



HAL
open science

Forms of Consensus in Medieval Medical Practice

Marilyn Nicoud

► **To cite this version:**

Marilyn Nicoud. Forms of Consensus in Medieval Medical Practice. Consensus. 43. Kölner Medieval-istentagung, Universität zu Köln. Philosophische Fakultät, Sep 2022, Cologne, Germany. pp.413-430, 10.1515/9783111418674-025 . halshs-04692733

HAL Id: halshs-04692733

<https://shs.hal.science/halshs-04692733>

Submitted on 10 Sep 2024

HAL is a multi-disciplinary open access archive for the deposit and dissemination of scientific research documents, whether they are published or not. The documents may come from teaching and research institutions in France or abroad, or from public or private research centers.

L'archive ouverte pluridisciplinaire **HAL**, est destinée au dépôt et à la diffusion de documents scientifiques de niveau recherche, publiés ou non, émanant des établissements d'enseignement et de recherche français ou étrangers, des laboratoires publics ou privés.

Forms of Consensus in Medieval Medical Practice

MARILYN NICLOUD (Avignon)

It is perhaps paradoxical to speak of forms of consensus in medieval medical practice when the term does not appear in the sources. This documentary absence is matched by a historiographical silence: with few exceptions, medieval historiography studies the notion of consensus mainly from a political perspective. It is discussed in the context of electoral procedures, voting modalities, and more generally in relation to problems of legitimacy, the regulation of conflicts and contentious politics, but also in relation to assemblies and questions of representation¹. In certain political systems (whether feudal, imperial, or urban, for example), consensus is one of the ways in which power is exercised².

Does this mean that consensus, as an agreement or understanding between several people, did not exist in the medical field³? Traces of it can be found in the field of knowledge and teaching. Firstly, consensus was expressed through the canon of texts from Antiquity and the Arab-Islamic world, translated into Latin, which at the time became the main source of authority (*auctoritates*) for

¹ Among a plethora of bibliography: O. Condorelli, *Principio elettivo, consenso, rappresenanza. Itinerari canonistici su elezioni episcopali, provvisioni papali e dottrine sulla potestà sacra da Graziano al tempo della crisi conciliare (secoli XII–XV)*, Roma 2003; J.-Ph. Genet/D. Le Page/O. Mattéoni (eds.), *Consensus et représentation. Le pouvoir symbolique en Occident (1300–1640)*, Paris 2017; M. P. Alberzoni/R. Lambertini (eds.), *Costruire il consenso. Modelli, pratiche, linguaggi (secoli XI–XV)*, Milano 2019; C. D. Liddy, *Who decides? Urban councils and consensus in Late Middle Ages*, in: *Social History* 46/4 (2021), 406–434, URL: <<https://doi.org/10.1080/03071022.2021.1967640>> (last access on January 13, 2023); J. M. Najemy, *Corporation and Consensus in Florentine Electoral Politics, 1280–1400*, Chapel Hill 1982; P. S. Barnwell/M. Mostert (eds.), *Political Assemblies in the Earlier Middle Ages (Studies in the Early Middle Ages 7)*, Turnhout 2003; L. Tanzani, *A consiglio. La vita politica nell'Italia dei comuni*, Roma–Bari 2014.

² J.-M. Moeglin, *Le Saint-Empire: contrat politique et souveraineté partagée*, in: F. Foronda (ed.), *Avant le contrat social. Le contrat politique dans l'Occident médiéval, XIII^e–XV^e siècle (Histoire ancienne et médiévale)*, Paris 2011, 173–191; B. Schneidmüller, *Rule by Consensus: Forms and Concepts of Political Order in the European Middle Ages*, in: *The Medieval History Journal* 16/2 (2013), 449–471. For Eastern Europe, S. Moździoch/P. Wisrewski (eds.), *Consensus or Violence? Cohesive Forces in Early and High Medieval Societies (9th–14th c.)*, Wrocław 2013.

³ For elements of definition of consensus in legal, historical and sociological contexts, M. Colasanto, *Consenso*, in: *Enciclopedia Italiana Treccani – VII Appendice (2006)*, URL: <https://www.treccani.it/enciclopedia/consenso_%28Enciclopedia-Italiana%29/>; M. Cotta, *Consenso*, in: *Enciclopedia delle scienze sociali Treccani (1992)*, URL: <https://www.treccani.it/enciclopedia/consenso_%28Enciclopedia-delle-scienze-sociali%29/> (last accesses on August 25, 2022).

university teachings: the ‘Articella’ (collection of Hippocratic, Galenic, and Byzantine treatises), the Arabic encyclopaedias of al-Majûsî (the ‘Pantegni’), Avicenna (the ‘Canon’), or even Rhazès (‘Liber ad Almansorem’) and some of the treatises of Isaac Israëlî constituted the theoretical foundations of medical learning⁴. Secondly, a consensus could be reached between the divergent positions of different authorities through scholarly disputes and questions that sought to construct a medical truth, that is, a common knowledge shared by the community of medical graduates, out of contradictory proposals⁵. Instead of the word *consensus*, related words, such as “concordances” (*concordantia*), were used in medical literature⁶. For example, it is used to designate the alphabetical lists of quotations and explanations by the Parisian masters of the 13th and 14th centuries, John of St. Amand and Peter of St. Flour, in which divergent positions were reconciled⁷; Pietro of Abano, professor in Paris and Padua, preferred the word *Conciliator* for the title of one of his treatises, which sought to reconcile medicine and astrology⁸.

Consensus also appeared in medical practice in the form of “concord” (*concordia*). It could be expressed within professional groups regulated by statute, such as colleges of university physicians or colleges of city physicians, defending common interests. Similar to professional practices in other fields of activity, they met in assemblies, deliberated, took decisions, organised examinations, elected their new members who took an oath, and so on. But the consensus of practitioners could also be required for expertise⁹ when, from the second half of the 13th century onwards, they were increasingly called upon to give their opinions, especially in the context of inquisitorial justice; for example, in criminal cases, the judge in Bologna would, in case of doubt, appoint at least two practitioners

⁴ C. O’Boyle, *The Art of Medicine. Medical Teaching at the University of Paris, 1250–1400*, Leiden 1998; J. Chandelier, *Avicenne et la médecine en Italie. Le ‘Canon’ dans les universités (1200–1350)*, Paris 2017; C. Crisciani, ‘Curricula’ e contenuti dell’insegnamento: la medicina dalle origini al sec. XV, in: G. P. Brizzi (ed.), *Storia delle Università in Italia*, vol. 2, Milano 1994, 239–276.

⁵ J. Agrimi/C. Crisciani, *Edocere medicos. Medicina scolastica nei secoli XIII–XV*, Napoli 1988; D. Jacquart, *La question disputée dans les facultés de médecine*, in: B. C. Bazàn/G. Fransen/J. W. Wippel/D. Jacquart (eds.), *Les questions disputées et les questions quodlibétiques dans les facultés de théologie, de droit et de médecine (Typologie des sources du Moyen Âge occidental 44/45)*, Turnhout 1985, 281–315; D. Jacquart, *La scolastique médicale*, in: M. D. Grmek (ed.), *Histoire de la pensée médicale en Occident*, vol. 1: *Antiquité et Moyen Âge*, Paris 1995, 175–210; C. O’Boyle/R. K. French/F. Salmón (eds.), *Learning Medieval Medicine: The Boundaries of University Teaching*, in: *Dynamis* 20 (2000).

⁶ O. Weijers, ‘Distinctiones’ et concordances in: O. Weijers, *Dictionnaires et répertoires au Moyen Âge (CIVICIMA 4)*, Turnhout 1991, 119–133.

⁷ D. Jacquart, *La médecine dans le cadre parisien, XIV^e–XV^e siècle*, Paris 1998, 183–194.

⁸ J.-P. Boudet/F. Collard /N. Weill-Parot (eds.), *Médecine, astrologie et magie entre Moyen Âge et Renaissance: autour de Pietro d’Abano (Micrologus Library 50)*, Firenze 2013.

⁹ On the concept of expertise and some situations of expertise in the Middle Ages, cf. M. Nicoud, *Faut-il historiciser l’expertise? L’autorité de l’expert dans les sociétés antiques et médiévales*, in: *Histoire, médecine et santé* 18 (2020), 9–25 and the articles published in the volume.

to examine the victims in order to qualify the offence¹⁰. In cases of suspected leprosy, it was also common for the courts to call doctors and surgeons to examine the accused and determine the presence or absence of leprosy¹¹. As Laurent Feller and Catherine Verna recall, the *iudicium* or *consilium* that they produced together “doit aboutir à un consensus exprimant la vérité: elle ne peut pas ressortir de l’opinion”¹². Expressed in a “unanimous and concordant” voice, as the sources stress, this consensus increased the probative value of the practitioners’ judgement¹³.

In this article on the forms of consensus, I will focus my research on the regular practice of medicine and, more precisely, on the relations between patients and practitioners and those within the professional community. It is possible to mobilise various sources belonging to different registers: on the one hand, documentary sources, such as contracts binding patients and caregivers by mutual obligations¹⁴, or correspondence between practitioners and laymen in court milieu; on the other hand, texts from medical literature whose aim was to advise future practitioners.

Through this collection of archives and medical works, I will try to show why consensus seemed necessary or even indispensable in medical practice, and who the actors participating in it were. I will examine the way it was constructed and the words that expressed it. Finally, I will question its aims and its role in decision-making processes.

¹⁰ G. Ortalli, *La perizia medica a Bologna nei secoli XIII e XIV*, in: *Atti e Memorie della Deputazione di Storia Patria per le Provincie di Romagna* 17/19 (1969), 223–259; J. Shatzmiller, *Médecine et justice en Provence médiévale, documents de Manosque, 1262–1348*, Aix-en-Provence 1989; C. Ferragud, *Expert Examination of Wounds in the Criminal Court of Justice in Cocentaina (Kingdom of Valencia) during the Late Middle Ages*, in: W. Turner/S. Butler (eds.), *Medicine and the Law in the Middle Ages (Medieval Law and Its Practice 17)*, Leiden 2014, 109–132; J. Carraway Vitiello, *Forensic Evidence, Lay Witnesses and Medical Expertise in the Criminal Courts of Late Medieval Italy*, *ibid.*, 133–156; J. Chandelier/M. Nicoud, *Entre droit et médecine: les origines de la médecine légale en Italie (XIII^e–XIV^e siècles)*, in: J. Chandelier/A. Robert (eds.), *Les frontières des savoirs (Collection de l’École française de Rome 505)*, Roma 2015, 233–293.

¹¹ L. Demaitre, *Leprosy in Premodern Medicine. A Malady of the Whole Body*, Baltimore 2007, 34–74; J. Picot, *La purge: une expertise juridico-médicale de la lèpre en Auvergne au Moyen Âge*, in: *Revue historique* 662/2 (2012), 292–321.

¹² L. Feller/C. Verna, *Expertises et cultures pratiques*, in: *Experts et expertise au Moyen Âge. Consilium quaeritur a perito. XLII^e Congrès de la SHMESP (Oxford, 31 mars–3 avril 2011) (Histoire ancienne et médiévale 116)*, Paris 2012, 27–43, at 36.

¹³ C. Leveux-Teixeira, *La pratique du conseil devant l’Inquisition (1323–1329)*, in: *Cahiers de Fanjeaux* 42 (2007), 165–198.

¹⁴ U. Stefanutti, *Sulla liceità giuridica e deontologica dei patti conclusi prima della cura fra medici e pazienti (secoli xiv, xv e xvi)*, in: *Giustizia e Società* 4 (1965), 364–370; L. García-Ballester, *Medical Ethics in Transition in the Latin Medicine of Thirteenth and Fourteenth Centuries: New Perspectives on the Physician-Patient Relationship and the Doctor’s Fee*, in: A. Wear/J. Geyer-Kordesch/R. French (eds.), *Doctors and Ethics. The Earlier Historical Setting of Professional Ethics*, Amsterdam 1993, 8–71; G. Pomata, *La promessa di guarigione. Malati e curatori in antico regime*. Bologna, XVI–XVIII, Bari 1994; E. Sandrini, *La professione medica nella dottrina del diritto comune secolo XIII–XVI*, parte II, Padova 2009.

I. A necessary consensus

Consensus appears to be necessary, even indispensable, for medical practice in the therapeutic context, particularly in the relationship between patient and practitioner but also within the medical community, among colleagues. This necessity can be explained by various factors specific to the practice of medicine in the Middle Ages.

First, as Gianna Pomata reminds us, there was no consensus on the idea that care should be paid for, regardless of the result obtained¹⁵. What seems obvious to us today was not so in the Middle Ages. Moreover, there was no pricing of care, except in the case of doctors employed by towns, who sometimes set prices according to the seriousness of the illness or the location of the patient¹⁶. These particularities made negotiations between patients and practitioners necessary. They could be formalised by contractual and written relationships and signed before a notary. Although they were frequent already in the 13th century in southern areas marked by the influence of Roman law¹⁷, these healing pacts also appeared in the registers of the ‘minutier du Châtelet’ in Paris in the 15th century, as Hélène Leuwers has recently discovered¹⁸.

Then, the heterogeneity of the medieval medical community should also be emphasised to explain the need for consensus. Despite attempts at regulating access to qualified practitioners, those who practised were very diverse: learned doctors constituted only a minority elite who wished to establish a monopoly¹⁹. They sought to exclude those who they called “empirical” practitioners,

¹⁵ Pomata, *La promessa di guarigione* (nt. 14), 73 sq.

¹⁶ V. Nutton, *Continuity or Rediscovery? The City Physician in Classical Antiquity and Mediaeval Italy*, in: A. W. Russel (ed.), *The Town and State Physician in Europe from the Middle Ages to the Enlightenment* (Wolfenbütteler Forschungen 17), Wolfenbüttel 1981, 9–46; reprinted in: V. Nutton, *From Democedes to Harvey. Studien in the History of Medicine* (Variorum Collected Studies Series 277), London 1988.

¹⁷ As G. Pomata points out, contracts have their origin in the ‘Corpus juris civilis’ (Pomata, *La promessa di guarigione* [nt. 14], 37–42). For some other meridional examples, cf. H. Bresc, *Documents siciliens*, in: Razo 4 (1984), 109–114; N. Coulet, *Documents aixois* (première moitié du XV^e siècle), *ibid.*, 115–125; M. R. McVaugh, *Medicine before the Plague. Practitioners and their Patients in the Crown of Aragon. 1295–1345*, Cambridge 1993, 171–189; K. Wagner, *Regesto de documentos del Archivo de protocolos de Sevilla: referentes a judíos y moros*, Sevilla 1978, 36 n. 116, 37 nn. 120 and 124; Shatzmiller, *Médecine et justice en Provence médiévale* (nt. 10).

¹⁸ H. Leuwers, *Les praticiens de santé devant la justice. Conflits et structuration des activités de soin à Paris et à Londres (XIV^e–milieu du XVI^e siècle)*, thèse de l’Université Paris Nanterre, Paris 2022, 501–545.

¹⁹ V. L. Bullough, *The Development of Medicine as a Profession: The Contribution of the Medieval University to Modern Medicine*, Basel–New York 1966; L. García-Ballester, *The Construction of a New Form of Learning and Practicing Medicine in Medieval Latin Europe*, in: *Science in Context* 8 (1995), 75–102; L. García-Ballester/M. R. McVaugh/A. Rubio, *Medical Licensing and Learning in Fourteenth-Century Valencia* (Transactions of the American Philosophical Society. New Series 79/6), Philadelphia, PA 1989; M. Luz López Terrada, *Medical Pluralism in the Iberian Kingdoms: The Control of Extra-academic Practitioners in Valencia*, in: *Medical History* 53 (2009), 7–25; I. McCleery, *Medical Licensing in Late Medieval Portugal*, in: Turner/Butler

that is, those without diplomas. Contractualisation helped stabilise the therapeutic relationship in a highly competitive medical marketplace where relationships were often conflictual²⁰. As early as the beginning of the 13th century, the physician Gilles de Corbeil, who had been trained in Salerno, where he claimed to have observed such contractual relationships, advised any future practitioner to:

“Remember to bind patients to yourself by a pact, especially those whose reputation says they are rich and whom popular opinion accuses of ingratitude, [...] because simple oaths are worthless and because promises are blown away by the wind.”²¹

While the contracts represented a guarantee for the practitioner to get paid at the end of the treatment, they also were a means of ensuring the continuity of care for the patient. By establishing a set of rights for each of them, they formed the basis of a trusting relationship.

In terms of actors, these pacts reveal a plurality of figures: on the side of the patients, there were individuals, mostly from the urban world and from various socio-professional groups, but also communities with a tradition of preventive and therapeutic care of families, or religious institutions²². On the practitioner side, there were authorised doctors, but also an increasing number of barbers, simple healers, and itinerant specialists for the treatment of specific diseases, who were little known or simply passing through.

Consensus was not only essential in patient-practitioner relationships²³; it could also be necessary within the medical community, especially in cases of collective practices of medicine²⁴, more particularly in the training of medical

(eds.), *Medicine and the Law* (nt. 10), 196–219; T. Duranti, “Doctores” e dottori: laurea in medicina e professioni mediche nel Medioevo europeo, in: M. T. Guerrini/R. Lupi/M. Malatesta (eds.), *Un monopolio imperfetto. Titoli di studio, professioni, università* (secc. XIV–XXI) (Studi 28), Bologna 2016, 1–13.

²⁰ For the Parisian organisation and some conflicts, cf. P. Kibre, *The Faculty of Medicine at Paris. Charlatanism, and Unlicensed Medical Practice in the Later Middle Ages*, in: *Bulletin of the History of Medicine* 27/1 (1953), 1–20; Jacquart, *La médecine dans le cadre parisien* (nt. 7), 303–310; L. Garrigues, *Les professions médicales à Paris au début du XV^e siècle. Praticiens en procès au Parlement*, in: *Bibliothèque de l'École des chartes* 156/2 (1998), 317–367; H. Leuwers, *Jehan Leclerc et les chirurgiens jurés de Paris: une rivalité professionnelle à l'Hôtel-Dieu (1498–1500)*, in: *Histoire, médecine et santé* 13 (2018), 69–90.

²¹ Gilles de Corbeil, *Liber de uirtutibus et laudibus compositorum medicaminum*, ed. M. Ausécache (Edizione Nazionale La Scuola Medica Salernitana 8), Firenze 2017, vv. 1606–1615.

²² M. R. McVaugh, *Le coût de la pratique et l'accès aux soins au XIV^e siècle: l'exemple de la ville catalane de Manresa*, in: *Médiévales* 46 (2004), 45–54; Shatzmiller, *Médecine et justice en Provence médiévale* (nt. 10), 123 sq., doc. 29; J. B. Post, *Doctor Versus Patient: Two Fourteenth Century Law Suits*, in: *Medical History* 16/3 (1972), 296–300.

²³ On the relationship between patient and practitioner and medical behaviour, cf. M. R. McVaugh, *Bedsides Manners in the Middle Ages*, in: *Bulletin of the History of Medicine* 71 (1997), 201–222; C. Crisciani, *La formazione del medico nel Medioevo: dottrina ed etica*, in: M. Ferrari/P. Mazzarello (eds.), *Formare alle professioni. Figure della sanità* (Storia dell'educazione 7), Milano 2010, 36–57, at 51–57.

²⁴ Cf. C. Crisciani, *Éthique des “consilia” et de la consultation: à propos de la cohésion morale de la profession médicale (XIII^e–XIV^e siècle)*, in: *Médiévales* 46 (2004), 23–43.

students, which included following professors for two years during their visits to the sick at the end of university studies. A German student who assisted Parisian masters between 1398 and 1408 in their consultations described this collegial practice as a “*consortium in practica*”. In a text known as ‘Conseils de Guillaume Boucher’, he recounted the visits carried out by Guillaume Boucher and his colleague Pierre d’Auxon and some other masters and students²⁵. Patients who could move came to the practitioners who questioned and examined them before prescribing a treatment in a collegial manner. Concerning their sociological profile (when it is known), the text does not refer to indigents, but students, ecclesiastics, squires, Parisian bourgeois, and even aristocrats are mentioned.

Collective medical practices were also common in the court milieu, and not only in cases of serious illnesses, when the prince’s health was in danger²⁶. The employment of several physicians in the service of the sovereign and his family is well documented and shows a strong preoccupation with health²⁷. In 1418, in the letter appointing the Spaniard Andrea Cotolenqui as physician to the Duke of Savoy, Amedeus VIII mentioned the “consortium of other physicians” (*consortio aliorum phisicorum*), that is, the other regular practitioners who looked

²⁵ “*Incipiunt consilia et experimenta doctorum CARNIFICIS et DANSONIS, ordinariorum alme universitatis parisiensis, necnon medicorum regis Francie, collecta per quemdam magistrum de Almania qui frequentabat ipsorum consortium in practica*” (E. Wickersheimer, *Les secrets et les conseils de maître Guillaume Boucher et de ses confrères. Contribution à l’histoire de la médecine à Paris vers 1400*, in: *Bulletin de la Société française d’Histoire de la médecine I–V* [1909], 199–305, at 215). Besides Guillaume Boucher or Guillaume Carnificis (d. 1410), also physician of Charles VI and other princes, and Pierre d’Auxon or Danson (d. 1410), some other practitioners are sometimes mentioned: Guillaume de la Chambre (d. 1426), Jacques Saquespée, recently graduated, the surgeon Gilles de Soubzlefour, and other anonymous practitioners, such as a *italicus medicus regis*. On these different masters, cf. E. Wickersheimer, *Dictionnaire biographique des médecins en France au Moyen Âge*, Genève 1936, ²1979, vol. 1, 239; vol. 2, 614; vol. 1, 249; 337; 200 sq. Cf. also D. Jacquart, *Supplément au Dictionnaire biographique des médecins en France au Moyen Âge*, Genève 1979, 138 and 92. For an analysis of medical practice based on this testimony, cf. Jacquart, *La médecine dans le cadre parisien* (nt. 7), 501–509.

²⁶ During the various crises that affected the health of King Charles VI of France during his reign, many doctors were regularly called upon to treat him. An official order of July 1391 mentions 22 practitioners at his bedside, each of whom received 100 francs. Cf. B. Guinée, *La folie de Charles VI*, Paris 2004, ²2016, 120–123. For other examples, cf. M. Nicoud, *Expérience de la maladie et échange épistolaire: les derniers moments de Bianca Maria Visconti (mai–octobre 1468)*, in: *Mélanges de l’École française de Rome. Moyen Âge* 112/1 (2000), 311–458; about the long illness of Ludovic of Achaïa, I. Naso, *I Savoia e la cura del corpo. Medici a corte nel tardo medioevo*, in: E. Andretta/M. Nicoud (eds.), *Être médecin à la cour (France, Italie, Espagne, XIII^e–XVIII^e siècle)* (Micrologus Library 52), Firenze 2013, 51–85.

²⁷ V. Nutton (ed.), *Medicine and the Courts of Europe*, London–New York 1990; T. Pesenti, *Medici di corte e università*, in: *Medicina nei secoli 9/3* (1997), 391–401; C. Crisciani, *Tra Università, corte, città: note su alcuni medici “pavesi” del sec. XV*, in: *Annali di storia delle università italiane* 7 (2003), 55–70; Andretta/Nicoud (eds.), *Être médecin à la cour* (nt. 26); F. Collard, “En grande cure et diligence”. *Les professionnels de la santé auprès de Charles VII*, in: *Histoire, médecine et santé* 13 (2018), 91–111; M. Hilber/E. Taddei (eds.), *In fürstlicher Nähe – Ärzte bei Hof (1450–1800)* (Innsbrucker Historische Studien 33), Innsbruck 2021.

after his health²⁸: there were no fewer than seven, who were regularly paid by the prince. A few decades later, at the court of Francesco Sforza in Lombardy, there were even more doctors, and often more than two working together at the patient's bedside²⁹. This way of practising medicine, which was widespread among the elite, also affected certain privileged urban circles, as in Paris (according to the surgeon Henri de Mondeville) and in Italian cities (where the authorities tried to regulate the simultaneous or successive presence of different doctors called by the same patient by means of professional statutes). One of the aims of these regulations was to ensure that each practitioner was well paid and did not compete with others³⁰.

In his 'Surgery', written at the beginning of the 14th century, Henri de Mondeville (1260–1320) observed that "it often happens that certain Parisians, in their illness, call a number of men of different sects to consult them"³¹. He was hostile to such collective practices, pointing to two main dangers for practitioners in these specific contexts: their disempowerment and the risk of dissension. He wrote: "The more we are, the less each one feels responsible."³² He also stressed the risk of not arriving at a diagnosis and treatment shared by all those present; the multiplicity of actors and their different training (because they belonged to "different sects") could lead to multiple opinions:

"It is impossible for them [the doctors at the bedside] all to agree on the knowledge of the causes and nature of the disease, on the symptoms and the treatment, because

²⁸ J. Camus, *La cour du duc Amédée VIII à Rumilly en Albanais (1418–1419)*, Annecy 1902, 36 doc. VI, 54. A few decades earlier, in 1391, when Count Amedeus VII's state of health (treated by a certain Jean de Grandville, who was accused of having poisoned him after the prince's death) was worsening, two of his ordinary doctors and two other colleagues from Moudon were called in. The facts are reported in the trial of Jean de Grandville (*Archivio di Stato di Torino, Materie criminali, Atti del processo contro Giovanni Grandville [1392]*); cf. M. Bruchet, *Le château de Ripaille*, Paris 1907, 39–48; G. Carbonelli, *Gli ultimi giorni del Conte Rosso e i processi per la sua morte: studio con documenti inediti*, Pinerolo 1912. On Jean de Granville, cf. F. Collard, "Perfidus medicus" ou "inexpertus medicus". Le cas Jean de Grandville, médecin du comte Amédée VII de Savoie, in: F. Collard/É. Samama (eds.), *Mires, physiciens, barbiers et charlatans: les marges de la médecine de l'Antiquité au XVI^e siècle*, Langres 2004, 133–149.

²⁹ M. Nicoud, *Le prince et les médecins. Culture et pratique médicales à Milan (1402–1474)* (Collection de l'École française de Rome 488), Roma 2013.

³⁰ On medical professional rules, cf. A. Pastore, *Le regole di un corpo professionale: gli statuti dei collegi medici (sec. XV–XVII)*, in: *Archivio storico ticinese* 118 (1995), 219–236; and the bibliography about Italy in T. Durantì, *Il collegio dei dottori di medicina di Bologna: università, professioni e ruolo sociale in un organismo oligarchico della fine del medioevo*, in: *Annali di storia delle università italiane* 21/2 (2017), 151–178. Cf. also M. Nicoud, *Pratiquer la médecine dans l'Italie de la fin du Moyen Âge: enquête sur les statuts communaux et les statuts de métier*, in: J. Vons (ed.), *Pratique & pensée médicales à la Renaissance. 51^e Colloque international d'études humanistes*. Tours, 2–6 juillet 2007, Paris–Tours 2009, 9–23.

³¹ *Die Chirurgie des Heinrich von Mondeville (Hermondaville) nach Berliner, Erfurter und Pariser Codices*, ed. J. L. Pagel, Berlin 1892, 116.

³² *Ibid.*

there are as many heads as there are opinions. And if they happen to be of the same opinion, [...] they will only argue out of envy or hatred.”³³

Clearly, the lack of consensus led to bad practice. But it was not only the consequence of collective practice; for Mondeville, it was also the result of a group of practitioners who did not have the same training. To prevent the multitude from leading to confusion (*multitudo parit confusionem*³⁴), he recommended several things. Firstly, he stressed that it was better for each patient to have only one experienced and faithful surgeon at his or her bedside; if the patient wished to recruit several practitioners, he or she should limit himself to two and, if possible, find practitioners who were “friends, of the same sect, of the same spirit and of agreement (*unanimes et concordēs*); if such cannot be found, a third should be added to the first two, only to establish concord (*concordia*) between them after their discussion”³⁵.

According to the Parisian surgeon, consensus on the causes of disease, its diagnosis, prognosis, and treatment could only be reached within the same community: that of university-educated practitioners who shared the same degrees, the same knowledge, the same language, but also the same ethical behaviour in the exercise of their profession³⁶. The same profile appears in the ‘Conseils de Guillaume Boucher’ (where the different practitioners were all masters of the University of Paris), both in the letters of the doctors employed by the Duke of Lombardy, most of whom were professors of the *Studium* of Pavia. In addition to the danger to the patient’s life that could result from differences of opinion, for these learned physicians, disagreement also represented a danger to the cohesion of their community and, ultimately, to its honour and legitimacy. Consensus was also intended to distinguish the educated physician or surgeon from the empirics, the charlatan, the “*cursores*” (as the German student of the Paris *consilia* called the itinerant surgeons³⁷), and the other “*mechanicos illiteratos artifices bestiales*”³⁸, “*illiterati cyrurgici*”³⁹, “*barberii, sortilegi, locatores, insidiatores, falsarii, alchemistae,*

³³ Ibid., 123.

³⁴ Ibid., 122.

³⁵ Ibid.: “[...] *debet sufficere cuilibet patienti quod habeat unum solum cyrurgicum expertum et fidelem etc., [...] duos habeat et non plures, et si possint inveniri, quod ipsi sint amici et ejusdem sectae unanimes et concordēs, et si tales non inveniantur, cum aliis duobus potest tertius superaddi, scilicet ad hoc solum, quod ipsi discutiant, ut ponat concordiam inter ipsos*”.

³⁶ Crisciani, *Éthique des “consilia”* et de la consultation (nt. 24). It should be recalled here that Henri de Mondeville pleaded for a surgery based on the theoretical principles of medicine and wanted to convince surgeons to be trained in these principles. On this subject, cf. Jacquart, *La médecine dans le cadre parisien* (nt. 7), 48–82. On the development of medieval surgery, cf. M. R. McVaugh, *The Rational Surgery in the Middle Ages* (Micrologus Library 15), Firenze 2006.

³⁷ Some mentions are made of the care provided by itinerant surgeons to denounce the danger of their practice. Cf. Wickersheimer, *Les secrets et les conseils de maître Guillaume Boucher* (nt. 25), 223 n. 13, 295 n. 91.

³⁸ *Die Chirurgie des Heinrich von Mondeville*, ed. Pagel (nt. 31), 132.

³⁹ Ibid., 12, 67, 71, 132, 296, 450, 465, 482.

meretrices, metatrices, obstetrices, vetulae, Judaei conversi, Sarraceni [...] qui fingunt se cyrurgicos”, as Henri de Mondeville called them⁴⁰. This need for distinction was all the more important in the eyes of the Parisian surgeon, as he was trying, through his treatment, to plead for an art based on the principles of rational medicine and on the observation of the masters and the practice of the profession⁴¹. The possibility of consensus became a clear sign of the group’s professional identity.

If agreement could only take place within a selected and homogeneous group, excluding any layman or empiric, how was it constructed and how was it expressed?

II. Building and expressing consensus

Depending on the context and the actors involved in the process, consensus aims at settling precise issues that are the causes of disease, diagnosis, prognosis, and treatment, or to determine the conditions of care, the expected outcome, and the price to be paid. But we have few written traces of how it was reached. We only find the result of the agreement, expressed by the unanimity of the positions, the participation of all concerned parties in the negotiation, and a form of collective compliance. In the ‘Conseils de Guillaume Boucher’, the German student noted several times that “all said” (*dixerunt omnes*), “all judged” (*judicaverunt*), “all concluded” (*concluserunt*), “all agreed” (*concluserunt*), “all consulted” (*consuluerunt*), “all deliberated” (*deliberaverunt*)⁴². The vocabulary of discussion, deliberation, judgement, and expertise is expressed, leading to the same opinion, to an expression of agreement – concord – and finally to collective action, when they ordered (*ordinaverunt*) or applied (*applicaverunt*)⁴³. The space of debate is called *consilium*⁴⁴. Similar words were used in the collective letters written by the physicians at the bedside of the Sforza princes. For example, in the autumn of 1462, Giovanni Matteo Ferrari, Guido Parato, and Tebbaldo Maggi da Sale, who attended Filippo Maria Sforza in a critical state of health, regularly sent letters to the Duke and Duchess explaining the results of their joint deliberations⁴⁵. A few days later, Benedetto Reguardati (d. 1469), the court’s most eminent physician, joined his colleagues at the heir’s bedside. He

⁴⁰ Ibid., 65.

⁴¹ Jacquart, *La médecine dans le cadre parisien* (nt. 7), 48–82.

⁴² Wickersheimer, *Les secrets et les conseils de maître Guillaume Boucher* (nt. 25), 217 n. 3, 226 n. 13, 247–250 n. 47, 266 n. 72, 295 n. 99, 297 n. 104.

⁴³ Ibid., 227 sq. n. 13, 256 n. 56, 280 n. 88.

⁴⁴ Ibid., 266 n. 72: “*Dixerunt omnes in consilio*”. On the function of *consilium/consiliare* in medieval medicine and on the genre of *consilia*, cf. J. Agrimi/C. Crisciani, *Les “consilia” médicaux* (Typologie des sources du Moyen Âge occidental 69), Turnhout 1994; C. Crisciani, “*Consilia*”, *responsi, consulti. I pareri del medico tra insegnamento e professione*, in: C. Casagrande/C. Crisciani/S. Vecchio (eds.), “*Consilium*”. *Teorie e pratiche del consigliare nella cultura medievale* (Micrologus Library 10), Firenze 2004, 259–279.

⁴⁵ The letter file is edited in Nicoud, *Le prince et les médecins* (nt. 29), 618–674.

testified to their discussions and to the judgement they had reached through collective reasoning:

“I have been with my fellow doctors (*padri medici*) and we have reasoned and agreed (*rasonato e conferito*) what can reasonably be written to your lordship about the verdict on this disease. And indeed, as they have written to you, it would be too presumptuous to give a judgement (*iudicio*), for reason does not agree. But we all agreed (*in concordia*) that if we were forced to say what our consciences dictated, we would rather give a good hope for his health than the opposite.”⁴⁶

The prognosis given under duress was the result of deliberation and consensus reached by medical reasoning among peers.

In all cases, consensus is the subject of discussion and debate, of which written sources are only the final stage. None of the things that were said were written down. There was undoubtedly an exchange of views, sometimes marked by confrontation and opposition, because the diagnosis and prognosis were not always based on a common interpretation of the facts observed. It was therefore not uncommon for consensus to be built on the expression of disagreement, as in the academic *disputatio*.

To gain some insight into these discussions, we must turn to medical literature. Henri de Mondeville is the most prolix on this topic. Although his comments have no normative value, they do reflect the documents of practice:

“This is the way the consultations (*collationes*) are to be held: first we must discuss the illness in question, by careful examination and palpation. [...] Each one carries out the examination one after the other. Then, if the case requires it, they examine the patient again, all together, showing each other the signs of the disease and the particular considerations that depend on the disease or the patient. Then one of the consultants, the most senior, especially if he is a doctor, asks the patient questions. When all the questions required by the case have been carefully put to the patient, they all leave the room and enter another where they are alone, for in each conference (*collatione*) the masters argue (*disputant*) with each other in order to better discern the truth, and sometimes by discussion (*disputazione*) they come to agreements which would lead outsiders to believe that there is discord (*discordia*) or a struggle (*litigium*), and this is sometimes the case. Then he who is the eldest, the most distinguished, or the most illustrious, if there is one, as the king’s physician or the supreme pontiff would be, will suggest to the others that they speak one after the other, and if they all remain silent, as they must before him, he himself will speak and question them all one after the other, beginning with the youngest and the least distinguished, and so on, always ascending from the inferior to the superior. For if the eldest or the oldest spoke first, the youngest or the least important would have nothing to add, and the colloquy would be void, whereas whatever the youngest says, the eldest is free to

⁴⁶ Benedetto Reguardati to Bianca Maria Visconti, Pavia, Oct. 26, 1462, *ibid.*, 625: “*So suto con questi mey padri medici et havemo rasonato et conferito quel che se po rasonelmente [sic] scrivere ad vostra signoria del iudicio de questa paxione. Et in verita como loro scrivono serria troppo presumtuoso chi volesse in questo dare iudicio per che la rasono nol consente. Niente meno, tucti semo suti in concordia che se fossemo costrecti ad dire la nostra concientia, noy simo piu pronti ad la bona spezanza della salute che del contrario*”.

regulate, add, subtract, destroy or approve, and this is not without value. Let him therefore ask everyone, in the order just described, what the present disease is, what it is called according to the experience of expert men, which authors mention it, and in what part of their works. When the answer has been given, let him ask whether the disease is curable or not, and if so, by what means.”⁴⁷

Henri de Mondeville’s proposal took into account the entire patient visit: first, the examination of the patient, individually and collectively if necessary, and the first exchanges between colleagues at the bedside; then the questioning of the patient and his or her entourage to determine his or her condition, the history of the illness and how he or she felt. Finally, the patient’s account was followed by a second discussion between the practitioners in a secluded place. According to Henri de Mondeville, this discussion, which may have been lively, had to follow a strict protocol, which allowed everyone to express themselves, but according to a precise order or even a questionnaire, and under the authority of the oldest, most experienced or most illustrious practitioner. It was clearly designed to train the younger practitioners, both practically and theoretically. It seems that the same procedure was followed by the 22 physicians at the bedside of Charles VI, if we are to believe, as B. Guinée proposes, the way in which their names are given in the royal letter; they are listed in a hierarchical order, from the most prestigious, the “first physician of the king”, Regnault Fréron, to the youngest, recently graduated masters of the faculty⁴⁸. In this, we find an echo of the ‘Conseils de Guillaume Boucher’, which recorded the consultations of some Parisian masters followed by university students. Taking notes of these consultations, undoubtedly recorded on the spot (since the text gives an account of oral exchanges between masters, interrogations of patients and speeches in a direct style) and then copied into a manuscript, certainly served the future German practitioner in his own therapeutic practice⁴⁹.

This discussion, which only took place when several practitioners were present at the patient’s bedside, is qualified by Henri de Mondeville as a *collatio*, a term also used in the ecclesiastical sphere to designate discussions about candidates for election⁵⁰. This *collatio* had to lead to a consensus, which for him and Benedetto Reguardati was synonymous with “truth”: a medical truth about diagnosis, prognosis, and treatment, which had to be consensual. Discussion made it possible to express divergent positions and remove any tensions within the group through conversation. Lay people were unaware of this because the content of the discussion had to remain secret.

For their part, the contracts between patients and doctors were also the outcome of a discussion, no doubt sometimes difficult, of which they also revealed

⁴⁷ Die Chirurgie des Heinrich von Mondeville, ed. Pagel (nt. 31), 127.

⁴⁸ Cf. *supra*, nt. 26.

⁴⁹ For traces of orality, cf. Wickersheimer, *Les secrets et les conseils de maître Guillaume Boucher* (nt. 25), 216 n. 2, 227 n. 14, 230 n. 15, 236 n. 30, 237 n. 33, 239 n. 35.

⁵⁰ J. Théry, *Moyen Âge*, in: P. Perrineau/D. Reynié (eds.), *Dictionnaire du vote*, Paris 2001, 667–678.

only the consensual result. In a spirit of fairness, each party “promised and convened” (*promisit et convenit*) the content of the pact. The agreement mainly defined the duration of the treatment, the conditions of care, the expected result, and the price to be paid. However, it was often supplemented by a series of clauses, sometimes different from one contract to another, suggesting complicated discussions to reach an agreement. If their aim was to reduce the risks inherent to a science that was by no means infallible, they were also testimony to mutual obligations and the sharing of responsibilities⁵¹: as Henri de Mondeville summarised after Galen, “the cure of an illness depends on the doctor, the patient, the assistants and external accidents, and the surgeon is responsible for only a quarter of the cure”⁵². According to the medieval conceptions of healing, the patient was also a protagonist in his or her own health. He or she had to follow the doctor’s instructions, especially regarding diet. This was a crucial point that was often beyond the doctor’s control if he did not live in the patient’s home⁵³. It is therefore not uncommon to find, for example, clauses specifying the diet to be followed as part of the therapeutic treatment.

Such clauses were designed to make the patient responsible and to protect the doctor in case of non-retribution. Obviously, the pacts sought to limit the risks for both parties: the risk of mistreatment, unsatisfactory results, and relapse on the one hand, and non-payment on the other. Thus, from one contract to the next, and beyond the use of a notarial form, we sometimes read a wide variety of provisions that were the result of these negotiations: the patient could be obliged to visit the caregiver at regular intervals or to pay a deposit for medicines; the practitioner could undertake to treat the patient again in the event of a relapse, to be held responsible or not in the event of death.

All these decisions testified to a mutual desire to provide as much as possible for anything that might invalidate the contract and to precisely define the expectations of care and treatment⁵⁴. This type of contract, as medieval jurists often said, was a commitment to results rather than to means⁵⁵. This may also explain why contracts seem to have been concluded more often with surgeons and barbers than with physicians, i. e., with those for whom it was easier to measure the result achieved. However, because of the uncertainties and dangers of surgical operations, in some cases it seems that the pacts did not offer to “treat and cure” (*sanare et guarire*), but simply to improve the patient’s health by describing

⁵¹ D. Jacquart, De la faillibilité de l’art médical aux erreurs du praticien au début du XIV^e siècle: une imperceptible marge, in: M. Gadebusch Bondio/A. Paravicini Bagliani (eds.), *Errors and Mistakes. A Cultural History of Fallibility* (Micrologus Library 49), Firenze 2012, 129–146.

⁵² Die Chirurgie des Heinrich von Mondeville, ed. Pagel (nt. 31), 11.

⁵³ M. Nicoud, Governing Health: The Doctor’s Authority, the Patient’s Agency, and the Reading of “Regimina sanitatis” Literature, in: *Early Science and Medicine* 28 (2023), 8–33.

⁵⁴ Cf. M. Nicoud, Salute, malattia e guarigione. Concezioni dei medici e punti di vista dei pazienti, in: *Quaderni storici* 136/1 (2011), 47–74.

⁵⁵ For instance, in Bartolus of Sassoferrato (1313–1357): “*medici [...] salarium ab infirmis non debent recipere nisi cum sanati fuerint*” (quoted by Sandrini, *La professione medica* [nt. 14], 58, nt. 29).

precisely the actions that the patient would be able to perform again after the treatment. For example, in this pact signed in Genoa in 1244 between a woollen craftsman and an empiric from Bergamo:

“I, Roger de Bruch of Bergamo, promise and agree with you, Bosso, woollen craftsman, to cure you and to improve the infirmity that affects your person, that is to say your hand, foot and mouth, in good faith and with all the help of God, from now on, in the next month and a half, in such a way that you will be able to feed yourself with your hand, cut bread and kick (tread), move better and speak as you don’t [currently].”⁵⁶

The same type of detail can be found in contracts with doctors, as in Bologna in 1316, where the master Johannes de Anglio took charge and undertook the care and cure of a certain Bertoluccio, a citizen of the city, for 40 days, until the latter experienced a feeling of convalescence and improvement (of his condition), so that he could perform a certain number of gestures by himself⁵⁷. The price of the care, 50 gold florins, also justified the length of the notarial pact.

The state of health was described in simple terms. It allowed the patient to measure his or her condition and to assess whether the treatment was successful. It also helped to know whether the practitioner should be paid, since the remuneration was in fact dependent on the result defined in the contract, the fruit of the agreement between the two contracting parties. Non-retribution was a leitmotif in medical literature, which often insisted on the ingratitude of patients once they had been cured. For this reason, Gilles de Corbeil proposed that this contract be made with a guarantee and that it be made when the patient was suffering, because:

“After that moment, when the pain has subsided, the cold torpor of greed returns, the desire to give cools, the doctor becomes unbearable and his presence annoying. The patient, ungrateful, thinks only of belittling what the doctor has done, disapproving of his *modus operandi*, diminishing his merits, forcing him to leave empty-handed in the end.”⁵⁸

While the agreement served to ensure payment for care and to remind us that the medical act is also an economic act, it also aimed to construct a medical truth essential for decision-making. Consensus could then also take on a performative dimension.

⁵⁶ C. Mancini, Un singolare contratto del 1200, in: Atti e memorie dell’Accademia di Storia dell’Arte Sanitaria. Serie II 36/2 (1965), 47 sq. Quoted by Pomata, La promessa di guarigione (nt. 14), 349 sq.

⁵⁷ Pomata, La promessa di guarigione (nt. 14), 350 sq.: “[...] *sapiens vir dominus magister Johannes de Anglio medicus asumpsit et suscepit curam et medicam nobilis viri domini Bartolucci nati quondam domini Guidonis de Samaritanis civis Bononiensis fiendam per magistrum Johannem pro quinquaginta florensis boni et puri auri [...] usque ad quadraginta dies proxime securos sentiet convalescentiam et melioramentum tali modo, quod poterit aliquantulum ducere manum, brachium, pedem, cossam cum tibia ac se fibullare et se calciare cum manu predicta et se lavare manum sanam cum manu nunc patiente [...]*”

⁵⁸ Gilles de Corbeil, Liber de uirtutibus, ed. Ausécache (nt. 20), vv. 1618–1624.

III. Uses and purposes of consensus

This performative value of consensus is somehow proven *a contrario* by an episode recounted by the chronicler Juvenal des Ursins about one of King Charles VI's crises in 1399:

“In that year, (Charles VI) fell into insanity six times [...]. The Dukes of Berry, Burgundy and Bourbon were anxious to know the cause of the king's illness, and they summoned all the masters of the University of Paris and others. The question was put in these terms, and in particular whether the illness he had came from intrinsic things and causes or from extrinsic accidents. And there were various arguments and reflections. And in the end it was not known what to conclude, and the question remained undecided and without any decision or determination, which did not please the lords.”⁵⁹

A few years earlier, the same chronicler reported that “on several occasions the king's physicians were brought together with other physicians who had been sought in other places. But they could not find the cause of the disease, nor the means to cure it”⁶⁰. While indecision was somehow synonymous with inaction, consensus was a necessary condition of medical practice that involved patients and caregivers in various ways.

In his commentary on the first ‘Aphorism’ of Hippocrates, the Bolognese professor Taddeo Alderotti (d. 1295) defined the roles of the two parties as follows: “the doctor must intervene as he should and the patient must be obedient”⁶¹. Firstly, the agreement between the practitioners allowed decision-making and therapeutic action: as the German student repeatedly pointed out, it was based on this collective discussion (*habito consilio*) that the Parisian masters applied their therapy or ordered treatment⁶². Secondly, it facilitated the patient's obedience. This obedience, which was essential for the success of the treatment, was also perceived as an obligation by the patients. Several letters from the Lombard Chancellery insist on this point: when she was ill, the Duke advised his wife Bianca Maria to “pay attention to the advice of the doctors, to what they will say and order”⁶³; during the long attack of dropsy from which Frances-

⁵⁹ Guenée, *La folie de Charles VI* (nt. 25), 127.

⁶⁰ Jean Juvenal des Ursins, *Chronique de Charles VI, roi de France*, ed. J. Blanchard/S. Cazalas, Paris 2022. Another chronicle, written by Michel Pintoin, also mentions the many physicians, most of whom came from the Parisian faculty, who tried to cure the king through numerous consultations and discussions (*multas collaciones*). The lack of results led to the intervention of two magicians at the king's bedside who, due to the failure of their treatment, ended up being burnt alive.

⁶¹ Taddeo Alderotti, *Expositiones in arduum Aphorismorum Iprocratis volumen*, Venetiis 1527, fol. 2vb: “[...] *quod medicus operetur sicut oportet et infirmus sit obediens et ministri eius sint idoneos et res extrinsece sint sicure oportet*”. On Taddeo Alderotti, N. G. Siraisi, *Taddeo Alderotti and his Pupils. Two Generations of Italian Medical Learning*, Princeton, NJ 1981.

⁶² Cf. *supra*, nt. 44.

⁶³ Nicoud, *Le prince et les médecins* (nt. 29), 297 sq., nt. 107: “[...] *confortando et pregando quella voglia attendere a fare lo consilio dessi medici et quanto dirano et ordinarano*”.

co Sforza suffered in 1461–1462, the Mantuan orator at the Sforza court, Vincenzo della Scalona, regularly informed the marchioness Barbara of Brandenburg, writing that “if he allows himself to be governed, there is no doubt that he will return to good health, but it is necessary not to neglect the orders”⁶⁴. The court physician Giovanni Matteo Ferrari (d. 1471) warned Galeazzo Maria Sforza about the attitude of certain recalcitrant patients, who were responsible for their illnesses because of their disobedience, so that he would not adopt the same behaviour⁶⁵.

However, this obedience did not mean a passive attitude⁶⁶, but rather an acceptance of the doctor’s decisions. In a way, it was similar to an “informed consent” before the letter, which could not exist without a consensus that covered the actions, procedures, expectations, and obligations of everyone. It could even be necessary in the case of particularly painful and invasive procedures. Henri de Mondeville therefore recommended asking the patient “if he is willing to endure all this art, cautery and others, if necessary”⁶⁷. It was therefore necessary to specify in contracts what the patient could expect from the treatment and how it would be managed. As Danielle Jacquart reminds us, “il s’agit d’abord de ménager la sensibilité du malade et de son entourage, afin de maintenir la confiance nécessaire au succès de la cure. Il s’agit aussi de ne pas laisser s’installer le doute sur la fiabilité du savoir mis en œuvre”⁶⁸. All these elements, consensus, trust, and obedience created the necessary conditions for a successful cure, thus reassuring the patient about the practitioners’ abilities and making him hope that the outcome of the treatment would match the initial prognosis.

The way in which the contracts were drafted was aimed at establishing a relationship of trust, without which there could be no obedience⁶⁹. In fact,

⁶⁴ Cf. Carteggio degli oratori mantovani alla corte sforzesca (1450–1500), vol. 4: 1462, ed. I. Lazzarini, Roma 2004, 101, letter 50: “*Da uno delli intendenti m’è dicto che s’el si lassará gubernare non è più da dubitare nol redrizano a buon termine, ma tamen non bisogna desistere de li remedii, ni che sua excellentia manchi dal ordine*” (Milan, January 30, 1462).

⁶⁵ H.-M. Ferrari, Une chaire de médecine au XV^e siècle. Un professeur à l’Université de Pavie, de 1432 à 1472, Paris 1899, ²1977, 319–320, letter 39: “*Per che accadendo molte volte ad infermi alcuni accidenti de li quali ne per medicina ne per altra via si puo trovare la caxone, essendo la piu parte de li infermi prevaricatori de li comandamenti de medici [...]*”.

⁶⁶ F. Salmón, The Physician as Cure in Medical Scholasticism, in: I. Csepregi/Ch. Burnett (eds.), *Ritual Healing. Magic, Ritual and Medical Therapy from Antiquity until the Early Modern Period* (Micrologus Library 48), Roma 2012, 193–215.

⁶⁷ Die Chirurgie des Heinrich von Mondeville, ed. Pagel (nt. 31), 112. This question is part of a set of questions addressed to the patient in case of certain pathologies.

⁶⁸ D. Jacquart, Du genre des secrets dans la médecine médiévale, in: *Micrologus* 14 (2006), 345–357, at 346; reprinted in: D. Jacquart, *Recherches médiévales sur la nature humaine: essais sur la réflexion médicale* (Micrologus Library 63), Firenze 2014, 181–194.

⁶⁹ Cf. supra, nt. 23. Cf. also T. Duranti, Doctor and Patient: Two Actors in the Medieval Therapeutic Relation, in: M. Malatesta (ed.), *Doctors and Patients. History, Representation, Communication, from Antiquity to the Present*, San Francisco, CA 2015, 49–77; T. Duranti, “*Confidentia tamen de medico debet precedere*”. La fiducia verso i medici tra pieno Medioevo e prima età moderna, in: M. Malatesta (ed.), *L’invenzione della fiducia. Medici e pazienti dall’età classica a oggi*, Roma 2021, 59–80.

neither the titles nor the reputation of the practitioners, nor a science of uncertain knowledge, were sufficient to create the necessary conditions for trust⁷⁰. As Gentile da Foligno (d. 1348), a professor in Perugia, acknowledged: “It may happen that the most expert physician (*medicum peritissimum*) in this art is mistaken, so that not everything is known with certainty”⁷¹. Medical science was uncertain because it dealt with special cases in which medical reasoning sometimes faced ambiguous signs or relied on the subjective perception of the patient⁷². Sometimes knowledge could only be gained through conjecture.

Therefore, the greatest caution was required, especially regarding the pledge of healing. The doctor should not promise what he knew he could not do, in order to avoid false hopes on the part of the patient. Many authors echo this advice of caution, such as the two Masters of Montpellier, Bernard of Gordon (d. around 1320) and Guy of Chauliac (d. 1368), who advised against making false promises, which could also lead to the doctor’s disgrace⁷³. According to learned physicians, this prudence distinguished the true *medicus* from the charlatans. It was intended to inspire the patient’s and his family’s trust in the caregivers. This confidence was also considered a therapeutic tool, because it helped the practitioners conduct their treatment under the best conditions and, at least in theory, successfully⁷⁴. It was also based on medical consensus, a guarantee of a shared opinion among colleagues and of more reliable knowledge. This unanimous opinion was synonymous with truth, at least in the short term.

But consensus also served other purposes. First, it facilitated the integration of students in training into the group of doctors, since the *collatio*, understood as a means of perfecting their training, allowed them to speak within a collective to which they aspired; second, it reinforced the cohesion of the community, its legitimacy, its authority, and even its identity. As Henri de Mondeville reminded us, *collatio* could only involve people who were friends and of the “same sect”: such as the court physicians of Milan, whom Benedetto Reguardati called “*padri*”. They were all professors in Pavia, and in their collective letters they asserted their status as physicians (*physici*), specialists in natural philosophy (Tafel 1–2). Finally, consensus was synonymous with commitment and obligation, as evi-

⁷⁰ J. Chandelier, L’expert peut-il se tromper? La médecine scolastique face à ses limites à la fin du Moyen Âge, in: Histoire, médecine et santé 18 (2020), 63–78.

⁷¹ Gentile da Foligno, Commentarium in Canonem medicinae Avicennae, Prohemium, Venetiis 1520, fol. 3ra. Quoted by Chandelier, L’expert (nt. 70).

⁷² L. Loviconi, Le diagnostic différentiel au Moyen Âge. Distinguer les maladies d’apparence voisine, Paris 2020.

⁷³ London, British Library, Harley MS 3698, fol. 33r: “*Nolite debonestare vos ipsos cum vanis et falsis promissionibus*”. Guignonis de Caulhiaco Inventarium sive Chirurgia magna, ed. R. McVaugh, vol. 1: Text, Leiden e. a. 1997, 3: “*Et hoc est facere quod est possibile, et non propter pecuniam promittere impossibilia. A malis curis et a falsis promissionibus caveas, ne nomen mali medici subeas neque super corpus tuum accipias*”. Cf. also D. E. J. Linden, “De cautelis medicorum” and the Tradition of Medical Prudence, in: Bulletin of the History of Medicine 73 (1999), 19–37.

⁷⁴ On the explanation of the role of trust, hope, and, more broadly, positive emotions in the success of the cure, cf. Salmón, The Physician as Cure (nt. 66).

denced by the promises and agreements made in contracts and medical correspondence.

If it often seemed indispensable to the practice of medicine, it was also because consensus was the result of constraints⁷⁵: those inherent to the modalities of medical care and to practice in a court environment, where practitioners were the stipendiaries of the princes. While the ‘Conseils de Guillaume Boucher’ sometimes suggest disagreement between the masters (one of them pursuing the treatment he had recommended alone, while his colleagues turned their backs on the case⁷⁶), the letters from the Lombard chancellery always convey the image of a united group. There is no trace of competition or division, despite the different salaries. This could suggest a strong cohesion, where the common interest took precedence over individual interest, because consensus protected the medical staff to a certain extent.

There was also an interest in making this common view public, especially in the court milieu where rumours were common, and the health of princes was a political issue. Publicity, through oral correspondences or a contract signed before a notary, reinforced the effectiveness of the consensus⁷⁷, even though it could always be challenged: whether it was to review a medical judgment or correct a treatment, or whether it was to denounce the promise of a cure for an unobtained recovery or for non-payment in court.

Consensus, which was a determining factor in medieval medical practice, expressed a medical truth through a convergence of ideas and wills. It did not mean a completely equal relationship between the two parties of a healing contract or of the discussion at the patient’s bedside, where, on the contrary, the *collatio* was organised by the eminent physician and revealed hierarchical relationships. Debate, and possibly disagreement, was essential in the process of reaching a consensus, which could express a potentially tense relationship between those who knew and those who paid. In this sense, it was not a passive adherence to a decision, but a real involvement of the parties. It implied mutual obligations between patients and practitioners, or the corporate responsibility of professionals at the bedside. In other words, consensus was also the result of constraints and, in turn, it produced new constraints. At the same time, it was the basis on which a relationship of trust could be built and through which doctors and surgeons could establish themselves as figures of authority and

⁷⁵ D. Jacquart, De la “practica” à la pratique médicale effective à la fin du Moyen Âge, in: J. Chandelier/C. Verna/N. Weill-Parot (eds.), *Science et technique au Moyen Âge (XII^e–XV^e siècle)*, Saint-Denis 2017, 293–304.

⁷⁶ For instance, Wickersheimer, *Les secrets et les conseils de maître Guillaume Boucher* (nt. 25), 251 n. 47.

⁷⁷ C. Dourlens, Consensus, in: E. Henry/C. Gilbert/J.-N. Jouzel/P. Marichalar (eds.), *Dictionnaire critique de l’expertise (Références)*, Paris 2015, 79–86.

legitimacy. Keeping discussions and possible disputes secret and organising the debate away from the patient and his or her entourage, in some ways dramatised the medical decision and also helped reinforce medical authority.

If consensus was involved in the decision-making process and was an essential prerequisite for the medical act, because it also had the value of a commitment, it could have a limited lifespan, even in writing. It could always be challenged by one of the parties: whether it was a question of revising a medical judgement or correcting a treatment because of the patient's condition, or because of new circumstances, which could justify new negotiations and new strategies to convince the patient to continue to be treated by the same caregiver; or whether it was a question of denouncing the promise of a cure in court because of an unattained recovery or default of payment. Consensus was only effective as long as it was not formally challenged⁷⁸.

⁷⁸ For instance, cf. Pomata, *La promessa di guarigione* (nt. 14) and Leuwers, *Les praticiens de santé devant la justice* (nt. 18).