffered from a lack of success in the healing arts. Medical science was still in its fledgling stage, and the theories about hygiene in

44 See also Michaela Laichmann, Arbeitsvieh und Schoßtier. Hunde im mittelalterlichen und frühneuzeitlichen Wien, in: Karl Brunner, Petra Schneider (eds.), Umwelt Stadt. Geschichte des Natur- und Lebensraumes Wien, Vienna et al. 2004, pp. 414–418.

45 Haarmann, Berufsstand (cf. note 26), p. 102. The exact date of opening is unknown.

46 For an overview of the topic "Animals and War", see Rainer Pöppinghege (ed.), Tiere im Krieg. Von der Antike bis zur Gegenwart, Paderborn et al. 2009.

47 Driesch, Peters, Geschichte (cf. note 2), p. 92.

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medicine, such as the discovery of bacterial and viral pathogens, which would revolutionise medicine at the end of the nineteenth century, was still unforeseeable in the 1820s. A proof for this thesis is a note from the Hungarian prefecture originating in 1787, which stated bluntly that Wolstein's book concerning cattle diseases was completely effectless.[48]

Another reason, this time in connection with the military strand of veterinary education, was that blacksmiths were craftsmen, lacking the necessary educational requirements to follow the lessons. That many of them were also illiterate (or mastered only the most basic reading skills) was a point of severe criticism by the civilian side of the Viennese veterinary school, which tirelessly continued to demonstrate against the unequal treatment between military and civilian students throughout the nineteenth century.[49]

An additional aspect of the ongoing conflict between the two strings of veterinary education stemmed from the way in which the Viennese institute was governed. In the face of the French Revolution and the Napoleonic Wars, from 1796 to 1812, the Animal Hospital, later *k. k. Militär-Thierarzneischule* (royal-imperial Military Veterinary School) was under military command. This led to a reduction of civil education and research,[50] even though Habsburg universities at this time undertook the education of civil servants rather than conducting research.[51] As a consequence, the (military) horse became again the most important patient as an object of teaching. The conflict even touched on the main purpose of the veterinary school: while the civil side referred to the importance of veterinary medicine for public health, the military side saw the only reason for its existence as the education of servicemen. Characteristic of the latter position is a statement by the former director of the institute, Field Marshal Josef Wenzel von Radetzky (1766–1858), who claimed that the Viennese institute was becoming impractical after installing a civilian supervisor: "After the war of 1809, the institute got under the administration of the university, and became – as soon as it was not under military custody anymore – again bad and non practical."[52]

A further reason for the problems associated with the emerging institutionalised veterinary system was civil veterinary education's lack of prestige, which was connected to the profession's low status in relation to human medicine. After all, who would want to work with sick animals if he (and it was only men) was also

48 Magyar Nemzeti Levéltár, Országos Levéltár, C = Helytartótanácsi levéltár, Departamentum sanitatis (C66), protocol vol. 23, Nr. 32982 (25th October 1787).

49 For a summary of this conflict, see Hönel, Querelen (cf. note 12).

50 Ibid., p. 25.

51 Surman, Universities (cf. note 30), p. 20.

52 Cf. Hönel, Querelen (cf. note 12), p. 25: "*Nach dem Kriege von 11809 kam das Institut unter die Universität und wurde, sowie es außer die militärische Obhut kam, wieder schlecht und unpraktisch*".

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a trained physician for humans? Accordingly, the Hungarian *Protomedicus* could not imagine that a physician would "demean" (*herbeilaßen*) himself to run a veterinary practice in the countryside.[53] Furthermore, in the early nineteenth century, the work of a veterinarian meant mostly the treatment of cattle, which was regarded as dirty work. Most students of medicine were, however, of urban and middle-class origin and thus were not especially interested in caring for the livestock of country folk. Becoming veterinarians meant a decline in social status. For their part, rural people and peasants did not trust those "city boys",[54] and did not want them near their prestigious cattle, as officials in Milan reported to Vienna in 1847.[55] The Hungarian *Protomedicus* summarised the problem as follows: "Capable veterinarians for the peasant, who would go into the stables and depend on a low wage, can only originate from the low class of society."[56] Moreover, during the early modern period, working with the bodies of sick and dead animals was typically conducted by so-called *unehrliche Berufe* (dishonest professions), such as hangmen or renderers.[57] Those associated with these unglamorous professions faced social discrimination and ostracism.[58] This reality almost certainly underlies Maria Theresa's declaration in her 1765 foundation letter that her government would punish all those "which would indecently assault the teachers of this lectureship".[59] Only one year later, the Empress emphasised that work with dead horses (which demanded the equivalent of a doctorate in medicine) was honourable, and those who demeaned it would be punished severely.[60]

Consequently, the idea to establish a homogeneous system for veterinary education that would also "reach the last subject" failed only after a few deca-

53 Oesta, AVA, StHK Teil 2, box 997, Fasc. 5159 (20th August 1842).

54 Cf. Haarmann, Berufsstand (cf. note 26), p. 103; original quote in: Oesta, AVA, Unterricht, StHK Teil 2, box 369, Fasc. 6439 (18th September 1847).

55 Oesta, AVA, Unterricht, StHK Teil 2, box 369, Fasc. 6439 (18th September 1847).

56 Oesta, AVA, StHK Teil 2, box 997, Fasc. 5159 (20th August 1842): "*Fähige Thierärte für den Landmann, die in die Ställe gehen u. für geringen Lohn über allselbst angewiesen, können nur aus der niederen Volksklasse hervorgehen*".

57 Dishonourable crafts were occupations that—as a social category—were occupations that were seen as being "low, common, or dirty" (*niedrig, gemein oder schmutzig*), and derived from the concept *infamia* as established by the Roman Law. Cf. Anne-Marie Dubler, Unehrliche Berufe, in: Historisches Lexikon der Schweiz, https://hls-dhs-dss.ch/de/articles/025613/2013–01–25/ (16.6.2022).

58 Ibid.

59 Letter of Maria Theresa to Count Rudolph Chotek (23rd March 1765), Oesta, AVA, StHK, Unterricht Teil 1, box 9, signatur (sign.) 4 Med. Tierarznei, 17 ex 1765: "[…] *welche sich gegen der sich in diesem Lehr-Amte Lehrer vergehen sollte* […]."

60 Oesta, AVA, StHK, Unterricht Teil 1, box 19. Fasc. 28 ex 1766 (23rd November 1766). Even today, professions working with animal carcasses are not of the highest social reputation, although they are essential for public health.

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des.[61] On the one hand, on an educational level, medical students were not interested in the allegedly inferior veterinary science, and were disinclined to work in a profession that had the image of being dirty and socially dishonest. On a practical level, the peasants and rural folk did not trust urban dandies and preferred to rely on the lay healers whom they had known for generations. Additionally, at that point of their development, both human and veterinary medicine were neither in theory nor in practice very successful, since the causes, spread and concepts of diseases were still undiscovered, and the importance of hygiene still neglected.[62] As good as van Swieten's initial idea might have been, its realisation failed because of set traditions, prestige, and social aspects.

Military veterinary medicine was less affected by these factors, yet it had to fight problems of its own. After a heyday of control over the Veterinary Institute in Vienna during the Napoleonic Wars, the military lost this power in 1812, just before the end of the Napoleonic Wars. Despite this administrative outcome, the military students still had privileges over the civil students. This favouritism of military over civil students did not help the case to make veterinary medicine more attractive to medical students but at least guaranteed a constant number of artisanal actors at the Institute.

What remains open is the question of whether or not the military side of the veterinary system was more successful in this foundation period. As mentioned above, the early military veterinary system remains largely unstudied. However, we can assume that it faced similar problems to those of its civil equivalent. It goes without saying that the military line also had neither the knowledge of bacteriology and hygiene, nor a detailed concept of different maladies and diseases and their pathogens. So, they too could not treat their patients effectively. But since military veterinary medicine also focused on artisanal aspects like horseshoeing, the success might have been larger in this field. However, more research needs to be conducted on this question. It is also not clear if the military education in the other schools in L'viv and Pest worked more smoothly than in Vienna. Yet, since the students of the *cursus hippiatriae* in Pest just needed to prove to be able to read and write, and the course of study lasted only a couple of

61 Lilla Krász, Quackery versus Professionalism? Characters, Places and Media of Medical Knowledge in Eighteenth-Century Hungary, in: Studies in History and Philosophy of Biological and Biomedical Sciences 43 (2012), pp. 700–709, here, p. 700.

62 The great discoveries and theories (bacteriology, hygiene, cell pathology, etc.) that would lead to the scientific revolution that would turn modern medicine finally to a story of success and lay grounds for today's medical concepts, would not happen before the middle of the nineteenth century.

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months, it is most likely that the conflicts were the same.[63] Here, too, more research is needed.

Thus, after a promising start, the idea of a veterinary system failed after only a few decades. The conflicts between the military and civil line, the lack of success in the prevention of diseases, and the low prestige of the veterinarian profession, caused the system to face a severe existential crisis in the first half of the nineteenth century. However, the need for a solution for the ongoing issues of animal diseases, both on the civil as on the military line, might have been the cause for the system to survive and to continue.

4. Conclusion

This essay discussed the phase of the institutional foundation of veterinary medicine in the Habsburg Monarchy from the first foundation of a veterinary school in Vienna in 1765 until the large phase of closing veterinary schools in the Monarchy during the 1820s. During this period, Habsburg veterinary education consisted of two strings and different healing actors: a military string that sought to improve the health of military horses and whose main actors were farriers and blacksmiths, and a civil string that was part of a public health programme to prevent and control cattle diseases and whose actors derived from human medicine. From the beginning, both strings conflicted with each other concerning the core of veterinary education. However, both the military as the civil string were essential parts of the public health agenda of the Habsburg Monarchy and in fact complemented each other, as the schematisation of the Veterinary Police illustrated. Furthermore, practitioners of human medicine were not strictly restricted to cattle diseases, neither was the training of the artisanal actors only focused on the artisanal aspects of horse medicine. The first had also to treat horses as the latter had to learn basic medical knowledge about the horse. Indeed, the veterinary system was in fact a subsystem of the human medical system since both students and medical or veterinary bureaucrats were from the same educational background. This is also partially true for the military veterinary system whose education, structure, and scope of duties mirrored also the human and civil veterinary system.

The veterinary system spanned over the whole territory of the Habsburg Monarchy, as did the schools. Most of them were just chairs at the faculties of medicine at the different universities in the Monarchy. However, the schools in Vienna, Pest, and L'viv became eventually independent veterinary universities

63 István Kótai, A magyar állatorvosképzés 225 éves története / The 225 Years' History of Hungarian Veterinary Education, in: Perényi, 225 éves (cf. note 42), pp. 13–42, here p. 17.

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still existing today. Corresponding to the political conception of Vienna as the centre of the Monarchy, the Viennese school not only trained the first generation of Habsburgian professors, medical bureaucrats, and practical healers of veterinary medicine, but remained the centre of education, science, and control over the veterinary system for many decades.

However, the practitioners of institutionalised veterinary medicine often faced contempt from both civilian and military society for different reasons: The work with sick and dead animals was associated with dishonest professions, military found the civil string of the veterinary education useless while civil graduates found it hardly attractive to become veterinarians in the countryside when they could also be practitioners for humans. Furthermore, those abstractly trained medical men often had to compete with traditional, yet largely ignorant healers.

Thus, the history of veterinary medicine in its foundation period was in the short term a story of failure. The fledgling stage of both human and animal medicine destroyed, at least for the contemporaries, all hopes to fight epi- and pandemics in the Habsburg Monarchy. Only from a military view, was the education of blacksmiths and stablemen of *k. k. Kurschmiede* at least partially successful. Yet, the blacksmiths often lacked an educational background and even reading and writing skills to be able to understand the courses and reading material.

Despite the short-term failure, both the human and the veterinary system established in the last 35 years of the eighteenth century were role models for comparable systems in Europe, and Vienna was at the forefront of the revolution of medical education and treatments, be it human or animal medicine. When the medical revolution happened in the second half of the nineteenth century, the general idea of medical systems turned into a story of success. This essay could only touch upon some of the many aspects and try to show how veterinary medicine was and still is part of human history, and how the ideas and failures of the late eighteenth and early nineteenth centuries formed the basis of veterinary systems in public health as military agendas in the countries of Southeast and East, and Central Europe today.

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Abstracts [German]

Anke Fischer-Kattner

Commissaire ordinnateur Hocquard bei der Belagerung von Philippsburg (1734): administrativer Angelpunkt der Militärmedizin in der Kriegsführung des Ancien Régime

Schon als Otto Hintze und Carl Schmitt im frühen 20. Jahrhundert die historische Rolle des Commissarius untersuchten, stellten sie seine Bedeutung für Staatsbildungsprozesse heraus. Ihnen folgend hat die Forschung zu Krieg und Staatsbildung die Tätigkeiten der Kommissare in der Entstehung von Steuersystem und Bürokratie betont. Doch ihre Funktion im Zusammenhang von Medizin, Militär und Staat, im „medizinisch-militärischen Komplex" (Sebastian Pranghofer), hat bisher kaum Beachtung gefunden. Allerdings nahm das Medizinalwesen unter den Pflichten französischer *commissaires de guerre* einen hohen Stellenwert ein, wie ihre Korrespondenz mit Kriegsministern seit dem späten 17. Jahrhundert beweist. Die Belagerung von Philippsburg (Mai–Juli 1734) im Polnischen Thronfolgekrieg dient als Fallbeispiel, um den archivalischen Spuren der Arbeit des französischen Kommissars Hocquard zu folgen. Auf Anweisung des Straßburger Intendanten de Brou verwaltete er u. a. die Logistik der Feldhospitäler bei der Operation. Über seine vielfältigen Pflichten korrespondierte er mit Kriegsminister d'Angervilliers in Versailles, der wie sein Vorgänger Louvois exakte Berichte einforderte. Die kommunikative Verbindung in das Machtzentrum Ludwigs XV. zeigt, welche gesteigerte Bedeutung die medizinische Versorgung in der Kriegführung des 18. Jahrhunderts besaß. Im Detail demonstrieren Hocquards Berichte, wie ein hierarchisches System von Feldhospitälern aufgebaut wurde – von der Erstversorgung am Einstieg der Annäherungsgräben über das Lagerhospital zum rückwärtigen Hauptfeldhospital in Speyer. Doch der Eigensinn verwundeter adeliger Offiziere, die angesichts der guten medizinischen Versorgung im Lager einen Weitertransport verweigerten, sowie die räumlichen Hindernisse, die Regen und Rheinflut bei der Belagerung schufen, bereiteten Kommissar Hocquard und den Feldchirurgen immense Probleme. Der Blick des Kriegskommissars auf die Belagerung von Philippsburg

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enthüllt die räumlich-logistischen Abläufe der Militärmedizin im Feld ebenso wie die organisatorischen Herausforderungen, denen sich das Verwaltungspersonal hierbei stellen musste. Darüber hinaus bezeugt die Fallstudie, dass sich die politische Elite im Frankreich der Aufklärung um das Wohlergehen der eigenen Soldaten sorgte – bis hin zu Kriegsminister und Monarch, der ausdrücklich über die Verwundetenversorgung informiert zu werden wünschte. In der Figur des Kommissars im Belagerungskrieg verbinden sich Militärmedizin, Staatsbildungsprozesse und die Geschichte humanitärer Sensibilisierung.

Matthew Neufeld
Korruption innerhalb der Gesundheitsverwaltung der Britischen Marine während des Österreichischen Erbfolgekrieges
In einer kürzlich erschienenen Monografie vertritt Mark Knight die These, dass sich der moderne, britische Blick auf Korruption aus einer konzeptionellen Entwicklung der öffentlichen Ämter entwickelt habe, in welcher Beamte sich im Interesse der Öffentlichkeit selbstlos verhalten sollten. Der Beitrag untersucht anhand von zwei Fallbeispielen – Sir James Barclay und John Butler – wie zwei Beamte der Gesundheitsverwaltung der Marine in der Hafenstadt Gosport aufgrund von Korruptionsvorwürfen von ihren Posten entlassen worden sind. Die Untersuchungen der Fälle lassen darauf schließen, dass Korruption im Gesundheitssystem der Marine ein Produkt dessen war, dass Beamte aus partiell berechtigten Eigeninteressen und Selbstschutz den Dienstethos der Marine umgingen. Das Kernanliegen der Marine ihre Seeleute zu schützen und zu versorgen, verband die Rettung von Leben mit einer Bereitschaft zu Sparmaßnahmen, und rechtfertigte infolgedessen die Praxis Beamte der Gesundheitsverwaltung mit Aufgaben zu beladen, welche sich als nicht erfüllbar erwiesen. Der gleiche rationale Ethos kommt durch die Festlegung von fixen Preisen für die Bereitstellung von Pflege zum Ausdruck, wie auch die Präferenz sich Pflegeleistungen eher von vertragsgebundenen Unternehmen als von vor Ort lebenden Personen zu beschaffen, obwohl die Marine auf letztere Personenkreise zur Rettung von Seemännern etwa infolge von Krisen wie Epidemien angewiesen war. Die Art und Weise wie die britische Marine dieses Gesundheitssystem auf der Grundlage ihres Dienstethos organisierte, ermunterte einige Beamte ihr Schicksal selbst in die Hand zu nehmen. Vor diesem Hintergrund kam die Gesundheitsverwaltung der britischen Marine um die Mitte des 18. Jahrhunderts verstärkt mit Korruption in Kontakt, als in Folge einer Priorisierung ihrer Humanressourcen die Marine ihre Beamten übergebührlich belastete und den kranken und verletzten Seemännern den Vorzug gab. Solange die Beamten ihre Ämter nicht vordergründig für ihre eigenen Zwecke missbrauchten, mussten sie sich keine Sorgen über eine drohende Verurteilung aufgrund von Korruption machen. Unglücklicherweise bereitete die Marine ihre Beamten nicht darauf vor,

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wie ein erkleckliches Gleichgewicht zwischen den Interessen der Marine und deren Eigeninteressen erzielt werden hätte können.

Erin Elizabeth Spinney
Die Frauen von Haslar und Plymouth: Waschfrauen, Krankenschwestern und ihr Beitrag zur Schaffung einer heilenden medizinischen Umgebung
Krankenschwestern, Waschfrauen und weitere weibliche Arbeitskräfte waren zentral für die Funktionalität der Britischen Marine Spitäler Haslar und Portsmourth im 18. und 19. Jahrhundert. Krankenschwestern versorgten die erkrankten und verwundeten Seemänner nicht nur mit Medizin, sondern übernahmen auch bedeutende Rollen im Zuge der Überwachung von Hygienestandards als auch der Reinigung von Bettwäsche und Kleidung als gewichtigen Teil dieser Standards. Diese Art der Reinigung galt als besonders bedeutsam in der Seuchenprävention. Für die kontinuierliche Versorgung mit sauberer Wäsche war ein Heer von Wäscherinnen unter der Aufsicht einer leitenden „Washer Matron" (Ober Waschfrau) zuständig. Der Beitrag fußt auf einem prosopografischen Ansatz und analysiert anhand von Gehaltslisten aus Haslar und der Korrespondenz des „Sick and Hurt Bords" als zuständige Behörde die Rolle von im Öffentlichen Dienst arbeitenden Frauen innerhalt eines sich entwickelnden staatlichen Gesundheitswesens. Neben dem Umstand, dass die Arbeitskraft dieser Frauen als essentiell für den Heilungserfolg erkrankter Seeleute einzustufen ist, wird in diesem Beitrag deutlich, dass diese Frauen Teil eines umfassenden Netzwerkes innerhalb der Marine waren, da Ehefrauen und Witwen von Seeleuten bevorzugt angestellt wurden. Die Arbeit dieser Frauen wurde als wichtig für und von der Marine eingestuft und galt somit als eine vom Staat anerkannte Tätigkeit. Der prosopografische Zugang erlaubt es, diese Frauen als Individuen wahrzunehmen und ihre Karrieren und Aufstiegsmöglichkeiten zu untersuchen. Dabei wird evident das die Wertschätzung der Tätigkeit zunahm und sich die Arbeitsbedingungen für diese Frauen graduell verbesserten. Der Beitrag bietet neue Erkenntnisse aus einer geschlechterspezifischen Perspektive von weiblicher Arbeit in frühmodernen medikalen Räumen.

Sabine Jesner
Gesundheit und Moral. Geschlechtskrankheiten und die Habsburgische Armee im späten 18. Jahrhundert
Das Wortpaar „Gesundheit" und „Moral" tritt im Laufe des 18. Jahrhunderts in eine enge Beziehung miteinander. Diese Verschränkung hatte für die zeitgenössischen Gesellschaften bedeutsame Auswirkungen. Der Ursprung und die Behandlung von Krankheiten sollten fortan verstärkt mit moralisierenden Erklärungsmodellen verknüpft werden. Ein Umstand welcher sich in der Etablierung einer *Medicinal Policey* als erstes Gesundheitsprogramm der Habsburger

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Monarchie spiegelt und zivile und militärische Lebensbereiche einschneidend prägte. Der vorliegende Beitrag nähert sich dem Thema, indem früh moderne staatliche Strategien zur Bekämpfung sexuell übertragbarer Krankheiten ins Zentrum gestellt werden. Zentral ist dabei die Rolle der Habsburgischen Armee als maßgebliche Determinante für die Verbreitung von Geschlechtskrankheiten. Berücksichtigt werden traditionelle oftmals im religiösen Kontext verankerte Denkmuster und deren Einfluss auf staatliche Bewältigungsstrategien. In bestimmten Phasen des Übergangs wie von Kriegs- auf Friedenszeiten aber auch infolge einer Intensivierung von Kontakten zwischen städtischen und ländlichen Räumen wurde die Ausbreitung der *Liebes- oder Lustseuche* erleichtert und verstärkt von zivilen und militärischen Amtsträgern wahrgenommen sowie von diesen als existentes Problem erkannt. Ein Problem, welches der habsburgischen Bevölkerungspolitik zu wieder lief und die militärische Schlagkraft der habsburgischen Armee unterminimierte. Es wird gezeigt wie der Wiener Hof sich neuen Lösungsansätzen zuwandte und dabei moralische Tabus durchbrach um neue Wege in der Pflege und Behandlung geschlechtskranker Personen zu gehen. Im Zuge dessen wurden Geschlechterstereotype geprägt und ethnische Zuschreibungen verfestigt, welche gleichermaßen in ihrer kulturellen Ausformung ein ethnisches Dilemma provozierten. Der geografische Schwerpunkt der Studie liegt auf den Provinzen Banat und Siebenbürgen sowie der Habsburgischen Militärgrenze im Südosten der Habsburger Monarchie. Der Beitrag stützt sich auf bisher unveröffentlichtes Quellenmaterial und versucht neue Perspektiven auf eine frühneuzeitliche Militärmedizin in Verbindung mit Geschlechterforschung zu eröffnen.

Christian Promitzer / Marcel Chahrour
Blinde Kameraden: Die medizinische Behandlung von Trachomen in der Habsburgischen Armee während den frühen post-napoleonischen Jahren
Anfang der 1820er Jahre führte eine lokale Epidemie der Augenkrankheit (Trachom) innerhalt der Garnison der österreichischen Stadt Klagenfurt zu einer intensiven Debatte zwischen Militär- und Zivilärzten über den Charakter und die Behandlung der Krankheit, deren Ursprung mit dem napoleonischen Feldzug in Ägypten zusammenhing. Der fachliche Diskurs offenbart einen eindrucksvollen Einblick in die Position der habsburgischen Militärmedizin in einer Zeit, in der sich die medizinischen Methoden und Theorien über die Ursachen von Krankheiten im Allgemeinen im Wandel befanden. Während Militärärzte wie Wilhelm Werneck (1787–1842) für den ansteckenden Charakter der Krankheit plädierten und auf ihrem ägyptischen Ursprung beharrten, waren zivile Ärzte, angeführt von Professor Anton Rosas (1791–1855), überwiegend anderer Meinung und vertraten die Auffassung vom miasmatischen (katarrhalisch-rheumatischen) Charakter der Epidemie mit lokalem Ursprung. Diese konkrete Diskussion kann

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als Vorspann eines Konflikts zwischen dem zivilen und dem militärischen Zweig der Medizin wahrgenommen werden, welcher sich in den folgenden Jahren zu einem allgemeinen Streit innerhalb der medizinischen Fachdisziplin zwischen Ansteckungstheoretikern und den Verfechtern der Miasmatheorie entwickelte, und zugleich die medizinische Debatte bis zum Aufkommen der Bakteriologie beherrschen sollte. Der Beitrag verdeutlicht, neben einer vertiefenden medizinhistorischen Betrachtung, dass in der Zeit nach den napoleonischen Kriegen die Gesundheit des Militärs nicht mehr als eigenständiges Thema, gänzlich abgegrenzt von der zivilen Sphäre, behandelt wurde, da es besonders durch die Garnisonen in den Städten zu vielfältigen Kontakten mit der Zivilbevölkerung kam. Der Beitrag untersucht jene Maßnahmen, die zur Eindämmung der Augenkrankheit ergriffen wurden und infolgedessen jene intensiven Debatten zwischen zivilen Vertretern und denen des Militärs auslöste. Dies erfolgte mitunter durch die Bildung von gemischt zivil-militärischen Kommissionen, welche eine beratende Funktion für den Staat innehatten. Das Fallbeispiel verdeutlicht, wie sich die Behandlungsmöglichkeiten dank neuer Methoden nach einem epidemischen Krankheitsausbruch im militärischen Umfeld zugunsten breiter ziviler Bevölkerungsschichten verbesserten und somit zugleich zur Verbesserung des Gesundheitssystems beitrug.

Nebiha Guiga
Soldaten, Chirurgen, Zivilisten und der Staat. Formelle und Informelle medizinischen Versorgung während der Napoleonischen Kriege
Ein oberflächlicher Blick auf die während der Napoleonischen Kriege geltenden Vorschriften für das französische und österreichische Militärsanitätswesen vermittelt das Bild einer rein staatlich kontrollierten medizinischen Versorgung. Bei näherer Betrachtung zeigt sich jedoch bereits die Bedeutung nichtstaatlicher Akteure für die Militärmedizin in diesen Konflikten. Dieser Beitrag zeigt die Wechselwirkungen zwischen offiziellen und inoffiziellen Formen der medizinischen Versorgung und den verschiedenen Akteuren, die an der Behandlung und Pflege verwundeter Soldaten während der Napoleonischen Kriege beteiligt waren. Da die informellen Formen der Pflege im Vergleich zu den formellen in der Geschichtsschreibung bisher wenig untersucht worden sind, konzentriert sich dieser Aufsatz insbesondere auf die informelle Seite dieses Ansatzes. Der Fokus liegt auf den Feldzügen 1805, 1809 und 1813, wobei hauptsächlich Quellen der französischen und österreichischen Armeen herangezogen werden. Bei den verwendeten Quellen handelt es sich sowohl um „Ego-Dokumente“ als auch um Verwaltungsdokumente. Im Zentrum steht die gegenseitige Bedingtheit dieser beiden Modi einer medizinischen Versorgung, wobei insbesondere die Rolle der Zivilbevölkerung berücksichtigt wird. Die Zivilbevölkerung nahm an jedem Schritt des Weges eines verwundeten Soldaten teil, von der Vorbereitung der

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Schlacht bis zur Unterbringung der Rekonvaleszenten. Sie waren sowohl in den offiziellen Strukturen eingebunden als auch an der informellen medizinischen Versorgung beteiligt. Ihre Mitwirkung erfolgte als staatliche*r Akteur*in, umfasste aber auch freiwillige oder wohltätige Tätigkeiten. Die strukturelle Abgrenzung einer formellen offiziellen von einer informellen Betreuung war oft nicht möglich, weshalb eine Unterscheidung in der Praxis als fließend umschreibbar ist. Der Beitrag bietet neue Erkenntnisse in die Funktionsweise und den Ausbau des frühneuzeitlichen Staates, und bietet zugleich neue Einsichten zur Komplexität einer Militarisierung der Medizin und einer Medikalisierung des Krieges. Im Zuge der Napoleonischen Kriege kann zweifellos eine stärkere staatliche Kontrolle der Militärmedizin festgestellt werden, wenngleich ihre Reichweite nicht überschätzt werden sollte. Der Beitrag untersucht den Aktionsradius von zivilen Personengruppen im Rahmen einer militärmedizinischen Versorgung, die zwar vom Staat nicht vordergründig initiiert und gesteuert wurde aber zum Vorteil des Staates erfolgte.

Vojtěch Szajkó
Zur Professionalisierung von Militärmedizinern in der Habsburger Monarchie, in Preußen und im Osmanischen Reich (1660–1830)

Ab der zweiten Hälfte des 17. Jahrhundert wurde eine gut organisierte Militärmedizin als eine wichtige Säule für Stehende Armeen wahrgenommen. Eine schlagkräftige Stehende Armee war abhängig von einer guten körperlichen und seelischen Konstitution ihrer Soldaten. Um dies zu gewährleisten wurde eine qualitativ hochwertige medizinische Versorgung benötigten, die nur von gut ausgebildeten Spezialisten gewährleistet werden konnte. Dieser Umstand mündete in eine stetige Professionalisierung der Ausbildung von Militärmedizinern. Dieser Prozess galt als langwierig und konnte schließlich schrittweise durch die Einrichtung von eigenen Militärmedizinischen Akademien in verschiedenen Staaten im Untersuchungszeitraum dieses Beitrages zu einem vorläufigen Abschluss geführt werden. Der Beitrag untersucht die Ausbildung von Militärmedizinern in der Habsburger Monarchie, in Preußen und im Osmanischen Reich und diskutiert dabei Stärken, Mängel und Grenzen hinsichtlich der Qualität von Ausbildung als auch der Verankerung von Institutionen. Dieser Ansatz will verdeutlichen, dass eine Professionalisierung der Militärmedizin mit der Versorgung einer Stehenden Armee, einer graduellen Modernisierung von Gesellschaften in Dunstkreis der Aufklärung und ökonomischen Aspekten zusammenhing. Die Analyse fußt auf einer vergleichenden Perspektive, berücksichtigt die theoretischen Ansätze einer Neuen Militärgeschichte und setzt die Professionalisierung und Institutionalisierung der Ausbildung von Militärmedizinern in einen sozio-kulturellen Kontext. Die Auswahl der drei Fallbeispiele – Habsburger Monarchie, Preußen, Osmanische Reich – begründet sich zum einen in

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ihrer ähnlichen Formierung von Staatlichkeit, zum anderen durch ihre unterschiedlichen religiös kulturellen Traditionen.

Brigitte Lohff
Konkurrierende Interessen. Die medizinisch-chirurgische Ausbildung am Wiener Josephinum von 1775 bis 1824

An der Josephs-Akademie, eröffnet am 7. November 1785 im dafür erbauten Josephinum, sollten in der Habsburger Armee zukünftig alle Feldchirurgen in ihren jeweiligen Bereichen eine entsprechende medizinisch-chirurgische Ausbildung durchlaufen. Giovanni Allessandro Brambillas hatte mit Unterstützung von Joseph II. nun das Ziel erreicht, innerhalb der Habsburger Monarchie die volle Entscheidung darüber zu haben, wer zur Ausbildung als Unterchirurg, Magister oder Doktor der Chirurgie zugelassen wird und welcher Lehrstoff vermittelt werden soll. Der Akademiedirektor war zugleich Oberster Feldchirurg als auch Präsident der Feld-Sanitätskommission. Diese Machtkonzentration wurde bereits Anfang der 1790er-Jahre seitens der Professoren an der Akademie als auch von aktiven Feldchirurgen zunehmend kritisiert. Die erste Reformierung des Lehrplans für Militärchirurgen führte zu einer deutlichen Modernisierung und Verbesserung der Lehre in den drei Ausbildungsabschlüsse. Bedingt durch die Koalitionskriege, die finanziellen Staatskrisen und dem wachsenden Konkurrenzdruck seitens der Wiener Medizinischen Fakultät auf die Josephs-Akademie kam es Anfang des 19. Jahrhundert zu Versuchen, die Lehrbefugnis der Akademie einzuschränken. In Phasen der vorübergehenden Schließung des Lehrbetriebs nach dem Wiener Kongress versuchte die Medizinprofessoren die Ausbildung von Doktoren der Militärchirurgie vollständig an die Universität zu verlagern. Mit dem kaiserlichen Erlass von 21. September 1822 wurde dieses verhindert. In diesem Beitrag soll das ursprüngliche Konzept einer geregelten Ausbildung für angehende Militärchirurgen näher beleuchtet und gezeigt werden, welche Veränderungen im Lehrplan in den Reformen von1795 und 1824 letztlich zur Verbesserung der Ausbildung beitrugen. Zudem wird darauf eingegangen, dass die Josephs-Professoren, die Leitung der Akademie als auch die Administration des Hof-Kriegsministeriums früh erkannten, dass die Institution immer wieder auf die veränderten Anforderungen in der Ausbildung von Militärchirurgen reagieren muss, wenn sie weiterhin neben der Universität bestehen sollte. Durch eine gute Berufungspolitik und durch die erfolgreichen Bemühungen der Josephs-Professoren konnte das Niveau der Ausbildung stetig verbessert und dem Wandel in den medizinischen Disziplinen angepasst werden. Obwohl die Josephs-Akademie sich zu einer wichtigen medizinischen Lehr- und Forschungseinrichtung neben der Universitätsmedizin entwickelte, wurde sie dennoch zum 31. Juli 1874 endgültig geschlossen.

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Daniela Haarmann

Kranke Pferde und verlorene Kriege. Zur Bedeutung und zur Entwicklung eines modernen veterinärmedizinischen Systems für die Habsburger Monarchie (ca. 1765–1830)

Tierseuchen zählen zu dem größten Leidwesen der Menschheit: Der gesundheitliche Zustand von Militärpferde war vor dem 20. Jahrhundert kriegsentscheidend, der von Nutztieren ist bis heute essentiell für die Sicherstellung der Lebensmittelversorgung. Entsprechend war die Behandlung von Pferden wie Nutztieren ein Anliegen der Heilkunde seit der Antike. Mit der Modernisierung von Human- und Veterinärmedizin und medizinischer Ausbildung im Zusammen mit dem Konzept des Aufgeklärten Absolutismus entstand ein von Staat zentral kontrolliertes medizinisches System. Der vorliegende Beitrag behandelt diese erste Reform- und Gründungsphase eines Veterinärsystems in der Habsburgermonarchie. Dieses begann mit der Gründung der ersten Veterinärinstitution in Wien im Jahre 1765 und endete im Laufe der 1820er mit der massenhaften Schließung von in den Jahrzehnten zuvor erst gegründeten Veterinärschulen. Der Beitrag fragt hierbei nach den Gründen über Erfolg und Misserfolg dieser ersten Phase, über Heilungsansätze, heilenden Akteuren und ihren Patienten. Er zeigt, dass neben Vertrauen der Tierbesitzer in die Heilenden auch der Status Quo des medizinischen Wissens noch unzureichend waren, um einen kurzfristigen Erfolg zu gewährleisten. Dennoch waren die medizinischen Reformen, wie hier ausgeführt, wegweisend für die langfristige Etablierung einer *Medicinal Policey* und einer frühen Form der heutigen Public Health Agency in Zentral- (Südost)europa. Die Habsburgermonarchie und vor allem sein Zentrum Wien standen hier Ende des 18. Jahrhunderts an der Spitze eines medizinischen Reformprozesses, der beispielgebend in Europa war, sodass auch die Veterinärmedizin als Teil der viel gerühmten „Wiener Medizinschule“ angesehen werden kann. Ziel der Ausführungen ist es, einen Beitrag zur Wissenschaftsgeschichte der Human- und Veterinärmedizin zu leisten. Es soll gezeigt werden, dass die Veterinärmedizin ein zentraler Aspekt zur Erhaltung der öffentlichen Gesundheit war und ist.

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Zur Schriftenreihe »Herrschaft und soziale Systeme in der Frühen Neuzeit«

herausgegeben im Auftrag des Arbeitskreises Militär und Gesellschaft in der Frühen Neuzeit e. V.

von Matthias Asche, Horst Carl, Marian Füssel, Bernhard R. Kroener, Stefan Kroll, Markus Meumann, Ute Planert und Ralf Pröve

Legitimation, Praxis und Wirksamkeit von Herrschaft gehören zu den zentralen Themen der Geschichtswissenschaft. Insbesondere die Frühe Neuzeit war maßgeblich von einem Verdichtungsprozess von Herrschaft geprägt. Allerdings sind die bisher dominierenden Interpretationsmuster zur Beschreibung von Herrschaftspraxis und Staatsbildung in der letzten Zeit immer mehr in die Kritik geraten. Dies gilt schon seit längerem für den der Ideenwelt des 19. Jahrhunderts entlehnten, ursprünglich teleologisch fundierten Staatsbegriff im Allgemeinen sowie für das davon abgeleitete Konzept des Absolutismus. Aber auch jüngere, stärker auf sozialen und räumlichen Vorstellungen basierende Modelle wie Otto Brunners »Land und Herrschaft« oder Gerhard Oestreichs Konzept der Sozialdisziplinierung sind problematisch geworden. Ursächlich für dieses Unbehagen ist nicht zuletzt die idealtypische Begriffsbildung, die den Ergebnissen empirischer Forschung auf Dauer nicht standhalten konnte und so schließlich an erkenntnistheoretischem Nutzen verloren hat.

Über die idealtypische Begriffsbildung hinaus scheint es deshalb notwendig, Herrschaft konkret, und zwar in ihren räumlichen wie in ihren sozialen Dimensionen und Reichweiten zu beschreiben. Herrschaft wird somit als soziale Praxis begriffen, die Herrschende und Beherrschte in einer kommunikativen und sich wandelnden, allerdings durch obrigkeitlich gesetzte Normen einerseits sowie ungeschriebene Traditionen andererseits begrenzten Beziehung verband.

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Diese soziale Praxis entwickelte sich innerhalb der Grenzen eines Herrschaftsgebietes, oftmals aber zunächst innerhalb des kleineren Rahmens rechtlich, ökonomisch und sozial in sich geschlossener, voneinander abgegrenzter räumlicher und sozialer Einheiten. Um Herrschaft präzise beschreiben zu können, erscheint es daher ratsam, sie im Rahmen solcher Einheiten zu untersuchen, die oftmals zugleich Herrschaftsraum wie Herrschaftsinstrument sein konnten. Besonders gilt dies für Formationen, die sich aufgrund von Selbstbeschreibung und Sinnstiftung, aber auch ihrer funktionalen und kommunikativen Binnenstrukturen als »soziale Systeme« charakterisieren lassen.

Zweifellos das herausragende Beispiel eines solchen sozialen Systems ist das Militär, also die Söldnerhaufen der aufziehenden Neuzeit und die Stehenden Heere des 17. und 18. Jahrhunderts. Gerade in diesen sich im und nach dem Dreißigjährigen Krieg immer stärker institutionalisierenden, mittels spezifischer Regeln und Symbole zusammenschließenden und zugleich nach außen abgrenzenden Armeen spiegelt sich die Herrschaftsproblematik der Frühen Neuzeit in besonders eindringlicher Weise wider. Zum einen war die militärische Gesellschaft der Frühen Neuzeit mit ihren Soldaten und deren Angehörigen in ihrer Binnenstruktur zugleich sozial wie auch rechtlich und hierarchisch, also herrschaftlich organisiert. Zum anderen war das Militär selbst Herrschaftsinstrument – im Krieg nach außen und im Frieden nach innen. Aber auch andere, weniger geschlossen auftretende Formationen und Institutionen kannten die doppelte Funktion als Objekt und Subjekt von Herrschaft, als deren Erprobungsfeld wie als deren Instrument. Dazu gehörten beispielsweise die übrigen Bereiche organisierter öffentlicher Herrschaftsausübung wie der sich immer weiter differenzierende Polizei- und Verwaltungsapparat oder die Justiz.

Die in der vorliegenden Schriftenreihe erscheinenden Bände widmen sich der Geschichte dieser sozialen Systeme in unterschiedlichen thematischen und methodischen Zugängen, aus der Binnensicht ebenso wie aus der Außenperspektive. Immer aber steht dabei die doppelte Frage nach ihrer Herrschaftsfunktion wie nach ihrer Herrschaftsintensität im Vordergrund.

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